

BUREAU OF INSURANCE

BASIS STATEMENT AND SUMMARY OF COMMENTS
AMENDMENTS TO RULE CHAPTER 850
HEALTH PLAN ACCOUNTABILITY

In this rulemaking, Superintendent of Insurance Eric Cioppa adopts amendments to Chapter 850, “Health Plan Accountability.” Pursuant to a November 27, 2019 Notice of Rulemaking, Superintendent Cioppa held a public hearing on December 17, 2019, and the public comment period was open until December 30, 2019 at 4:30 p.m. The primary purpose of the amendments is to conform the rule to changes made to the Health Plan Improvement Act by legislation enacted during the First Regular Session of the 129th Maine Legislature. The legislation specifically authorizes routine technical amendments to achieve this purpose. The legislation is as follows:

- P.L. 2019, ch. 171, “An Act To Ensure Protection of Patients in Medical Reviews by Health Insurance Carriers,” which amended the clinical peer requirements for carriers’ medical reviews;
- P.L. 2019, ch. 238, “An Act To Protect Patients and the Prudent Layperson Standard,” which amended the requirements for coverage of emergency services and defined “emergency service” and “emergency medical condition”; and
- P.L. 2019, ch. 273, “An Act Regarding the Process for Obtaining Prior Authorization for Health Insurance Purposes,” which amended the requirements for prior authorization of nonemergency services. In addition, an unallocated provision of Chapter 273 directed the Superintendent to amend Chapter 850 to replace the term “urgent care” with the term “exigent circumstances” and to require review within 24 hours in exigent circumstances.

For the reasons discussed below, the amendments are adopted as proposed.

A. The following persons testified at the hearing:

Nancy H. Johnson, JD, CLU, ChFC, AIE
Vice President
Community Health Options

B. The following persons submitted written comments on or before December 30, 2019:

Hilary Schneider
Government Relations Director, Maine
American Cancer Society Cancer Action Network

Andrew B. MacLean, JD
CEO
Maine Medical Association

Nancy H. Johnson, JD, CLU, ChFC, AIE
Vice President
Community Health Options

C. Summary of comments and Bureau of Insurance responses

1. General Comments

Comments: The Maine Medical Association (“MMA”) and the American Cancer Society Cancer Action Network (“ACS CAN”) expressed support for the Bureau’s proposed amendments to the rule.

ACS CAN supports the changes to the laws authorizing the proposed amendments, believing these changes make “significant improvements that will reduce barriers patients with private insurance coverage were facing in obtaining access to timely, appropriate care recommended by their health care team.” ACS CAN noted that utilization review and appeals “cost money and cause undue stress,” adding up to “potential delays in care, which can lead to progression of disease, avoidable side effects, or less effective treatment of disease.” ACS CAN stressed the importance of “greater clarity and transparency in the utilization review process, as well as reduced decision timelines,” particularly for cancer patients.

MMA pointed out that it was the principal moving party for two of the laws authorizing the proposed amendments, P.L. 2019, ch. 171 and 273, and that the Maine Chapter of the American College of Emergency Physicians was the principal moving party for P.L. 2019, ch. 238. MMA commented that both organizations appreciate the Bureau’s efforts to amend the rule to reflect these statutory changes.

Bureau Response: The Bureau appreciates the commenters’ support of the proposed amendments.

2. Sections 1, 2, and 12

The authority, purpose, and effective date provisions have been updated to reflect the current rulemaking process. No comments were received on these sections.

3. Section 5, subsection H

The definition of “clinical peer” has been amended to remain consistent with the statutory definition, 24-A M.R.S. § 4301-A(4), which was amended by P.L. 2019, ch. 171, to strengthen the clinical requirements, and also to add a conflict of interest test, under which a practitioner is not considered a clinical peer if the practitioner’s compensation “depend[s], directly or indirectly, upon the quantity, type or cost of the medical condition, procedure or treatment that the ... practitioner approves or denies on behalf of a carrier.”

Comment: Community Health Options (“CHO”) stated that it has no compensation agreements with any individual practitioner, and requested “clarification” that even though “performance-based risk arrangements [are] not permitted at the level of an individual practitioner,” that “does not prohibit a performance-based risk arrangement

with a Utilization Review Organization so long as no Clinical Peer has direct or indirect compensation based upon the decisions made by the practitioner.”

Bureau Response: CHO correctly observes that the compensation standard in the statutory definition of “clinical peer” applies only at the practitioner level, not to a contract between a carrier and a utilization review entity (URE). Therefore, whether a particular “performance-based risk arrangement” might result “directly or indirectly” in prohibited practitioner compensation would require an analysis of the facts of the particular arrangement and is not a question that can be answered here on a blanket basis. Carriers should also be mindful that their responsibilities under Section 8 of the Rule for the activities of their contracted UREs are not limited to ensuring that utilization review is conducted by clinical peers of the treating provider. In particular, Paragraph 8(D)(9) provides that “Compensation to persons providing utilization review services for a health carrier or the carrier’s designated URE may not be based on the quantity of adverse health care treatment decisions rendered, or otherwise include incentives for reviewers to render inappropriate review decisions.”

