Prior Authorization Data for Calendar Years 2021-2023

Prepared by the Maine Bureau of Insurance

February 2025

Janet T. Mills
Governor

Joan F. Cohen
Commissioner

Robert L. Carey
Superintendent

Introduction

The 131st Legislature enacted P.L. 2023, Chapter 680, which directs the Bureau of Insurance to collect prior authorization data from each health insurance carrier for calendar year (CY) 2021 through CY 2023. Per the statute, the Bureau collected the following:

- A list of all items and services that require prior authorization; and
- On an aggregated basis for all items and services subject to prior authorization:
    - The number and percentage of standard prior authorization requests approved;
    - The number and percentage of standard prior authorization requests denied;
    - The number and percentage of standard prior authorization requests approved after appeal;
    - The number and percentage of prior authorization requests for which the time frame for review was extended and the request approved;
    - The number and percentage of expedited prior authorization requests approved;
    - The number and percentage of expedited prior authorization requests denied;
    - The average and median time that elapsed between the submission of a request and a determination by the carrier, for standard prior authorizations;
    - The average and median time that elapsed between the submission of a request and a decision by the carrier for expedited prior authorizations; and
    - The average and median time that elapsed between the submission of a concurrent care prior authorization request to extend a course of treatment and a determination by the carrier.

The Bureau surveyed health insurance carriers with more than 1,000 Maine covered lives for this report, resulting in data from the following six carriers: Aetna Life Insurance Company; Anthem Health Plans of Maine, Inc; Cigna Health and Life Insurance Company; Community Health Options; Harvard Pilgrim Healthcare/HPHC Insurance Company; and UnitedHealthcare Insurance Company.

Based on data submitted by these six health insurers, the number of prior authorization requests per 1,000 member months (MMs) increased 39% over this time period, from 37.6 prior authorization requests per 1,000 MMs in CY 2021 to 52.4 requests per 1,000 MMs in CY 2023. Table 1 below shows the number of prior authorization requests per 1,000 MMs for each health insurer for each year.

Table 1
Prior Authorization Requests Per 1,000 Member Months
CY 2021 - CY 2023

Health Insurer	CY 2021	CY 2022	CY 2023
Aetna Life Ins. Co.	14.9	12.1	14.5
Anthem Health Plans of ME	39.1	44.9	62.5
Cigna	57.0	58.4	64.3
Community Health Options	60.7	61.5	61.7
Harvard Pilgrim Health Care[1]	28.7	28.4	30.6
UnitedHealthCare	23.3	23.3	25.1
Total	37.6	41.4	52.4

[1] - Harvard Pilgrim Health Care includes members covered under HPHC Insurance Co.

Overall, the percentage of standard prior authorization requests approved and denied held relatively stable over these three years, with roughly 87% approved and 13% denied. Insurers must answer a standard prior authorization request within 72 hours or two business days, whichever is less. Data on the percentage of standard prior authorization requests approved and denied for each health insurer for each year is shown below in Tables 2 and 3.

Table 2
Standard Prior Authorization Requests - Percentage Approved
CY 2021 - CY 2023

Health Insurer	CY 2021	CY 2022	CY 2023
Aetna Life Ins. Co.	89.7%	87.6%	93.3%
Anthem Health Plans of ME	87.7%	87.7%	86.4%
Cigna	85.9%	87.3%	88.2%
Community Health Options	91.6%	93.5%	94.1%
Harvard Pilgrim Health Care[1]	79.8%	81.1%	84.8%
UnitedHealthCare	81.8%	80.2%	76.4%
Total	86.4%	87.3%	87.3%

[1] - Harvard Pilgrim Health Care includes members covered under HPHC Insurance Co.

Table 3
Standard Prior Authorization Requests - Percentage Denied
CY 2021 - CY 2023

Health Insurer	CY 2021	CY 2022	CY 2023
Aetna Life Ins. Co.	10.3%	12.4%	6.7%
Anthem Health Plans of ME	12.3%	12.3%	13.6%
Cigna	14.1%	12.7%	11.8%
Community Health Options	8.4%	6.5%	5.9%
Harvard Pilgrim Health Care[1]	20.2%	18.9%	15.2%
UnitedHealthCare	18.2%	19.8%	23.6%
Total	13.6%	12.7%	12.7%

[1] - Harvard Pilgrim Health Care includes members covered under HPHC Insurance Co.

