Mar 27, 2025

Oregon State Legislature,

I am writing to urge you to **support HB 3414** which creates a process that exempts certain health care providers from prior authorization requirements under certain circumstances.

As a staff therapist at a private practice Physical Therapy clinic in Eugene, OR I can attest to the misuse of prior authorization and utilization management in our state. Nearly all non-federal based health insurance carriers in Oregon use Evicore to administer unnecessary, non-evidenced, opaque, and inconsistent prior authorization systems. Their system does nothing to improve quality or efficiency of care. In fact, it achieves quite the opposite. These spurious barriers create needless delays and gaps in care which lead to documented diminished outcomes, relapse of chronic conditions, and in some cases reinjury for patients. It is important to keep in mind these obstructions are to insurance plan subscribers who are already paying high monthly premiums, and have physical therapy listed in their covered benefits. This outrage is why so many Oregonians have lodged complaints against their own health insurance carriers and Evicore with the Oregon Department of Justice Consumer Protection Department.

In addition, the current system drives up the real costs of delivering healthcare in Oregon in a post COVID-19 era when we desperately need providers. Clinics like mine typically require an additional 25% staffing for health care administrators to navigate the system engineered to be difficult and slow. I personally advocate for our patients rights in fighting health insurance authorization denials by participating in the infamous “Peer to Peer”, aka P2P meetings. However, this advocacy costs my clinic approximately $ 4,000 in 2024 alone as it takes away from time that could be spent on patient care.

HB 3414 provides much needed help to our struggling health care system by securing the following.

- **No authorization required for the first 16 visits of a new episode of care.**
- **Faster insurer responses** – 24-hour turnaround required for all prior auth decisions and clear rationale for additional information required.
- Preventing insurers from denying claims on services already approved.
- Transparency in requiring insurers to publicly post prior auth rules and denial/approval metrics.

Please feel free to contact me at the number above should you want further testimony on this matter.

Sincerely,

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