

Congress of the United States
U.S. House of Representatives
Committee on Small Business
2361 Rayburn House Office Building
Washington, DC 20515-6515

TO: Members, Committee on Small Business

FROM: Nydia M. Velázquez, Chairwoman

DATE: September 11, 2019

RE: Full Committee Hearing: “Utilization Management: Barriers to Care and Burdens on Small Medical Practices” in room 2360 of the Rayburn House Office Building

The Committee on Small Business will hold a hearing entitled, “Utilization Management: Barriers to Care and Burdens on Small Medical Practices” on Wednesday, September 11, 2019 at 11:30 a.m. in Room 2360 of the Rayburn House Office Building.

Health care providers want nothing more than to provide their patients the highest quality and most clinically appropriate care. However, due to utilization management programs such as prior authorization and step therapy, doctors are forced to spend their time working with insurance companies and pharmacy benefit managers instead of treating patients. While cost saving efforts are critical to the nation’s health system, such programs are affecting the quality of care and proving burdensome to many small medical practices. The hearing will examine how the programs work and how they are impacting small medical practitioners in a variety of settings.

Witnesses

- Dr. Paul M. Harari, M.D., Professor and Chairman, Department of Human Oncology, University of Wisconsin School of Medicine and Public Health; Testifying on behalf of the American Society for Radiation Oncology
- Dr. David R. Walega, M.D., MSCI, Associate Professor of Anesthesiology; Chief, Division of Pain Medicine; Vice Chair for Research, Department of Anesthesiology, Northwestern University Feinberg School of Medicine; Testifying on behalf of the American Society of Anesthesiology
- Dr. John Cullen, M.D., President, American Academy of Family Physicians
- Dr. Howard Rogers, M.D., FAAD, Advanced Dermatology, Testifying on behalf of the American Academy of Dermatology Association

Background

The United States spends more on health care than any country in the world. In 2016, health care expenses totaled 17.8 percent of gross domestic product, nearly double that of other high-income

countries.¹ Meanwhile, only 90 percent of our population is covered by health insurance, while those same high-income countries cover between 99 and 100 percent of their population.² Much of the large and growing health care expenses in the U.S. emerge from administrative costs, particularly those from billing and insurance-related activities in a multi-payer model.³

Administrative complexities such as prior authorization and step therapy have put small private practices at a disadvantage. In many cases, the support staff at a small medical practice often rivals that of the physicians who treat patients. Some estimates suggest that for every ten physicians, seven administrative staff members are required.⁴ These practices are essential parts of their communities. However, their inability to achieve economies of scale, compared to the degree of their larger counterparts, results in physicians spending more time dealing with paperwork, health insurance companies, and less time with patients. Smaller private practices, particularly those in rural or underserved communities, already operate on very thin margins, so the added burdens and costs associated with overhead and administrative costs can be the difference between staying open or closing the business.

What is Prior Authorization?

Prior Authorization is a process ordered by health insurance plans requiring a physician to first obtain approval before conducting a procedure or prescribing a medication. The purpose is to prevent waste within the health care system. For instance, making sure there is a cheaper drug alternative before jumping straight to what a physician prescribes or preventing a physician from conducting an MRI on a patient with an injured back. While it was initially introduced as a cost-saving measure, many physicians, primary care doctors and specialists alike, suggest that these precautions have become overly-burdensome. As a result, physicians are spending more time on paperwork and billing, while patients are delayed critical care.

According to a survey conducted by the American Medical Association, 91 percent of physicians state that prior authorization either always or often delays access to necessary care and many doctors must hire administrative staff dedicated solely to obtaining prior authorization from insurance companies.⁵ According to the American College of Physicians, prior authorization involves varying forms, data elements, and submission mechanisms that force physicians to enter unnecessary data in the electronic health record (EHR) or perform duplicative tasks outside the clinical workflow.⁶ Furthermore, the process of obtaining a prior authorization is time consuming and inconsistent between insurance providers.

¹ Irene Papanicolas, Liana R. Woskie, and Ashish K. Jha, *Health Care Spending in the United States and Other High-Income Countries*, 319(10) JAMA 1024 (2018), <https://jamanetwork.com/journals/jama/article-abstract/2674671> (last visited Sep. 4, 2019).

² *Id.*

³ *Id.*

⁴ Julie Ann Sakowski, James G. Kahn, Richard G. Kronick, Jeffrey M. Newman, and Harold S. Luft, *Peering Into The Black Box: Billing and Insurance Activities in a Medical Group*, HEALTH AFFAIRS (2009) <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.28.4.w544>.

⁵ AM. MED. ASS'N, *2018 AMA Prior Authorization (PA) Physician Survey*, <https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf> (last visited Sep. 4, 2019).

