TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
INSURANCE AND REAL ESTATE COMMITTEE
Thursday, March 9, 2023

SB 6, An Act Concerning Utilization Review And Health Care Contracts, Health Insurance Coverage For Newborns And Step Therapy

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **SB 6, An Act Concerning Utilization Review And Health Care Contracts, Health Insurance Coverage For Newborns And Step Therapy.** CHA supports this bill.

Connecticut hospitals continue to meet the challenges posed by the COVID-19 pandemic and are now facing new challenges of treating sicker patients than they saw before the pandemic, with a dedicated but smaller workforce who are exemplary but exhausted. They are also experiencing significant financial hardships brought on by record inflation. Through it all, hospitals have been steadfast, providing high-quality care for everyone who walks through their doors, regardless of ability to pay.

Section 2 of SB 6 proposes to require health carriers to establish an electronic program to provide for the secure electronic filing of prospective and concurrent review (also referred to here as prior authorization) requests and other requests for prospective or concurrent utilization reviews by hospitals and healthcare professionals. It further requires that such program provide for the submission of available clinical information in support of these requests and transmission of health carriers' responses.

Section 3 of SB 6 seeks to address the inordinate delays in prospective and concurrent review that jeopardize patient health and safety by establishing substantially shorter timeframes for routine and urgent care review determinations; processing of requests twenty-four hours a day, seven days a week; and the timely acknowledgement of receipt of each request. Section 3 takes additional steps to rein in common abuses of the authorization process by precluding a carrier from requiring the submission of additional information that was not reasonably available at the time the hospital or professional filed the request. Subsequent sections provide important protections related to step therapies and authorizations for recurring healthcare services or prescription drugs.

Electronic Program Requirements for Prospective and Concurrent Review

We applaud the provisions in Section 2 of SB 6 that establish electronic program requirements for the conduct of prospective and concurrent reviews. However, we request additional specificity regarding essential electronic program capabilities that enable hospitals to do the following:

- Identify when prior authorization or predetermination is applicable for an item or service, using clinical decision support and/or user input, and for receiving notifications of changes
- Query a payer's system for updates on a pending prior authorization request and have a reason returned as to why a request is still pending
- Schedule a peer-to-peer review with the health plan's clinical staff if a service is denied
- Update inpatient authorizations to reflect the full range of pertinent diagnoses and level of services provided
- Update post-surgical or other procedure authorizations to document and solicit approval for adjusted diagnoses and procedure codes aligned with clinical needs addressed in the course of such procedures

The requirements for electronic prior authorization proposed in Section 2 are long overdue. Health plans commonly use inconsistent administrative protocols and a dizzying array of timelines and requirements for prior authorization requests, reviews, approvals, and communication. In addition, prior authorization processes are woefully inefficient. Authorizations frequently are conducted by phone, with long wait times, in some cases as much as several hours. Clinical information may be shared with initial reviewers who then pass the requesting physician along to additional clinical reviewers. The processes employed seem at times to disregard the value of clinical staff time and resources. The burdensome processes, multifarious requirements, and manual processing inevitably result in some failures of authorization or adherence to requirements and a loss of reimbursement.

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.

These compounded inefficiencies exact an enormous cost. 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 who do nothing but monitor plan bulletins for changes to the rules." Such costs are incurred by providers most directly, but ultimately contribute to the burden of healthcare cost growth borne by employers, taxpayers, and patients. The proposed requirements are an important first step to address these issues.

Requirements to Protect Patient Health and Safety

Section 3 and subsequent sections of SB 6 stem from the growing recognition that health plans have begun abusing the prior authorization process in a manner that negatively affects patient care and results in significant added costs and burden to hospitals and other healthcare providers throughout the state. 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 adversely 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 may need to wait all weekend to be discharged to a more appropriate level of care.

Section 3 of SB 6 takes direct aim at these inappropriate and inefficient authorization and review practices by ensuring timely response to requests and the effective communication of such responses, reducing the use of step therapy when it can be harmful, and avoiding pointless repeat reviews for recurring healthcare services and prescription drugs.

We are grateful for the legislature's attention to these important issues and the proposed remedies, which will help improve patient care and the well-being of the essential healthcare workers on whom their care depends, while reducing avoidable administrative cost and burden.

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