Utilization Management Transparency Act

Senate Bill 139

Utilization Management protocols, such as prior authorization (PA) and step therapy (ST), are important cost-containment and quality assurance tools employed by insurers, but they often result in higher levels of administrative burden and can contribute to delayed treatment and negative patient outcomes. PA is a process that requires physician offices to ask permission from a patient's insurance company before performing certain medical procedures or prescribing certain medications; ST protocols require patients to try and fail certain therapies before qualifying for others. This legislation seeks to ensure that if commercial or state payers employ such cost-containment programs, the process be transparent, efficient, and fair.

Senate Bill 139 applies to medical, prescription, and dental plans of commercial and Medicaid payers.

Transparency

New rule requirements and drug formulary changes can have a direct impact on patient care by delaying or altering a course of treatment. Utilization review entities must provide process information and approval criteria, and must disclose rule changes up front to allow patients and providers to properly navigate the processes and choose health plans accordingly. Denials should include specific reasoning. Additionally, requiring payers to submit statistics on such protocols will help ensure cost containment and quality assurance programs are effective.

Efficiency

To ensure that patients have prompt access to care, utilization review entities need to allow the submission of information through web-based portals and make coverage determinations in a timely manner. If a PA is incomplete, payers must indicate what is needed. Providers must provide accurate and complete information. Many conditions require ongoing treatment plans that need strict adherence and require recurring PAs. PA for health services should be valid for a reasonable length of time and should be continuous for medications for the duration of the treatment plan. Furthermore, payers must allow for appeals and exceptions processes for PA and ST.

Fairness

Patients review formulary and coverage restrictions prior to purchasing a plan, and unanticipated changes throughout the plan year can negatively impact care; a drug or device removed from the formulary after enrollment should be covered for the remainder of the plan year. Patients who switch plans from year to year often are required to repeat step therapy protocols already completed previously; this legislation allows a patient's step therapy to follow them to new plans. Finally, providers often encounter instances where entities deny payment for previously approved services or drugs, resulting in administrative burden and care delays; patients and physicians should be able to rely on an authorization as a commitment to coverage and payment of the corresponding claim.

Patient story: Trish, Eugene resident

For nine months I endured step therapy when a psoriatic flareup covered 80% of my body with scaly, itchy patches. First I was put on a chemotherapy drug that resulted in liver failure. Next was a medication used to treat malaria patients; I had a severe allergic reaction to the medication within the first couple of days. I was then placed on an immunosuppressant used for transplants; I was on this regime for several months with no significant change or improvement in my psoriasis or psoriatic arthritis. I was hospitalized with severe nausea and acute abdominal pain later being diagnosed with pancreatitis, a potential side effect of the drug. I finally was placed on a biologic which has worked for years. Now that I have switched insurance companies, the new company is denying me coverage of my biologic and wants me to go through the step therapy process again.

For more information, contact OMA Government Relations:
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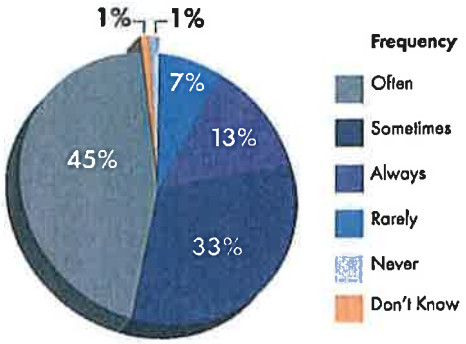
98 % report care delays

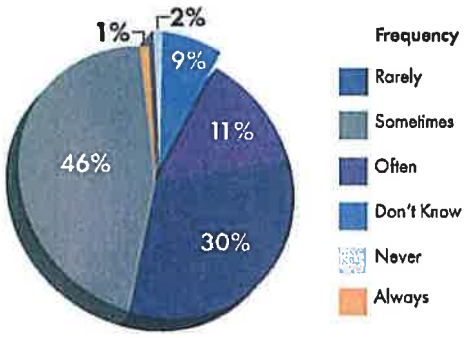
Q: For those patients whose treatment requires prior authorizations, how often does this process delay access to necessary care?



98 % report care delays

Abandoned treatment associated with PA

Q: For those patients whose treatment requires prior authorization, how often do issues related to this process lead to patients abandoning their recommended course of treatment?



89% report that PAs can at least sometimes lead to treatment abandonment

Additional findings:
78% of practices are sometimes, often or always required to repeat PAs for prescription medications when a patient is stabilized on a treatment regimen for a chronic condition.

The legislation is not intended to:
Ban the use of utilization management protocols; require creation of new clinical guidelines for utilization management; prevent insurers from requiring patients first try equivalent generics before brand name drugs; change the benefit design of insurance plans, with the exceptions of mid-year formulary changes; address provider networks; or hinder insurers or providers developing other provider-driven alternatives such as preferred provider programs or attestation of appropriate use criteria programs.

NATIONAL PSORIASIS FOUNDATION

Arthritis Foundation

OREGON ASSOCIATION OF ORTHOPAEDIC SURGEONS

ONA Oregon Nurses Association
Voice of Oregon Nurses Since 1904

CSRO Coalition of State Rheumatology Organizations

OANP Oregon Association of Naturopathic Physicians

OREGON CHIROPRACTIC ASSOCIATION

amta american massage therapy association — OREGON CHAPTER

OPSO Osteopathic Physicians & Surgeons of Oregon

opma oregon podiatric medical association

Chronic Disease Coalition

MS National Multiple Sclerosis Society

oda

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EPILEPSY FOUNDATION Oregon

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OREGON ACADEMY OF OPHTHALMOLOGY
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OPTA OREGON PHYSICAL THERAPY ASSOCIATION

COLUMBIA Pain Management, P.C.

OREGON ACADEMY OF FAMILY PHYSICIANS