With regard to expedited prior authorization requests, the percentage of these requests approved dropped from 91% in CY 2021 to 85% in CY 2022. Insurers are required to perform an expedited review of a prior authorization request within 24 hours. Tables 4 and 5 show the expedited prior authorization requests approved and denied for each insurer for each year.

Table 4
Expedited Prior Authorization Requests - Percentage Approved
CY 2021 - CY 2023

Health Insurer	CY 2021	CY 2022	CY 2023
Aetna Life Ins. Co.	N/A	88.8%	88.5%
Anthem Health Plans of ME	90.3%	87.5%	80.9%
Cigna	93.7%	93.0%	88.9%
Community Health Options	94.0%	96.5%	95.5%
Harvard Pilgrim Health Care[1]	91.7%	97.4%	92.5%
UnitedHealthCare	75.4%	85.1%	80.0%
Total	91.1%	90.0%	85.3%

[1] - Harvard Pilgrim Health Care includes members covered under HPHC Insurance Co.

Table 5
Expedited Prior Authorization Requests - Percentage Denied
CY 2021 - CY 2023

Health Insurer	CY 2021	CY 2022	CY 2023
Aetna Life Ins. Co.	N/A	11.2%	11.5%
Anthem Health Plans of ME	9.7%	12.5%	19.1%
Cigna	6.3%	7.0%	11.1%
Community Health Options	6.0%	3.5%	4.5%
Harvard Pilgrim Health Care[1]	8.3%	2.6%	7.5%
UnitedHealthCare	24.6%	14.9%	20.0%
Total	8.9%	10.0%	14.7%

[1] - Harvard Pilgrim Health Care includes members covered under HPHC Insurance Co.

Appendix A includes the data submitted by each carrier; the full text of the law is included as Appendix B; and the instructions and form for the report, both of which are posted on the Bureau's website, are attached as Appendix C. Also posted on the Bureau's website is each insurer's list of items and services that are subject to prior authorization.

Appendix A: Health Insurer Data

- Insurers must answer a request for a prior authorization of nonemergency services within 72 hours or two business days, whichever is less. See 24-A M.R.S.§ 4304(2). If the carrier responds that more time is needed before rendering a decision, the carrier must make a decision within 72 hours or two business days, whichever is less, from the time of the carrier's initial response. See 24-A M.R.S.§ 4304(2)(C).

- Carriers are required to perform an expedited review of a prior authorization request 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 course of treatment using a nonformulary drug. An expedited review must be completed within 24 hours. See 24-A M.R.S. § 4311(1-A)(B); Rule 850.§ 8 (E)(3).

- Data collected under Section IV of each carrier's report pertaining to the list of items and services that required prior authorization for the applicable year may be found on the Bureau's website at Health Insurers' Annual Prior Authorization Reports.

Aetna Life Insurance Company

P.L. 2023 Chapter 680 Report

All companies must complete Sections I through IV. All fields are required. Due Date: 9/1/2024

Section I. Company Information

Company Name:	Aetna Life Insurance Company
NAIC:	60054

Section II. Contact Information

First Name:		Last Name:	
E-Mail:		Phone Number:	

Section III. Prior Authorization History

	2021	2022	2023	2021	2022	2023
Total Number of Prior Authorizations Requested	1560	1234	1497	**Percent of Total**		
B: Standard Requests Approved	1399	715	903	89.74%	87.62%	93.29%
C: Standard Requests Denied	160	101	65	10.26%	12.38%	6.71%
H: Standard Request Average Approval Time (Days)	1.8	1.8	1.8			
H: Standard Request Median Approval Time (Days)	0	0	0			
D: Appealed Requests Approved	0	1	2			
E: Extended Reviews Approved	0	0	0			
F: Expedited Reviews Approved	0	371	468	0.00%	88.76%	88.47%
G: Expedited Reviews Denied	1	47	61	100.00%	11.24%	11.53%
I: Expedited Review Average Approval Time (Days)	0.1	0.1	0.1			
I: Expedited Review Median Approval Time (Days)	0	0	0			
J: Concurrent Care Request Average Approval Time (Days)	0.3	0.5	0.5			
J: Concurrent Care Request Median Approval Time (Days)	0	0	0			

Anthem Health Plans of Maine, Inc

P.L. 2023 Chapter 680 Report

All companies must complete Sections I through IV. All fields are required. Due Date: 9/1/2024

