Testimony to the Senate Health Care and Human Services Committee
Oregon State Senate

IN SUPPORT OF

Senate Bills 382

Concerning prior authorization for coverage of prescription drugs

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3:00 pm hearing

Submitted by:

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Good afternoon and thank you, Madam Chair and members of the committee for this opportunity to testify in support of SB 382. My name is Debi Johnson. I here on behalf of the Oregon State Urological Society and the patients served by our membership. Our society represents urologic surgeons, their practice administrators and staff who are instrumental in the delivery of high quality urologic care to our communities throughout our state.

We commend the first steps by the Oregon Health Leadership Council in the creation of an Administrative Simplification Claims and Eligibility work group who has recommended the "use of a common form" for prior authorizations but their work falls short. In order to be meaningful, all insurance carriers must be *required* to use the "common form" and the form must incorporate all prior-authorization needs, including prescription pharmaceuticals.

The process of prior authorizations in our state has become so cumbersome that many of our members report having to hire 0.25-0.5 full time employees (FTE) per physician to keep up with the bureaucracy.

Just last week I received communication from Angela Jordan (OUS Board member and practice administrator for Bend Urology - the largest urology practice in Central Oregon). She said "We have one FTE (Vanessa) who does all of our preauthorization requests, with the exception of DMAP and COIHS (Lyndsey) which take an additional 2 hours/day on average. We have had to delay or cancel procedures because the carrier requests additional information before they will authorize the procedure. Particularly in Central Oregon, distances hamper timely patient care. When bureaucratic inefficiencies prevent access to care, patients suffer. Their care takes longer to receive and their condition can worsen while they wait for needed prescriptions, surgeries, tests, and procedures. Patients leave the physician's office with unresolved health care decisions and wait (and wait) until insurance hurdles are met. Office staffs are under pressure from patients and physicians to get needed tests scheduled yet cannot get timely answers from insurers."

OUS has already reached out to our membership on suggestions on how to improve the process and you have those recommendations before you in written testimony. "

Knowing the bill calls for the establishment of a work group to identify best practices for the prior authorization and recommendations for its simplification, I have asked my membership to provide comments/suggestions as to how to improve the process. Here is a summary of the comments to date:

1. A standard form (or small group of forms) makes entering "complete" information more accurate, especially if all the fields are in the same order. This way we (health care providers and their respective practices) will always know what to have prepared to send or attach. Reduces multiple communications concerning the same prior auth request.
2. The form should not exceed 2 pages since several states have already proven the prior authorization process can be done with a two page form for ultimate simplification (ex. California and Hawaii).
3. Since each plan may have different medical necessity policies regarding the same procedures, being able to easily find the list of pre-auth requirements is vital. (i.e. some plans require cystos and Urodynamics prior to authorizing a TOT.....others do not)
4. Not all online forms list all possible options in some of the fields.....this is especially true when the provider or facility are not on that payers network. Sometimes only the in-network choices are listed.
5. The form must be available and transmittable both electronically and in downloadable formats. The ability to print (or save to our desktops) the form with all the fields complete, is vital. I know we're trying to go paperless, but when proof that a pre-auth was submitted and received is the difference

between being paid or being denied, having a copy of the form that is from the payer's website makes the difference.

6. There is a need for some kind of reference number that proves the payer received the online form.
7. The form needs to include all prior authorization needs (pharmaceuticals, procedures, DME, etc) Pharmaceuticals must be included. No one can physically keep up with all the medications that require authorization any more.

We appreciate the intent of the bill to assist in simplifying this huge administrative burden and recognizing that pharmaceuticals need to be included in the universal standard prior authorization form and process. However, it will be meaningless without the deliverables to bring and keep meaning to the legislation such as:

a. All Oregon health plans and insurers (public and private) must be required to implement the recommendations of the Administrative Simplification Claims and Eligibility work group by a specified date and be used for ALL prior authorization requests (including pharmaceuticals). We suggest page 1 line 6, last word "may" be changed to "must".

b. If a health plan or insurer does not use the form or respond within 48 hours, the prior authorization is deemed granted. (This should not be an issue since Medicaid can do this in 24 hours).

c. All healthcare providers must be required to be trained and utilizing the standard pre-authorization form within 6 months of the implementation date required by the insureds set by the new law.

d. If a provider does not use the standardized form by the end of the transition time (6 months after the insure implementation date specified by law) the authorization will be denied.

We commend Senator Bates on his leadership to bring this bill to the State Legislature this year. We further appreciate the bipartisan recognition for the need of administrative simplification within medical practices several years ago when the Oregon Leadership Council was formed. Our organization joins the voices of many providers and patients who support improving efficiencies in patient care. It is our belief that SB 382 is needed to insure the universal pre-authorization for the "common form" is comprehensive for all prior authorization needs concerning prescriptions. We believe it is the first step to achieving the ultimate need of a standardized form for ALL prior authorization needs.

We urge your support of this bill and consider our request to consider the feedback from our membership previously noted. It will definitely assist in getting patients, including you and your constituents your medically necessary treatments (including pharmaceuticals) in a more efficient manner.

My best regards,

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cc: Madam Chair, Senator Laurie Monnes Anderson
Vice Chair, Senator Jeff Kruse
Senator Tim Knopp
Senator Chip Shields
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