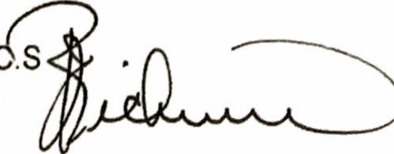
TO (via email):	Senate Committee on Health Care Senator Laurie Monnes Anderson, R.N., Chair Senator Jeff Kruse, Co-Chair Senator Lee Beyer Senator Tim Knopp Senator Elizabeth Steiner Hayward, M.D. Oliver Droppers, Committee Administrator/LPFO Analyst
FROM:	Judith Richmond, M.D., F.A.C.S Oregon Breast Center Lake Oswego, Oregon
DATE:	March 30, 2017
RE:	Senate Bill 783



Because of the demands of my medical practice, I am unable to personally appear today. Please accept this as my testimony.

I support this bill, with amendments to the current prior authorization statute (ORS 473B.420) to make prior authorizations truly binding on insurance companies and easily accessible to patients and providers.

The current prior authorization statute needs to be amended because it is *not* working ..... for patients or providers. It is *neither medically practical nor financially feasible* for the two primary stakeholders—patients and providers—it was intended to assist. In practice, it is obscure, nebulous, and indeterminate. Additionally, in its current form, insurance companies can and do use this statute as a means to arbitrarily deny payment for treatment that appears to be covered under its own contract of coverage.

What follows are some reasons and real-life examples of why the Legislature needs to fix this problem now.

Current insurance company practices are not transparent and allow insurance companies, not doctors, to "set" the medical standard of care. The patient is left unaware of what their insurance does and does not cover.

- For example, Patient A was diagnosed with Stage III cancer. There are 4 stages of cancer and, left untreated, Stage III generally progresses rapidly to a terminal condition. Cancer was a stated covered condition in Patient A's insurance policy. Prior authorization for treatment was obtained. Her medical standard of care treatment plan called for surgery and 8 weeks of chemotherapy. She underwent surgery and began her 8 week course of chemotherapy. *Midway through her chemotherapy,* ***her insurance company denied completion of the previously-authorized chemotherapy treatment.*** ***When the insurance company midway denied the previously-authorized remaining treatment, Patient A had to choose between (1) life or (2) early, certain death.***

- It's important to note that, at the time of the insurance company's mid-treatment denial, Patient A had coverage. Patient A chose life. Because the insurance company refused to pay, she ultimately had to use her life savings, sell her home, and file for bankruptcy just to complete her life-saving treatment. Ironically, she was weakened by the treatment and became ill, losing her job, and the insurance coverage while undergoing treatment. (Again, her remaining treatment was denied **before** she lost coverage.) It's difficult enough just to deal with cancer.

This example is somewhat analogous to an insurance company stating it covers the condition of pregnancy, paying for the 9 months of prenatal treatment, and, at full term, denying the costs of delivery of the baby and care for the newborn.

The denial of the remaining previously-approved chemotherapy treatment was an indirect means to substitute the insurance company's opinion for the medical necessity standard of care as established by practicing medical doctors.

Irrespective of the dates of continuing, ongoing, or recurrent treatment, if a patient has Insurance coverage at the time a terminal condition is diagnosed or should have been diagnosed, the prior authorization statute should require insurance company policies in this state to pay for all treatment the medical standard of care determines is necessary for that terminal condition and its medical sequela. If the insurance company policy offers cancer or other terminal condition care, the insurance company should cover the entire course of the treatment.

Many prior authorizations are internally inconsistent, leaving both patient and provider muddled and confused. The disclaimer contained within supersedes the authorization given earlier within the same document.

- When prior authorization is requested, often the treatment first is "preauthorized," but later in the same document, the insurance company disclaims its preauthorization by stating that the preauthorization letter "[does] not guarantee payment."

Another problem readily apparent with ORS 743B420 is the 30-day time limitation. Medical care is increasingly complex and frequently the course of treatment includes multiple modalities, *many of which cannot be completed in 30 days for reasons beyond the patient's or physician's control.* Standard of medical care may require changes in the treatment plan beyond the 30-day period provided in the statute. The time limitations need to be amended for more flexibility, to reflect the current state of the practice of medicine, and to eliminate the need for reauthorization of continuing medically necessary treatment.

- Patients who read or call and ask about their insurance company policy see or are told that they are covered for a particular condition. Restrictions on the treatment are hidden, that is, nontransparent. When the patients' treatment course is longer than 30 days, they get a **surprise bill**, often after the fact.

Insurance companies skirt payment for prior authorizations in other ways, too.

- Patient J required a certain type of treatment for the covered condition. Prior authorization was obtained for that specific treatment. After completing the treatment, Patient J opened

her mailbox to find a large bill. *Subsequent* to its own prior authorization, the insurance company denied a portion of the (completed) treatment, asserting that it was unnecessary ..... even though the treatment met the medically necessary standard of care for that covered condition.

Insurance companies are innovative in narrowing prior authorizations.

- Patient K is insured with a large insurer, Blue Cross Blue Shield, who gave a prior authorization for surgery. At the last minute, Patient K learned that Blue Cross Blue Shield would only authorize the surgery if performed at a small community hospital. One of the surgeons did not have privileges at the small community hospital. Several larger hospitals within the same community had complete equipment for the surgery, but the small community hospital did not. An appeal was flatly denied. Patient K felt she had no choice but to proceed at the smaller community hospital even if it did not have the necessary equipment for optimal care. The insurer claimed that its small community hospital limitation did not restrict coverage, stating Patient K could always pay for the surgery at another hospital. Like many others, Patient K could not afford care outside of and in addition to her health insurance coverage.

The lack of transparency and ready access to answers about prior authorizations substantially adds to the provider cost of doing business and to patient frustration and inability to plan. Many doctors like myself are small business owners. The current statutory process is not cost efficient for patients or providers. It unduly administratively and bureaucratically burdens the physicians. Currently, 40% of my staff devote full time to insurance interactions, including obtaining prior authorizations. None of us became doctors just to learn how to dance with insurance companies. Prior authorization problems do not need to leave patients poor on care and poor in the pocket book.

At times the prior authorization statutory scheme seems like a systemic insanity.

- Recently, newly diagnosed Patient X asked me why I had to get permission (preauthorization) from her insurance company to remove her cancer. Ardently, she stated, "[t]hat's why I have insurance, to take care of things like this." I explained the process of how the medical machine works. In reality her question is poignant, and I didn't have a good substantive answer for her at the time. She replied, "But I have cancer."

Now, though, I believe we do have some answers: ORS 743B.420 should be amended to make prior authorizations binding not only in the spirit of the law, but binding in fact. And, the process should be made user-friendly through such things as web portals, documents, and recorded conversations with real people at a single number.

It's time to change the status quo. SB 783 is how. I encourage your support of SB 783, with amendments to correct the deficiencies others and I have pointed out. Thank you for your consideration.