Section I. Company Information

Company Name:	Anthem Health Plans of Maine, Inc
NAIC:	52618

Section II. Contact Information

First Name:		Last Name:	
E-Mail:		Phone Number:	

Section III. Prior Authorization History

	2021	2022	2023	2021	2022	2023
Total Number of Prior Authorizations Requested	76525	86518	114407	**Percent of Total**		
B: Standard Requests Approved	61212	69513	92286	87.68%	87.71%	86.37%
C: Standard Requests Denied	8601	9741	14561	12.32%	12.29%	13.63%
H: Standard Request Average Approval Time (Days)	1.1	1.04	1.07			
H: Standard Request Median Approval Time (Days)	1	1	1			
D: Appealed Requests Approved	99	94	174			
E: Extended Reviews Approved	1119	746	1506			
F: Expedited Reviews Approved	6058	6354	6117	90.26%	87.47%	80.91%
G: Expedited Reviews Denied	654	910	1443	9.74%	12.53%	19.09%
I: Expedited Review Average Approval Time (Days)	1.25	1.16	1.27			
I: Expedited Review Median Approval Time (Days)	1	1	1			
J: Concurrent Care Request Average Approval Time (Days)	1.25	1.13	1.19			
J: Concurrent Care Request Median Approval Time (Days)	1	1	1			

Cigna Health and Life Insurance Company

P.L. 2023 Chapter 680 Report

All companies must complete Sections I through IV. All fields are required. Due Date: 9/1/2024

Section I. Company Information

Company Name:	Cigna Health and Life Insurance Company
NAIC:	67369

Section II. Contact Information

First Name:		Last Name:	
E-Mail:		Phone Number:	

Section III. Prior Authorization History

	2021	2022	2023	2021	2022	2023
Total Number of Prior Authorizations Requested	9007	10271	13835	**Percent of Total**		
B: Standard Requests Approved	6287	7468	10307	85.88%	87.26%	88.18%
C: Standard Requests Denied	1034	1090	1381	14.12%	12.74%	11.82%
H: Standard Request Average Approval Time (Days)	8.09	9.93	4.2			
H: Standard Request Median Approval Time (Days)	3.25	2.5	2.5			
D: Appealed Requests Approved	36	35	53			
E: Extended Reviews Approved	353	483	632			
F: Expedited Reviews Approved	1579	1593	1909	93.65%	92.99%	88.91%
G: Expedited Reviews Denied	107	120	238	6.35%	7.01%	11.09%
I: Expedited Review Average Approval Time (Days)	3	1.49	2.28			
I: Expedited Review Median Approval Time (Days)	1.5	0.25	0.75			
J: Concurrent Care Request Average Approval Time (Days)	2.33	2.03	2.7			
J: Concurrent Care Request Median Approval Time (Days)	0.5	1.5	1.5			

Community Health Options

P.L. 2023 Chapter 680 Report

All companies must complete Sections I through IV. All fields are required. Due Date: 9/1/2024

Section I. Company Information

Company Name:	Community Health Options
NAIC:	15077

Section II. Contact Information

First Name:		Last Name:	
E-Mail:		Phone Number:	

Section III. Prior Authorization History

	2021	2022	2023	2021	2022	2023
Total Number of Prior Authorizations Requested	17276	21511	25055	Percent of Total		
B: Standard Requests Approved	14935	19323	22725	91.60%	93.54%	94.10%
C: Standard Requests Denied	1369	1335	1425	8.40%	6.46%	5.90%
H: Standard Request Average Approval Time (Days)	0.8	0.9	1			
H: Standard Request Median Approval Time (Days)	0	0	0			
D: Appealed Requests Approved	35	15	22			
E: Extended Reviews Approved	1611	1824	2041			
F: Expedited Reviews Approved	881	809	843	94.02%	96.54%	95.47%
G: Expedited Reviews Denied	56	29	40	5.98%	3.46%	4.53%
I: Expedited Review Average Approval Time (Days)	0.2	0.2	0.2			
I: Expedited Review Median Approval Time (Days)	0	0	0			
J: Concurrent Care Request Average Approval Time (Days)	0.3	0.2	0.2			
J: Concurrent Care Request Median Approval Time (Days)	0	0	0			

Harvard Pilgrim Healthcare/HPHC Insurance Company

P.L. 2023 Chapter 680 Report

All companies must complete Sections I through IV. All fields are required. Due Date: 9/1/2024

