HEALTHCARE
PURCHASER
ALLIANCE
OF MAINE

Testimony of Trevor Putnoky
to the Joint Standing Committee on Health Coverage, Insurance and Financial Services

In Opposition to

LD 1496, An Act to Ensure Ongoing Access to Medications and Care for Chronic Conditions and Conditions Requiring Long-term Care by Changing Requirements for Prior Authorizations

April 24, 2025

Good afternoon Senator Bailey, Representative Mathieson, and Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services.

My name is Trevor Putnoky. I'm the President and CEO of the Healthcare Purchaser Alliance of Maine and I'm here today to testify in opposition to LD 1496. The HPA is a nonprofit that represents the purchasers of health care in Maine. Our mission is to advance and support access to high-quality, affordable care. We have over 60 members, including some of the largest public and private employers and health trusts in Maine. Collectively, our members spend over a billion dollars annually providing health care for nearly one quarter of the commercially insured population in the state.

I agree with Rep. Zager that we need to fix burdensome prior authorizations. Those processes should be as streamlined, cost-efficient, and prompt as possible, so that clinicians can focus their time on patient care and patients can access needed services and medications without having to jump through unnecessary and frustrating bureaucratic hoops. But at the same time, plan sponsors need to know that plan dollars are supporting appropriate and cost-effective interventions, as overuse and low-value care are well documented problems in the US healthcare system.[1] And that inappropriate and low-value care doesn't just increase costs to plan sponsors, it also hurts patients, who bear some of those unnecessary costs in the form of higher member cost sharing and premiums.

I also share the sponsor's goal of trying to ensure continuity of care for patients facing chronic and other long-term conditions that require ongoing treatment. On that point, we support the provision in the bill that would require a new plan to cover for 90 days a prescription or service that has a prior authorization from a previous plan.

---

[1] Daniel P. O'Neill, David Scheinker, "Wasted Health Spending: Who's Picking Up The Tab," *Health Affairs,* May 31, 2018. Available at: https://www.healthaffairs.org/do/10.1377/forefront.20180530.245587/full/; BE Lehnert and RL Bree, "Analysis of Appropriateness of Outpatient CT and MRI Referred from Primary Care Clinics at an Academic Medical Center: How Critical is the Need for Improved Decision Support?" Journal of the American College of Radiology, 2010. Available at: https://www.jacr.org/article/S1546-1440(09)00589-4/fulltext; Heather Lyu, Tim Xu, et. al, "Overtreatment in the United States," PLOS ONE, September 2017. Available at: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181970; and Laura Dyrda, "Wal-Mart adds Mayo Clinic to spine centers of excellence, 50% copay for out-of-network care," *Becker's Spine Review,* November 16, 2016. Available at: https://www.beckersspine.com/spine/33671-walmart-adds-mayo-clinic-to-spine-centers-of-excellence-50-copay-for-out-of-network-care.html.

While that provision seems to be an improvement on current PA practices, we have significant concerns with other provisions in the bill. Specifically, while patients' conditions are sometimes chronic, treatment of those conditions is not necessarily static, and I'm concerned that LD 1496 would limit plans' ability to ensure that management of long-term and chronic conditions reflects the most up-to-date protocols and leverages the most cost-effective medications available. Of specific concern, the bill would allow open-ended prior authorizations that could last as long as five years, or indefinitely, as "duration of treatment" for a chronic condition would conceivably last for the patient's lifetime. A patient struggling with chronic low back pain, for instance, could be approved for physical therapy indefinitely.

I'm also afraid the bill would restrict a plan from moving patients to more cost-effective medications when appropriate. As I'm sure you're aware, new drugs become available all the time, and I would be concerned about situations where a patient is approved for an expensive medication, and one year later a new biosimilar that's a fraction of the cost becomes available. Under LD 1496, it appears that plans would be prohibited from shifting patients to that more cost-effective option. If the committee opts to limit prior authorizations for prescription medications, we would urge you to allow for more frequent prior authorizations in cases where less expensive versions of a medication become available.

Moreover, while we agree that provider judgement and expertise is paramount when determining a patient's treatment, the fact remains that overuse and low-value care do occur. For instance, a 2018 *Health Affairs* article estimated that nearly 8% of commercial payer dollars in 2016 was spent on overtreatment.[2] Another study of elective outpatient CT and MRIs found that 26% were not considered appropriate.[3] Even surveyed physicians said that they believed over 20% of medical care is unnecessary.[4] LD 1496 would severely restrict plans' ability to conduct prior authorizations that can guard against inappropriate or low-value care provided to patients with chronic conditions or conditions that require long-term care.

It's also unclear why the bill would limit prior authorizations to once every five years for treatments that may only be necessary for a year or two. What is the rationale for extending a prior authorization beyond the time frame that a treatment regimen is actually needed? Even patients with long-term or chronic conditions sometimes receive discrete, rather than long-term, treatments that would not warrant five-year, or even one year PAs, as proposed under the bill. Additionally, Section 1 of the bill states, "if health care services for the treatment of a chronic condition or a condition requiring long-term care are necessary for more than one year, a utilization review entity may not require the renewal of the prior authorization more frequently than once every 5 years." Who would decide whether those services are necessary for more than a year? The carrier? The provider?

We welcome the opportunity to work with stakeholders to address provider concerns, but we believe that any solutions must also preserve plan sponsors' ability to ensure that plan dollars are used to support

---

[2] Daniel P. O'Neill, David Scheinker, "Wasted Health Spending: Who's Picking Up The Tab," *Health Affairs*, May 31, 2018. Available at: https://www.healthaffairs.org/do/10.1377/forefront.20180530.245587/full/.

[3] BE Lehnert and RL Bree, "Analysis of Appropriateness of Outpatient CT and MRI Referred from Primary Care Clinics at an Academic Medical Center: How Critical is the Need for Improved Decision Support?" Journal of the American College of Radiology, 2010. Available at: https://www.jacr.org/article/S1546-1440(09)00589-4/fulltext.

[4] Heather Lyu, Tim Xu, et. al, "Overtreatment in the United States," PLOS ONE, September 2017. Available at: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181970.

appropriate and cost-effective care. As currently drafted, the restrictions proposed in LD 1496 would severely limit the tools that plan sponsors rely on to effectively manage their plans.

Thank you for the opportunity to share the HPA's views on LD 1496 and thank you to Rep. Zager for continuing to explore ways to streamline prior authorizations for both providers and patients. I'd be happy to answer any questions and will be available for the work session.