Testimony Before the
Senate Committee on Health Care regarding SB 139
Presented by Teresa Bailey
on behalf of the Oregon Medical Association
February 6, 2019

Thank you for allowing me to testify today. My name is Teresa Bailey, RN, and I am the manager of the Prior Authorization and Surgery Scheduling Department of Willamette ENT & Facial Plastic Surgery and River Road Surgery Center in Salem. I have been asked to testify before you today to clarify some of the real time problems and issues we face trying to provide timely, quality and cost-effective care to our patients. Our clinic started one of Salem's first Ambulatory Surgery Centers over 18 years ago, moving over 96% of our surgeries from Salem Hospital to an outpatient ambulatory setting. During that time, we have saved the health care system millions of dollars providing more personalized and efficient care to our patients. Our surgeons and administrator are very active promoting cost effective healthcare in their roles on various boards and committees including the Mid Valley IPA, Northwest Integrated Physicians, Oregon Ambulatory Surgery Association, Oregon Medical Group Management Association, and Oregon Medical Association to name a few.

The increasing complexity of ensuring and collecting payment for medical care has made the provision of care more difficult for health care providers and staff. Utilization management practices, such as prior authorization and step therapy are important tools to contain costs and ensure quality of care. However, they can often result in delayed treatment, abandonment of treatment and higher administrative burdens. Those complexities, coupled with differing authorization processes for each insurer, makes it difficult for both the patient and clinical staff to secure appropriate authorizations in an efficient amount of time.

Prior authorization is a process that requires provider offices to ask permission from a patient's insurance company before performing certain medical procedures or prescribing certain medications. Step therapy protocols require patients to try and fail certain therapies before qualifying for others.

The criteria used for prior authorization are often unclear and vary between insurers; our providers rarely know at the point-of-care if the prescribed treatment requires prior authorization, only to find out later when a patient's access is delayed or denied. Furthermore, providers are often required to repeat prior authorizations for prescription medications when a patient is stabilized on a treatment regimen for a chronic condition.

A survey conducted in 2018 by the Oregon Medical Association showed that 98% of practice managers report delays in care as a result of prior authorization and 89% report that prior authorization can mean patients end up walking away, abandoning the prescription, ultrasound, MRI, biopsy, or specialty care all together. A recent survey by the American Medical

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Association showed that 92% of physicians report that prior authorization can have a negative effect on clinical outcomes.

Every health plan has their own unique set of Administrative Rules, each totaling hundreds, if not thousands of pages. Each patient we see has a unique group number associated with their plan's customized benefit plan detailing their coverage. If you reach into your wallet or purse and pull out your Insurance Card, you will see the beginning of the process we navigate daily.

We are a specialty clinic, so patients likely need a referral from their primary care provider in order to make an appointment with us. If the specialist determines that the patient needs specialty care, we start the Prior Authorization Process. This means at least one more visit for something we could have done on the same day. 18 years ago, we had one PA employee, a couple of schedulers and receptionists. Now we have 4 PA employees, 6 receptionists and 6 call center-schedulers. They are necessary to make sure we collect and process the information necessary to get paid for the care we deliver to our patients. There is little standardization to the Prior Authorization Process or the clinical requirements necessary to determine if treatment is allowed, let alone a covered benefit. To make matters worse, it is largely a manual process to determine what clinical notes, pictures and diagnostic data are needed. Once the necessary information is collated, it is faxed or mailed to the payor. Yes, faxed or mailed because most payors do not support an online, secure digital data transfer. While the intent of the prior authorization is to prevent unnecessary care, it has resulted in a more than a tripling of our non-clinical staff and adds significant delays to the delivery of care. Rarely, is care denied but when it is, there is another cumbersome process – the Appeal Process. This process is costly to both the payor and the provider and introduces significant delays and frustrations for the patient. We rarely lose an appeal because the care we prescribe is warranted.

Senate Bill 139 seeks to ensure that the prior authorization process is transparent, efficient, and fair – using evidence-based practices that best supports the health needs of the patient. The key concerns addressed by SB 139 are to prevent treatment delays and treatment abandonment.

I would like to thank you once again for the opportunity to address the committee regarding this very important topic and I'm happy to answer any questions.

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