Section I. Company Information

Company Name:	Harvard Pilgrim Healthcare/HPHC Insurance Company
NAIC:	96911/18975

Section II. Contact Information

First Name:		Last Name:	
E-Mail:		Phone Number:	

Section III. Prior Authorization History

	2021	2022	2023	2021	2022	2023
Total Number of Prior Authorizations Requested	28017	26277	25777	**Percent of Total**		
B: Standard Requests Approved	20084	18650	19487	79.84%	81.06%	84.85%
C: Standard Requests Denied	5070	4357	3480	20.16%	18.94%	15.15%
H: Standard Request Average Approval Time (Days)	2	1	3			
H: Standard Request Median Approval Time (Days)	1	1	3			
D: Appealed Requests Approved	112	186	120			
E: Extended Reviews Approved	1056	1886	570			
F: Expedited Reviews Approved	1554	1167	1962	91.68%	97.41%	92.55%
G: Expedited Reviews Denied	141	31	158	8.32%	2.59%	7.45%
I: Expedited Review Average Approval Time (Days)	1	1	1			
I: Expedited Review Median Approval Time (Days)	1	1	1			
J: Concurrent Care Request Average Approval Time (Days)	1	1	1			
J: Concurrent Care Request Median Approval Time (Days)	1	1	1			

UnitedHealthcare Insurance Company

P.L. 2023 Chapter 680 Report

All companies must complete Sections I through IV. All fields are required. Due Date: 9/1/2024

Section I. Company Information

Company Name:	UnitedHealthcare Insurance Company
NAIC:	79413

Section II. Contact Information

First Name:		Last Name:	
E-Mail:		Phone Number:	

Section III. Prior Authorization History

	2021	2022	2023	2021	2022	2023
Total Number of Prior Authorizations Requested	2376	2460	2389	**Percent of Total**		
B: Standard Requests Approved	1806	1855	1704	81.76%	80.16%	76.41%
C: Standard Requests Denied	403	459	526	18.24%	19.84%	23.59%
H: Standard Request Average Approval Time (Days)	1.42	1.94	2.52			
H: Standard Request Median Approval Time (Days)	0.3	0.14	0.079			
D: Appealed Requests Approved	44	32	41			
E: Extended Reviews Approved	0	0	0			
F: Expedited Reviews Approved	104	103	100	75.36%	85.12%	80.00%
G: Expedited Reviews Denied	34	18	25	24.64%	14.88%	20.00%
I: Expedited Review Average Approval Time (Days)	1.07	0.381	0.377			
I: Expedited Review Median Approval Time (Days)	0.208	0.211	0.107			
J: Concurrent Care Request Average Approval Time (Days)	2.71	1.97	2.2			
J: Concurrent Care Request Median Approval Time (Days)	2.22	1.711	1.671			

Appendix B: Statutory Requirement

P.L. 2023 Chapter 680 Prior Authorization Report Instructions for Calendar Years 2021, 2022, and 2023

An Act Concerning Prior Authorizations for Health Care Provider Services

Be it enacted by the People of the State of Maine as follows:

PART A

Sec. A-1. 24-A MRSA §4301-A, sub-§1, as amended by PL 2011, c. 364, §20, is further amended to read:

1. Adverse health care treatment decision. "Adverse health care treatment decision" means a health care treatment decision made by or on behalf of a carrier offering or renewing a health plan denying in whole or in part payment for or provision of otherwise covered services requested by or on behalf of an enrollee. "Adverse health care treatment decision" includes a rescission determination and an initial coverage eligibility determination, consistent with the requirements of the federal Affordable Care Act, and a prior authorization determination in accordance with section 4304.

Sec. A-2. 24-A MRSA §4301-A, sub-§2, as enacted by PL 1999, c. 742, §3, is amended to read:

2. Authorized representative. "Authorized representative" means:

A. A person to whom an enrollee has given express written consent to represent the enrollee in an external review;

B. A person authorized by law to provide consent to request an external review for an enrollee; ~~or~~

C. A family member of an enrollee or an enrollee's treating health care provider when the enrollee is unable to provide consent to request an external review.; or

D. A provider that is actively treating an enrollee.

Sec. A-3. 24-A MRSA §4303, sub-§4, as amended by PL 2019, c. 5, Pt. A, §20, is further amended to read:

4. Grievance procedure for enrollees. A carrier offering or renewing a health plan in this State shall establish and maintain a grievance procedure that meets standards developed by the superintendent to provide for the resolution of claims denials, prior authorization denials or other matters by which enrollees are aggrieved.