4. Section 5, subsections O and P

The definitions of “emergency medical condition” and “emergency service” have been amended for consistency with the new statutory definitions, 24-A M.R.S. § 4301-A(4-A) & (4-B), which were added to the Health Plan Improvement Act by P.L. 2019, ch. 238. No comments were received on these amendments.

5. Section 5, subsections Q-1 & QQ; Section 8, subsection E, paragraphs 2, 3, & 6; Section 9, subsection A, paragraph 9

A new definition of “exigent circumstances” has been added, the definition of “urgent services” or “urgent care” has been revised, and conforming amendments have been made in several places within the body of the Rule, in accordance with P.L. 2019, ch. 273, § 4(2), directing the Superintendent to amend the Rule to “replace the term ‘urgent care’ with the term ‘exigent circumstances.’” The definition of urgent services/urgent care was revised rather than repealed because the Rule also contains several provisions requiring access to urgent services and timely provision of urgent care. Absent exigent circumstances, the carrier must now render its decisions within 72 hours or 2 business days, whichever is less. This deadline generally runs from the carrier’s receipt of the request, but is extended, as discussed more fully in the second comment below, if additional information or outside consultation is requested. In exigent circumstances, the deadline is now 24 hours. In addition to the substantive amendments to Subsection 8(E), former Paragraph 8(E)(2) has been broken into two paragraphs: Paragraph 2 now applies only to the standard timeframe, and new Paragraph 3 addresses exigent circumstances. Former Paragraphs 3 through 7 have been renumbered as 4 through 8.

Comment: CHO asserts that “exigent circumstances,” within the meaning of the Health Plan Improvement Act, can only exist in the context of a request for an exception to a carrier’s prescription drug formulary. CHO bases its interpretation on the following

language in 24-A M.R.S. § 4304(2): “Except for a request in exigent circumstances as described in section 4311, subsection 1-A, paragraph B, a request by a provider for prior authorization of a nonemergency service must be answered by a carrier within 72 hours or 2 business days, whichever is less, in accordance with this subsection.” Section 4311 establishes standards for access to prescription drugs, and has no application outside that context. Therefore, according to CHO, the phrase “request in exigent circumstances as described in section 4311” can only refer to requests relating to prescription drug coverage and not to other medical authorizations. Furthermore, CHO contends that the requirement to respond within 72 hours or 2 business days should likewise apply only to requests for access to non-formulary prescription drugs.

Bureau Response: The concept of “exigent circumstances” has been part of the Maine Health Plan Improvement Act since it was first enacted in 1996, and has not been limited to the prescription drug formulary exception process. The first sentence of 24-A M.R.S. § 4303(4)(A)(2) has always required carrier grievance procedures to include “Timelines within which grievances must be processed, including expedited processing for exigent circumstances,” and was not changed by any of the 2019 legislation. Separately, when P.L. 2019, ch. 5 amended the Insurance Code to incorporate various provisions of the Affordable Care Act (ACA) into state law, language was added adopting the ACA’s prescription drug coverage standards, including a definition of “exigent circumstances,” at 24-A M.R.S. § 4311(1-A)(B), that was taken *verbatim* from the ACA prescription drug benefit regulation, at 45 CFR § 156.122(c)(2)(ii).

The amendments to Section 4311 eliminated a conflict between the federal “72 hours or 2 business day” standard for prescription drug appeals and Maine’s pre-ACA “2 working day” standard codified under the previous version of Chapter 850, § 8(E)(2). However, this created a conflict between Rule 850 and the statute, and an inconsistency between the timeframes for prescription drug and medical determinations. The Legislature responded by enacting P.L. 2019, Chapter 273, which amended 24-A M.R.S. § 4304, the utilization review statute that applies generally to medical claims of all kinds, to make both Section 4304 and Chapter 850 consistent with Section 4311, establishing a uniform standard and uniform terminology. Specifically, Chapter 273 changed the deadline in 24-A M.R.S. § 4304(2) to “72 hours or 2 business days,” incorporated Section 4311’s definition of “exigent circumstances” by reference, and directed the Superintendent to amend Chapter 850 to incorporate both the new timeline and the term “exigent circumstances.”

The new statutory definition states that “Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee’s life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.” The core of that definition – a health condition that may seriously jeopardize the enrollee’s life, health or ability to regain maximum function – is a general standard that is an appropriate trigger for expedited review in all contexts. If that were not how the Legislature intended it to apply, they would not have inserted the new language into a statute of general applicability, nor directed the Superintendent to amend a rule of general applicability, without any limiting language at all referencing formulary exceptions or prescription drug requests, especially when the

new definition and timeline had already been in effect for formulary exception requests without the need to amend Section 4304.

