To Whom It May Concern:

I am writing to express my strong support for HB 3134 and to highlight the urgent need for reform in Oregon's prior authorization process. As a Co-Owner of Impact Physical Therapy, with clinics in Hillsboro and Banks, I witness firsthand the devastating impact that prior authorization delays have on patients and the excessive administrative burden placed on healthcare providers.

Our clinic treats a wide range of musculoskeletal conditions, including back, hip, shoulder, knee, and foot pain, with many involving post-surgical rehabilitation. Many of our patients require timely physical therapy to recover effectively, regain function, and prevent further complications. However, prior authorization requirements from multiple insurance providers routinely delay necessary care—often forcing patients to wait up to **10 days** before receiving treatment. This is unacceptable. Imagine being in pain and told you must wait days or even weeks before getting relief. These delays not only cause unnecessary suffering but also contribute to **functional regression, increased fall risks, and even avoidable surgical interventions** due to denied access to pre-operative and post-operative rehabilitation.

Furthermore, the burden placed on healthcare providers is unsustainable. At Impact Physical Therapy, **14 staff members spend significant time every day navigating the complexities of prior authorizations**, rather than focusing on direct patient care. This includes battling insurance companies that fail to communicate with third-party authorization entities, resulting in unnecessary claim denials—even when prior approval has already been granted. The redundancy and inefficiency of this system adds **excessive paperwork, financial strain, and staff burnout**, driving highly qualified professionals away from the field. The system is broken, and it is our patients who suffer the most.

A key concern is that prior authorization decisions are frequently made by individuals who lack the necessary medical training or licensing. Authorization companies should not have the power to override the decisions of **licensed medical professionals** who are trained to determine the appropriate course of treatment for their patients. If insurance providers want to limit the number of visits, they should do so directly, rather than outsourcing medical decision-making to non-clinical third parties.

Ultimately, prior authorization does not save money—it shifts costs elsewhere. Patients who do not receive timely therapy often require more extensive medical interventions, including additional surgeries or long-term pain management. Moreover, insurance companies are **paying third-party authorization companies** rather than simply covering the necessary care in the first place. If patients are paying premiums that include therapy benefits, they should not be denied access to those services through bureaucratic barriers. If they don't receive visits that they are paying for, doesn't that border on insurance fraud or breach of contract?

HB 3134 is essential to restoring timely, medically necessary care for patients while alleviating the undue administrative strain on providers. I urge you to support this bill and work toward a healthcare system that prioritizes **patient outcomes over paperwork**.

Sincerely,

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