OREGON MEDICAL ASSOCIATION

MEMORANDUM

To: Chair Laurie Monnes Anderson
Members of the Senate Health Care Committee

From: Courtni Dresser

Date: February 24, 2020

Re: Testimony on HB 4102-A

The increasing complexity of ensuring and collecting payment for medical care has made the provision of care more difficult for health care providers and their 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. Healthcare providers rarely know at the point-of-care if the prescribed treatment requires prior authorization, and only 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 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 has a unique group number associated with their plan's customized

11740 SW 68th Parkway, Suite 100
Portland, Oregon 97223-9038
phone 503.619.8000
fax 503.619.0609
www.theOMA.org

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 practices navigate daily.
Many practices have found it necessary to hire additional staff to collect and process the information necessary to get paid for the care they deliver to their 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 collected, it is faxed or mailed to the payor 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 significant increases in the number of necessary 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.

HB 4102-A 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 HB 4102 are to prevent treatment delays for Oregon patients.

11740 SW 68th Parkway, Suite 100
Portland, Oregon 97223-9038
phone **503.619.8000**
fax **503.619.0609**
*www.***theOMA.org**