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Testimony of

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On

SB 129

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Ohio Senate Insurance Committee

Chairman Hottinger, Ranking Member Brown, and members of the Senate Insurance Committee, my name is Mark Moseley. I am medical director for utilization management and for patient flow at the Ohio State University Health System, part of The Ohio State University Wexner Medical Center.

One of the nation's leading academic medical centers, The Ohio State University Wexner Medical Center offers healthcare services in virtually every specialty and subspecialty in medicine. Thousands of patients come to us each month for treatments and services they cannot find anywhere else. Providing access to healthcare information is core to our research, education and patient care mission. At Ohio State Wexner Medical Center, we are dedicated to creating the future of medicine to improve people's lives.

In 2015, *U.S. News & World Report* named Ohio State Wexner Medical Center to its list of "America's Best Hospitals," based on quality, outcomes and reputation, for the 23rd consecutive year.

I am here today in strong support of Senate Bill 129. This bill will create a standardized prior authorization processes and timeframe, which will benefit our patients and create consistency for providers in care planning. I commend Senators Gardner and Cafaro for introducing this important legislation.

Prior authorization is a process insurers utilize to review certain prescribed medications, procedures, treatments or services before they will provide coverage. Insurers typically require prior authorization requirements to determine medical necessity and whether there would be available, more cost-effective alternatives. While the intent of keeping costs in check for consumers is a reasonable goal, in practice prior authorization requirements can cause delay in needed care for patients and are time consuming and costly to implement for providers.

For our patients receiving acute inpatient care, we have a dedicated team that works to get approval for our patients to receive necessary post-acute care. Many of our patients, particularly those who have been treated in our intensive care units (ICU), need ongoing care upon discharge. We frequently seek approval to move a patient to a long-term acute care (LTAC) hospital, which is a facility that specializes in treatment of patients with serious medical conditions who have needs greater than they can receive in a skilled nursing facility or at home. Examples of such patients are those with complex wound care needs or burns, or significant respiratory care needs.

Currently we deal with different prior authorization rules for different insurers, with turn-around time generally ranging from 48 hours to five business days. There is great discrepancy among insurers for the kinds of information they seek, as well. Standardization of this process would benefit patient care significantly. Under the bill a health plan must respond to prior authorization requests within 48 hours, and within 24 hours for urgent medical needs.

Much of the current process is cumbersome, requiring paper authorization and faxing of information. SB 129 would require a web-based system. The bill also would require the Ohio Department of Insurance to develop a single form not to exceed two pages to be used by all insurers for these requests. Consistency in the information requested and use of an electronic system should result in time and cost savings for providers without eliminating necessary information for insurers.

The legislation includes safeguards for patients in how coverage decisions will be made. SB 129 would require that adverse decisions be made by a physician or a panel that includes a physician with expertise in the treatment under review.

More importantly, the bill establishes transparency in this new process. SB 129 would require insurers to disclose on their web sites statistics regarding prior authorization approvals and denials. One unintended consequence of establishing strict time requirements for prior authorization could be that insurers would increase the rate at which they deny coverage for services. Having the denial rates publicly reported provides a safeguard against this potential practice since, at a time of increasing consumer choice for health insurance coverage, an unusually high denial rate could be reviewed by patients.

The following is one typical case example where this new process will improve patient care and reduce provider costs. A patient with a severe infection was transferred from an outlying facility to OSU, and received care in our ICU. As soon as appropriate we begin to seek authorization to transfer that patient to the next level of care; and frankly, families also want to get out of the hospital. The patient's insurer, as a matter of course, denies coverage for an LTAC hospital, even though the physician documents that it is the best place for this patient's ongoing treatment. The insurer subsequently denies coverage for a skilled nursing facility. The insurer finally approves coverage for home health care. However, this could be after a five – six day delay. At the same time we are undertaking this process and the patient is waiting for an approved transfer, the insurer is denying coverage for the inpatient stay that they no longer deem medically necessary. The impact of this cumbersome process is threefold: 1.) stress on families already dealing with a difficult medical condition; 2.) denial of the most appropriate level of care and delay in treatment planning; and 3.) significant financial impact on a family for their hospital inpatient stay or financial losses to us as a provider.

We can improve this system to get the right care for patients and reduce burdens on providers. SB 129 is a good bill. It will level the playing field between our patients and insurers, create predictability for providers, and improve care. Thank you again for allowing me to testify. I would be happy to answer any questions you may have.