KANSAS MEDICAL SOCIETY
Established 1859

***To:*** House Committee on Insurance

***From:*** Rachelle Colombo
Executive Director

***Date:*** February 20, 2023

***Subject:*** HB 2283, restrictions and limitations on prior authorization

The Kansas Medical Society (KMS) is the only statewide association advocating for physicians in every specialty and is dedicated to improving the environment in which Kansas physicians practice medicine and to protecting the health of Kansans. We appreciate the opportunity to submit testimony in support to HB 2283, which would enact the ensuring transparency in prior authorization act; imposing certain requirements and limitations on the use of prior authorization.

Prior authorization (PA) is a cost-control process that requires health care professionals to obtain advance approval from health plans before a prescription medication or medical service qualifies for payment and can be delivered to the patient. While health plans and benefit managers contend PA programs are necessary to control costs, physicians and other providers find these programs to be time-consuming barriers to the delivery of necessary treatment. We urge you to consider the following as you deliberate on HB 2283.

**Prior authorization costs physicians and their team valuable time.** Physicians complete an average of 41 prior authorizations per week. This administrative nightmare eats up roughly two business days (13.0 hours) of a physician's and their staff's time. If an insurance plan covers a treatment that would benefit the patient, physicians shouldn't have to waste time ensuring access to it.

**Prior authorization undermines the medical team's expertise.** The criteria used for prior authorization are unclear. Physicians rarely know at the point-of-care if the prescribed treatment requires prior authorization, only to find out later when a patient's access is delayed or denied. This ineffective system causes needless tension between physicians and their patients.

**Prior authorization doesn't put the patients first.** Ninety-three percent of physicians say prior authorization sometimes, often or always results in care delays. Patients' illnesses go untreated for longer because of an unclear, complicated process. Prior authorization is more than an administrative nightmare; it's a barrier to providing timely, patient-centered care.

For these reasons, the Kansas Medical Society respectfully requests your support of HB 2283 and urge you to favorably recommend its passage.

**Attachment A.**

**Prior authorization is hurting patients:**

- 93% of physicians report care delays as a result of prior authorizations.
- 82% of physicians report that prior authorization can lead to treatment abandonment.
- 34% of physician reported that prior authorization has led to a serious adverse event for their patients.
- 24% of physicians reported that prior authorization has led to a patient's hospitalization.
- 18% of physicians reported life-threatening event or intervention to prevent permanent impairment or damage.
- 51% of physicians treating patients in the workforce report that prior authorization has interfered with a patient's ability to perform their job responsibilities.

**Prior authorization is costly:**

- Physicians and their staff spend more than 13 hours/week (nearly two business days) on prior authorizations.
- Physicians complete an average of 41 prior authorizations per week.
- 40% of physicians have staff who work exclusively on prior authorizations.
- 88% of physicians describe the prior authorization burden as high or extremely high.

**What can be done?**

As a start to fixing prior authorization, legislators and other stakeholders should consider how the volume of prior authorization is impacting patients, physicians and the health care system. While these programs may reduce the amount health insurers are paying on care in the short-term, delaying or denying medically necessary care is not an appropriate or effective long-term solution to reducing costs. Prior authorization, if used at all, must be used judiciously, efficiently, and in a manner that prevents cost-shifting onto patients, physicians and other providers.

As you consider legislation which puts patients ahead of prior authorization, like HB 2283, we recommend that you consider the following reforms:

- Establish quick response times (24 hours for urgent, 48 hours for non-urgent care).
- Adverse determinations should be made only by a physician licensed in the state and of the same specialty that typically manages the patient's condition.
- Prohibit retroactive denials if care is preauthorized.
- Authorization should be valid for at least 1 year, regardless of dose changes, and for those with chronic conditions, the prior authorization should be valid for the length of treatment.
- Require public release of insurers' prior authorization data by drug and service as it relates to approvals, denials, appeals, wait times and more.
- A new plan should honor the patient's prior authorization for at least 60 days.
- Volume reduction through the use of solutions like prior authorization exemptions or gold-carding programs.