It should also be noted that the cross-reference to Section 4311 applies only to the definition of exigent circumstances, not to any of the other provisions of the utilization review law. The 72-hour deadline and the specific procedures and exceptions spelled out in 24-A M.R.S. § 4304(2)(A) through (D) all stand on their own, without any reference to Section 4311, so they would continue to apply in all cases even if expedited review in “exigent circumstances” were limited to formulary exceptions. It is implausible that the Legislature would have intended Chapter 273 to repeal the existing provisions for expedited review outside the prescription drug context, which is further evidence that its intent was to extend the applicability of the new “exigent circumstances” definition, not to limit it.

Comment: CHO noted that Subparagraphs a and b both toll the deadline if the carrier (or its designated URE) requests additional information or determines that outside consultation is necessary. The deadline will then run either from the receipt of the information when additional information is requested, or from the carrier’s initial response when that response is that outside consultation is necessary. CHO recommended that the same “72 hours or 2 business days from receipt of the requested information” standard should apply in both cases, whether the information is requested from the provider or from the consultant.

Bureau Response: The different standards are expressly established by statute. The time frame specified in Subparagraph a is the one required by 24-A M.R.S. § 4304(2)(B), while the time frame specified in Subparagraph b is the one required by 24-A M.R.S. § 4304(2)(C). A carrier seeking outside consultation is granted a much more limited extension of the deadline for decision than a carrier is granted when the provider has failed to submit all the necessary information. The purpose of the statute and the implementing provisions of the Rule is to ensure that these decisions are made promptly. Consistent with that purpose, it is reasonable to place responsibility on the provider for promptly providing all necessary information, while placing responsibility on the carrier for promptly completing any outside consultation process that the carrier itself has initiated. When the carrier notifies the provider that outside consultation is necessary, the provider has the statutory right to “a decision within 72 hours or 2 business days, whichever is less, from the time of the carrier’s initial response,” and only the provider or the patient can waive that right. 24-A M.R.S. § 4304(2)(C).

Comment: CHO further argued that the rule is harmful to enrollees because it fails to give providers adequate opportunity to respond to carriers’ requests for additional information in exigent circumstances, and requested that the 24-hour deadline in Paragraph 8(E)(3) be revised to run from the carrier’s receipt of all necessary information, as to parallel the language in Paragraph 8(E)(2) that applies in the absence of exigent circumstances.

Bureau Response: This is another distinction that is created by statute and cannot be altered by rulemaking, especially routine technical rulemaking that was authorized for the

limited purpose of implementing the recent legislative changes. 24-A M.R.S. § 4304(2)(B), which extends the deadline for review when additional information is requested, does not apply to requests in exigent circumstances. Chapter 273, § 4(2), expressly mandates rulemaking to establish a 24-hour timeline for requests in exigent circumstances, with no exception when additional information is necessary. The purpose of expedited review is to require the carrier and provider to work together quickly when there is an imminent threat to the patient's health.

6. Section 8, subsection F, paragraph 2; subsection G, paragraph 1, subparagraph b & paragraph 2, subparagraph a; and subsection G-1, paragraph 2

The peer review standards have been amended to conform to 24-A M.R.S. § 4304(7), enacted by P.L. 2019, ch. 171, which excludes rescission determinations and initial coverage eligibility determinations from the peer review requirement and permits a provider involved in making the initial adverse decision to participate in an appeal when additional information not previously considered during the initial review is provided on appeal. As formerly worded in Chapter 850, § 8(G)(1)(b), the exception had applied when “the appeal presents additional information the decision maker was unaware of at the time of rendering the initial adverse health care treatment decision.” Language has also been added to clarify that the requirement for the reviewer to be “a clinical peer” means a clinical peer of the treating provider. When the initial adverse determination was not made by a clinical peer of the treating provider, the carrier may not satisfy the peer review requirement on appeal by designating someone who is merely a clinical peer of the reviewer who made the initial decision.

Comment: CHO asked whether the phrase “the treating provider,” when a referral is made to a specialist, means the rendering specialist rather than the requesting practitioner. For example, when prior authorization is denied for a colonoscopy requested by a primary care physician, should the appeal be conducted by a gastroenterologist, not by a primary care physician?

Bureau Response: Yes. We agree that in this referral scenario, the appeal should be conducted by a gastroenterologist.

7. Section 8, subsection H, paragraph 6

This paragraph has been added to incorporate the requirements of 24-A M.R.S. § 4304(5)(A), enacted by P.L. 2019, ch. 238, which establishes standards for utilization review of emergency claims, including a requirement that the review be conducted by a board-certified emergency physician. No comments were received on this paragraph.