CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
MARK C. SCHAEFER
VICE PRESIDENT, SYSTEM INNOVATION AND FINANCING
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
INSURANCE AND REAL ESTATE COMMITTEE
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HB 5447, An Act Concerning Prior Authorization For Health Care Provider Services

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **HB 5447, An Act Concerning Prior Authorization For Health Care Provider Services.** CHA supports legislative action to address serious problems with the conduct of prior authorization; however, this bill as written does not protect patients or their providers.

Since early 2020, hospitals and health systems have been at the center of Connecticut's response to the COVID-19 public health emergency, acting as a vital partner with the state and our communities. Hospitals expanded critical care capacity, procured essential equipment and supplies, and stood up countless community COVID-19 testing locations. Hospitals have been an essential component of the statewide vaccine distribution plan including efforts to reach and serve historically under-resourced communities disproportionately affected by the virus.

Private health insurance is the source of coverage in the employer-sponsored, small group, and individual insurance markets. Increasingly, private health insurers also offer Medicare Advantage plans, which administer Medicare benefits under full-risk, capitated arrangements with the federal government. Medicare Advantage is a major feature of today's healthcare market—enrollment has more than doubled in Connecticut in the past ten years. Nearly all private health plan coverage arrangements, whether commercial or Medicare Advantage, rely on utilization management, and specifically prior authorization, as a means to gate-keep access to medically necessary services.

In recent years, a number of health plans have begun abusing the prior authorization process. This has negatively affected patient care and results in significant added costs and burden to hospitals and other healthcare providers throughout the state. This approach is not new to Connecticut. In the late 1990s, shortly after the introduction of capitated Medicaid managed care, private health insurers used aggressive prior authorization processes to limit admissions to and continued care in inpatient settings, especially psychiatric settings. This resulted in significant industry penalties including loss of license. In subsequent years, aggressive practices seemed to subside in the Medicaid and commercial markets. It was not yet an issue in the then nascent Medicare Advantage market.

Today, aggressive prior authorization is common once more throughout the industry. Health plans are using prior authorization to restrict access to patients' covered services. Moreover, they are continually changing the rules that govern prior authorization, often in the middle of provider-insurer contract periods. While the stated intent of prior authorization is to help ensure patients receive care that is safe, efficacious, and beneficial to the individual patient, we have observed that many health plans are applying prior authorization requirements in ways that impact care.

Frequently, health plans establish different requirements for the information a provider must include in a prior authorization request for a particular covered benefit, and health plans often change those requirements unilaterally throughout a contract term. Moreover, they often delay prior authorization decisions, returning requests multiple times claiming insufficient information or simply not responding outside of traditional office hours.

Delays are most common when patients come in after hours or on weekends when most health plans do not have staff available to review routine requests. Keeping a patient in the emergency department or an inpatient bed while waiting for a plan's decision or response to a prior authorization request is not in the best interest of the patient. We strive to ensure that patients are receiving the right level of care when they need it. Those patients who no longer require an acute level of care should be transferred, as soon as possible, to a place where they can get the specialized, post-acute care they require. When patients wait for transfer to settings that focus on both medical and rehabilitative needs, their progress toward recovery can be negatively affected.

Our hospitals report some patients spending multiple days more in the hospital than necessary due to health plan delays in approving prior authorization to post-acute care. Most notably, because many plans don't staff prior authorization reviews over weekends, a patient ready for discharge after "business hours" on Friday will need to wait all weekend to be discharged to a more appropriate level of care.

Prior authorization processes also have an enormous impact on the cost of care. Many plans use inconsistent administrative protocols and a dizzying array of timelines and requirements for prior authorization requests, reviews, approvals, and communication, which are unnecessary at best, and have risen to the level of unconscionable during the public health emergency. Excessive requirements and variation between them add burden to the system as providers and their staff must ensure they are following the right set of rules and processes for each plan, which may change from one request to the next, and can also vary by plan, product, and vendor. Despite the tremendous time and resources needed to comply with such extensive requirements, prior authorization requests are often returned multiple times with requests to provide additional information and are further delayed by slow health plan responses or a failure to respond outside of traditional business hours. According to the American Hospital Association, "a large, national system spends $15 million per month in administrative costs associated with managing health plan contracts, including two to three full-time staff that do nothing but monitor plan bulletins for changes to the rules."[i]

During a time of national emergency where workforce shortages and strained health system capacity have been persistent challenges, there is simply insufficient bandwidth to comply with such cumbersome administrative procedures. Hospitals often have multiple full-time employees whose sole role is to manage health plan prior authorization requests. Prior authorization processes exacerbate workforce challenges and contribute to physician and other staff burnout. Expending staff resources to respond to health plan administrative requirements is unreasonable at any time, and far worse as we confront unprecedented and likely enduring challenges recruiting and retaining essential healthcare workers.

Our hospitals also report frequent occasions where a service is clearly medically necessary, but the health plan issues a denial anyway. This results in significant burden on the part of the provider to resolve the dispute. In fact, medical necessity is the most common reason health plans deny prior authorization requests. The routine denial of medically necessary care was highlighted by a 2018 Office of the Inspector General (OIG) report, which found that Medicare Advantage plans overturned 75 percent of denials that were appealed between 2014 and 2016.[ii] They are clearly denying requests even when the need for services is well within established clinical guidelines or accepted standards of care.

Our hospitals and health systems have made repeated appeals to health plans to address these practices, but to no avail.

Unfortunately, this bill does not address the urgent need for governmental action to end aggressive prior authorization practices. We have long identified the inappropriate prior authorization practices that harm patient care. Instead of a study, what we need are reasonable standards for prior authorization administration.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.

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[i] American Hospital Association, Special Bulletin: Addressing Commercial Health Plan Abuses to Ensure Fair Coverage for Patients and Providers, December 2020. https://www.aha.org/system/files/media/file/2020/12/addressing-commercial-health-plan-abuses-ensure-fair-coverage-patients-providers.pdf

[ii] U.S. Department of Health and Human Services Office of Inspector General. "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials," OEI-09-16-00410. September 2018.