A. The grievance procedure must include, at a minimum, the following:

(1) Notice to the enrollee and the enrollee's provider promptly of any claim denial, prior authorization denial or other matter by which enrollees are likely to be aggrieved, stating the basis for the decision, the right to file a

grievance, the procedure for doing so and the time period in which the grievance must be filed;

(2) Timelines within which grievances must be processed, including expedited processing for exigent circumstances. Timelines must be sufficiently expeditious to resolve grievances promptly. Decisions for second level grievance reviews as defined by bureau rules must be issued within 30 calendar days if the insured has not requested the opportunity to appear in person before authorized representatives of the health carrier;

(3) Procedures for the submission of relevant information and enrollee or provider participation;

(4) Provision to the aggrieved party of a written statement upon the conclusion of any grievance process, setting forth the reasons for any decision. The statement must include notice to the aggrieved party of any subsequent appeal or external review rights, the procedure and time limitations for exercising those rights and notice of the right to file a complaint with the Bureau of Insurance and the toll-free telephone number of the bureau; ~~and~~

(5) Decision-making by one or more individuals not previously involved in making the decision subject to the grievance.; and

(6) Procedures for a provider actively treating an enrollee to act as an authorized representative of the enrollee within the meaning of section 4301-A subsection 2, paragraph D and file a grievance on the enrollee's behalf as long as the provider notifies the enrollee in writing at least 14 days prior to filing a grievance and within 7 days after filing a grievance or withdrawing a grievance. The enrollee has the right to affirmatively object to a provider that has filed a grievance at any time, and the enrollee has the right to notify the health carrier at any time that the enrollee intends to take the place of the provider as a party to the grievance.

B. In any appeal under the grievance procedure in which a professional medical opinion regarding a health condition is a material issue in the dispute, the aggrieved party is entitled to an independent 2nd opinion, paid for by the plan, of a provider of the same specialty participating in the plan. If a provider of the same specialty does not participate in the plan, then the 2nd opinion must be given by a nonparticipating provider.

C. In any appeal under the grievance procedure, the carrier shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's right to an appeal under this subsection.

D. Notwithstanding this subsection, a group health plan sponsored by an

agricultural cooperative association located outside of this State that provides health insurance coverage to members of one or more agricultural cooperative associations located within this State may employ a grievance procedure for enrollees in the group health plan that meets the requirements of the state in which the group health plan is located if enrollees in the group health plan that reside in this State have the right to independent external review in accordance with section 4312 following any adverse health care treatment decision. Any difference in the grievance procedure requirements between those of the state in which the group health plan is located and those of this State must be limited to the number of days required for notification of prior authorization for nonemergency services and the number of days required for the issuance of a decision following the filing of an appeal of an adverse health care treatment decision. Enrollees in the group health plan that reside in this State must be notified as to the grievance procedure used by the group health plan and their right to independent external review in accordance with section 4312.

E. Health plans may not reduce or terminate benefits for an ongoing course of treatment, including coverage of a prescription drug, during the course of an appeal pursuant to the grievance procedure used by the carrier or any independent external review in accordance with section 4312.

Sec. A-4. 24-A MRSA §4304, sub-§2, ¶E is enacted to read:

E. If a 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.

Sec. A-5. 24-A MRSA §4304, sub-§2, ¶F is enacted to read:

F. For nonemergency services provided without a required prior authorization approval, a carrier may not deny a claim for nonemergency services that were within the scope of the enrollee's coverage pending medical necessity review and may not impose a penalty on the provider for failing to obtain a prior authorization of greater than 15% of the contractually allowed amount for the services that required prior authorization approval.

Sec. A-6. 24-A MRSA §4304, sub-§5, ¶B is enacted to read:

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.

Sec. A-7. 24-A MRSA §4304, sub-§5, ¶C is enacted to read:

C. If an enrollee receives an emergency service that requires immediate post-evaluation or post-stabilization services, a carrier 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 carrier shall make a utilization review determination within 24 hours of receiving a request for those services and the carrier is responsible for

payment for those services for the duration until the carrier affirmatively notifies the provider otherwise. If the utilization review determination is not made within 24 hours, the services for which the utilization review was requested are deemed approved until the carrier affirmatively notifies the provider otherwise.

