Senator Bailey, Representative Perry and distinguished members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services, I am Sarah Calder, Senior Government Affairs Director at MaineHealth, and I am here to testify in strong support of LD 796, “An Act Concerning Prior Authorizations for Health Care Provider Services.”

MaineHealth is an integrated non-profit health care system that provides a continuum of health care services to communities throughout Maine and New Hampshire. Every day, our almost 23,000 care team members support our vision of “Working Together so Our Communities are the Healthiest in America” by providing high-quality and efficient care, which is demonstrated by the numerous national quality recognitions our hospitals have received and the fact that Maine was recently named as “Top State of the Decade for Patient Safety” by Leapfrog.

Prior authorizations place a significant and expensive burden on practices, but, more importantly, prior authorizations can result in a delay of care for our patients. MaineHealth and our providers have stood before this Committee numerous times and shared examples of how prior authorizations do not support evidence-based medicine, represent a very expensive administrative cost to the health care system, and are a large factor in physician burnout. The legislation before you today will provide you with the data to prove just how pervasive the problem is. With this data, we hope that the Legislature can enact meaningful change for our patients.

In addition to data collection, this bill will make immediate improvements for our providers and their patients:

Sec. 7. 24-A MRSA §4304, subsection 2

E. For nonemergency services provided without a required prior authorization approval, a carrier may not deny a claim for covered nonemergency services that were medically necessary. The carrier may not impose a penalty of greater than 10 percent of the contractually allowed amount for failing to obtain a prior authorization.

This provision addresses the cases where we provide medically necessary care and only learn that prior authorization was required after the claim
has been denied and the care has already been provided. For example, our team called a carrier to receive prior authorization for a neurostimulator battery replacement and was informed by the carrier that the code did not require authorization. The procedure was performed, and the surgery was paid by the carrier, but the battery replacement was denied as it required authorization. It was only after appeal, mid-level, and senior-level escalation that the denial was overturned; however, in other cases, payers have refused to allow retro-authorization, resulting in write-offs of over $100,000 per case.

F. In the event that covered medically necessary service cannot be delivered on the approved date of an approved prior authorization request, a carrier may not deny the claim if the covered medically necessary service is provided within 14 days before or after the approved date.

This section addresses the cases where prior authorization was obtained and approved, but the procedure was not completed on the originally scheduled and approved date. A very common example of this is that a patient failed to fast before surgery and the surgery is rescheduled for days later. Payers often uphold their denial and advise that medical necessity does not negate the provider’s responsibility to obtain authorization.

In November 2022, when school shootings were reported across the state, Maine Medical Center and Southern Maine Health Care cleared their operating rooms to respond to the reports of mass casualties in Sanford. As we all know now, those reports were, thankfully, found to be hoaxes, but the surgeries that were originally scheduled that day required new authorizations because they were not performed on the approved date.

Sec. 8. 24-A MRSA §4304, subsection 5

B. The medical necessity of emergency services may not be based on whether those services were provided by participating or nonparticipating providers. Restrictions on coverage of emergency services provided by nonparticipating providers may not be greater than restrictions that apply when those services are provided by participating providers.

MaineHealth contracts with over 22 payers and it can take up to 120 days or more to fully enroll a provider with all contracted payers. This provision addresses the instances where a provider may be caring for patients, but not yet fully enrolled with all contracted payers. For example, a patient presents to the Emergency Department complaining of abdominal pain and it is determined that the patient has ovarian torsion and needs emergency removal of the impacted ovary. If the on-call OB-GYN specialist does not yet participate with the patient’s insurance, the
restrictions on coverage should be the same as if the procedure was performed by a participating provider.

C. If an enrollee receives an emergency service that requires immediate post-evaluation or post-stabilization services, an insurer may not require prior authorization for the post-evaluation or post-stabilization services provided during the same encounter. If the post-evaluation or post-stabilization services require an inpatient level of care, the insurer shall make a utilization review determination within 60 minutes of receiving a request for those services. If the authorization determination is not made within 60 minutes, then the services for which the utilization review was requested is deemed approved until the insurer affirmatively notifies the provider otherwise.

For example, a trauma patient presents to the Emergency Department, and the first priority to address medically is their collapsed lungs. Following stabilization, the patient is subsequently brought to the operating room to repair a fracture of their femur and admitted to the hospital to manage their pain and additional injuries. While not an emergency service, the repair of the fractured femur could not have waited 72 hours (which is currently in statute) for a carrier to respond to an authorization request.

It is important to note that in the examples provided throughout my testimony, it is unlikely that the patient was aware that their care was not covered due to a lack of authorization. It is for that reason that we are recommending amendment of the current statute to explicitly allow a provider to file a grievance on behalf of their patient and the right to file a complaint with the Bureau of Insurance.

Thank you for your consideration and I urge you to vote Ought to Pass on LD 796. I would be happy to answer any questions you may have.