



**TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
INSURANCE AND REAL ESTATE COMMITTEE
Tuesday, March 9, 2021**

**HB 6586, An Act Concerning Prior Authorizations And
Health Care Provider Contracts**

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **HB 6586, An Act Concerning Prior Authorizations And Health Care Provider Contracts**. CHA strongly supports this bill.

Before commenting on this bill, it is important to acknowledge that, since early 2020, Connecticut's hospitals and health systems have been at the center of the global public health emergency, acting as the critical partner in the state's response to COVID-19. Hospitals expanded critical care capacity, stood up countless community COVID-19 testing locations, and are a critical component of the vaccine distribution plan. Through it all, hospitals and health systems have continued to provide high-quality care for everyone, regardless of ability to pay.

Private health insurance is the dominant source of employer-sponsored healthcare coverage for most Connecticut residents. 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 impacted 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.

Prior authorization processes also have an enormous impact on the cost of care. These processes directly burden frontline clinicians and require that hospitals employ staff and develop infrastructure dedicated to the support of these processes. 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

There are a variety of ways that today's prior authorization processes are unnecessarily burdening providers and jeopardizing patient care. For example, there is a great deal of variation across health plans with respect to submission processes that govern prior authorization. This variation creates inefficiencies that are both unnecessary and costly. Plans also apply prior authorization for services where there is no evidence of inappropriate practice and care standards are well established.

Frequently, health plans also 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.

In fact, 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. Our hospitals report that patients can end up waiting for days in the emergency department or in an inpatient bed, modifying the patient's plan of care and the treating physician's discharge orders, and creating hospital backlogs that can strain capacity.

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. This bill addresses the urgent need for governmental action to end aggressive prior authorization practices. It will establish reasonable standards of prior authorization administration, the scope of services that are subject to management, and the clinical guidelines that may be applied. This bill will promote uniformity throughout the industry, protecting patient care and saving patients, providers, and taxpayers the cost of these wasteful practices.

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

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.