Sec. A-8. 24-A MRSA §4312, first ¶, as amended by PL 2007, c. 199, Pt. B, §17, is further amended to read:

An enrollee or the enrollee's authorized representative has the right to an independent external review of a carrier's adverse health care treatment decision made by or on behalf of a carrier offering or renewing a health plan in accordance with the requirements of this section. An enrollee's failure to obtain authorization prior to receiving an otherwise covered service may not preclude an enrollee from exercising the enrollee's rights under this section.

Sec. A-9. 24-A MRSA §4312, sub-§1-A is enacted to read:

1-A. Request for independent external review by enrollee's authorized representative. A request for an independent external review may be made by an enrollee's authorized representative as defined in section 4301-A, subsection 2, paragraph D in accordance with this subsection.

A. The enrollee's authorized representative shall notify the enrollee in writing at least 14 days prior to filing a request for independent external review and within 7 days after filing the request or withdrawing the request.

B. The enrollee may affirmatively object to the request for independent external review at any time prior to the filing of a request by an enrollee's authorized representative and, after a request has been filed, may notify the bureau at any time that the enrollee intends to take the place of the enrollee's authorized representative as a party in the independent external review.

Sec. A-10. Application. This Part applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed on or after January 1, 2025. For purposes of this Part, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

PART B

Sec. B-1. 24-A MRSA §4302, sub-§2, as amended by PL 2007, c. 199, Pt. B, §3, is further amended to read:

2. Plan ~~complaint;~~ complaints and adverse decisions~~; prior authorization~~ statistics. A carrier shall provide annually to the superintendent information for each health plan that it offers or renews on plan complaints, and adverse decisions ~~and prior authorization~~ statistics. This statistical information must contain, at a minimum:

A. The ratio of the number of complaints received by the plan to the total number of enrollees, reported by type of complaint and category of enrollee;

B. The ratio of the number of adverse decisions issued by the plan to the number of complaints received, reported by category;

C. ~~The ratio of the number of prior authorizations denied by the plan to the number of prior authorizations requested, reported by category;~~

D. The ratio of the number of successful enrollee appeals overturning the original denial to the total number of appeals filed;

E. The percentage of disenrollments by enrollees and providers from the health plan within the previous 12 months and the reasons for the disenrollments. With respect to enrollees, the information provided in this paragraph must differentiate between voluntary and involuntary disenrollments; and

F. Enrollee satisfaction statistics, including provider-to-enrollee ratio by geographic region and medical specialty and a report on what actions, if any, the carrier has taken to improve complaint handling and eliminate the causes of valid complaints.

Sec. B-2. 24-A MRSA §4302, sub-§2-A is enacted to read:

2-A. Reporting of information related to prior authorization. In addition to the information required to be provided under subsection 2, a carrier shall annually report to the superintendent the following information related to prior authorization determinations for the prior calendar year:

A. A list of all items and services that require prior authorization;

B. The number and percentage of standard prior authorization requests that were approved, aggregated for all items and services;

C. The number and percentage of standard prior authorization requests that were denied, aggregated for all items and services;

D. The number and percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services;

E. The number and percentage of prior authorization requests for which the time frame for review was extended and the request approved, aggregated for all items and services;

F. The number and percentage of expedited prior authorization requests that were approved, aggregated for all items and services;

G. The number and percentage of expedited prior authorization requests that were denied, aggregated for all items and services;

H. The average and median time that elapsed between the submission of a request and a determination by the carrier, for standard prior authorizations, aggregated for all items and services;

I. The average and median time that elapsed between the submission of a

request and a decision by the carrier for expedited prior authorizations, aggregated for all items and services; and

J. The average and median time that elapsed between the submission of a concurrent care prior authorization request to extend a course of treatment and a determination by the carrier, aggregated for all items and services.

Sec. B-3. 24-A MRSA §4302, sub-§2-B is enacted to read:

2-B. Data reporting; utilization review data. Beginning April 1, 2025 and April 1st of each year thereafter, the superintendent shall collect the information required under subsections 2 and 2-A, together with the utilization review information collected pursuant to section 2749, and post this information on the bureau's publicly accessible website.

Sec. B-4. Reporting on data submitted by health insurance carriers on prior authorization determinations. The Superintendent of Insurance shall survey health insurance carriers in this State to request data from carriers for calendar years 2021, 2022 and 2023 that, at a minimum, provides information related to prior authorization determinations as described in the Maine Revised Statutes, Title 24-A, section 4302, subsection 2-A. No later than January 15, 2025, the Superintendent shall submit to the joint standing committee of the Legislature having jurisdiction over health coverage, insurance and financial services matters a report that collects the data submitted by each carrier related to prior authorization determinations. The joint standing committee of the Legislature having jurisdiction over health coverage, insurance and financial services matters may report out a bill to the 132nd Legislature in 2025 based on the report provided in accordance with this section.

Appendix C: Instructions and Form

P.L. 2023 Chapter 680 Prior Authorization Report Instructions for Calendar Years 2021, 2022, and 2023

Due Date: September 1, 2024

Who Must File the Report?

Health carriers with more than 1,000 Maine covered lives as reported in Rule 940 and Rule 945 reports filed with the Maine Bureau of Insurance must report information required by P.L. 2023 Chapter 680 for calendar years 2021, 2022, and 2023.

Location of the Report Form

http://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/prior-auth-history.xlsx

What to Report

All information is required to be reported in the appropriate column for calendar years 2021, 2023, and 2023.

The following information is required:

1) All items and services that require a prior authorization, including the respective CPT code. (Note: Three columns appear, one for each year. Please list the service or item and CPT code and then check the applicable box with an "X" for the year a prior authorization was required.)
2) Number and percentage of standard prior authorization requests that were approved, aggregated for all items and services.
3) Number and percentage of standard prior authorization requests that were denied, aggregated for all items and services.
4) Number and percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.
5) Number and percentage of prior authorization requests for which the time frame for review was extended and the request approved, aggregated for all items and services.
6) Number and percentage of expedited prior authorization requests that were approved, aggregated for all items and services.
7) Number and percentage of expedited prior authorization requests that were denied, aggregated for all items and services.
8) Average and median time that elapsed between receiving all necessary

information following the submission of a prior authorization request and a determination by the carrier, for standard prior authorizations, aggregated for all items and services.

9) Average and median time that elapsed between receiving all necessary information following the submission of a prior authorization request and decision by the carrier for expedited prior authorizations, aggregated for all items and services, and
10) Average and median time that elapsed between receiving all necessary information following the submission of a concurrent care prior authorization request to extend a course of treatment and a determination by the carrier, aggregated for all items and services.

The percentages will be calculated automatically based on the numbers submitted.

Definitions

- "Standard" means a non-expedited review.
- "Expedited" means an expedited review for a service or a prescription drug 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 ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.
- "Concurrent" means a review conducted during a patient's hospital stay or course of treatment.

If you have questions about the content of the report, please contact Pamela Stutch at (207) 624-8458 or at pamela.stutch@maine.gov.

Please return the completed report by September 1, 2024 to keith.a.fougere@maine.gov.

Sample Report Form

P.L. 2023 Chapter 680 Report

All companies must complete Sections I through IV. All fields are required. Due Date: 9/1/2024

Section I. Company Information

Company Name:

NAIC:

Section II. Contact Information

First Name: Last Name:

E-Mail: Phone Number:

Section III. Prior Authorization History

	2021	2022	2023	2021	2022	2023
Total Number of Prior Authorizations Requested				Percent of Total		
B: Standard Requests Approved				#DIV/0!	#DIV/0!	#DIV/0!
C: Standard Requests Denied				#DIV/0!	#DIV/0!	#DIV/0!
H: Standard Request Average Approval Time (Days)						
H: Standard Request Median Approval Time (Days)						
D: Appealed Requests Approved				#DIV/0!	#DIV/0!	#DIV/0!
E: Extended Reviews Approved				#DIV/0!	#DIV/0!	#DIV/0!
F: Expedited Reviews Approved				#DIV/0!	#DIV/0!	#DIV/0!
G: Expedited Reviews Denied				#DIV/0!	#DIV/0!	#DIV/0!
I: Expedited Review Average Approval Time (Days)						
I: Expedited Review Median Approval Time (Days)						
J: Concurrent Care Request Average Approval Time (Days)						
J: Concurrent Care Request Median Approval Time (Days)						

Section IV. List all Items and Services that required prior authorization and the year(s) the requirement was in effect with an x

CPT Code	Description of Item or Service	2021	2022	2023
		x	x	x
		x	x	x
		x	x	x
		x	x	x