⁶ AM. COLL. OF PHYSICIANS, *Reduce Unnecessary Administrative Tasks on Physicians and Patients*, <https://www.acpservices.org/sites/default/files/shared/documents/leadership-day/19/priority-issues/8.pdf> (last visited Sep. 4, 2019).

Prior Authorization Process

The prior authorization process varies according to the health insurance plan, state laws, and federal laws and regulations. However, it typically follows a general trend. When a patient needs a certain drug or procedure, the health care provider, on behalf of that patient, reaches out to the patient's health plan for reimbursement. For the insurance company to cover the treatment or diagnostic test, the provider must submit medical records and a letter of medical necessity, often submitted via fax. A utilization review entity that works on behalf of the insurance company reviews the information and makes the decision whether to accept or deny the requested drug or procedure. Though, the procedure is much the same, the criteria for medical necessity can vary by plan. Given that doctors accept and interact with hundreds of different health plans, it can be unclear what information they need to provide to the utilization review entity, often resulting in incomplete forms and further delays to care.

One of the main factors slowing down this process is when an insurance company denies a treatment for a patient. When a procedure or prescription is denied, the patient is unable to undergo treatment, resulting in the provider appealing the denial. The appeals process can go through one or two stages, depending on the law. The appeal is reviewed by a physician who was not involved in the initial determination, and the original provider must often directly call the reviewer. This process is called peer-to-peer review and is especially challenging for specialty practices. Specialists argue that, for the most part, the reviewer has very limited knowledge of the procedure or medication they are attempting to provide.

Ultimately, about 71 percent of the services are approved, with a third of physicians getting approved 90 percent or more of the time.⁷ Additionally, over half of the denials are overturned after the appeal process.⁸ While the process generally approves most services and medications, small medical practices believe it is unduly burdensome. The justification from payers is that it serves as a deterrent to inappropriate care and ensures care is consistent with evidence-based practices. It can also be used when prescribing medications like opioids to make certain that they are only used when absolutely necessary. However, this requirement creates more costs for providers and hinders their ability to treat patients. In fact, over 90 percent of physicians state that prior authorization is a high or extremely high burden and over 87 percent report that it has a negative impact on their patient outcomes.⁹

Impact on Small Medical Practices and Health Outcomes

Small, physician-owned practices have been in a decades-long decline.¹⁰ In 1983, 76 percent of physicians owned their own practice;¹¹ however, this number dropped below 50% for the first time in 2016.¹² There are numerous reasons for this decline. Higher costs and lower reimbursement

⁷ REGULATORY RELIEF COAL., *Prior Authorization Survey*, https://www.cns.org/sites/default/files/legislative/prior_authorization_survey_results-final.pdf.

⁸ AM. PHYSICAL THERAPY ASS'N, *The Impact of Administrative Burden on Physical Therapist Services*, https://www.cns.org/sites/default/files/legislative/prior_authorization_survey_results-final.pdf (last visited Sep. 4, 2019).

⁹ *Supra* note 7.

¹⁰ Medical Billing Services, *The Decline of Independent Healthcare Providers*, <https://abcsrcm.com/the-decline-of-independent-healthcare-providers/> (last visited Sep. 4, 2019).

¹¹ *Id.*

¹² *Id.*

rates from insurance companies forced many practitioners to join large hospitals, physician networks, and health systems. This trend has been exacerbated by administrative burdens in the form of utilization management such as prior authorization. The effect is even more acute for smaller practices that serve an important role in their communities but have not achieved the economies of scale necessary to be efficient with required administrative tasks. Administrative costs when dealing with health plans are much higher for smaller practices. According to one study, primary care practices with one to two doctors spend an average of \$72,675 annually interacting with health plans. This number is only \$57,480 for practices with ten or more doctors.¹³ It is also much lower for large networks and hospital-based physicians as they tend to have a dedicated administrative staff to complete prior authorizations as the sole focus of their work.

Due to limited staffing capabilities, small and solo practitioners often rely on themselves to complete the requisite paperwork for prior authorizations. Many physicians work before or after patient hours or on weekends to complete this work, while others dedicate time they could be treating patients to prior authorization. The requirement for prior authorization can lead to physician burnout. According to a report by Medscape, 44 percent of all respondents across all medical specialties are experiencing burnout.¹⁴ This is especially high among urology (55%), neurology (over 50%), and primary care (around 50%).¹⁵ The overwhelming reason for this burnout is too many administrative tasks and interactions with payers, for things like prior authorization.¹⁶ Physician burnout exacerbates the already pressing issue of the need for more physicians to serve the health care needs of the country. According to projections by the AAMC, the country faces a physician shortage that could reach upwards of 100,000 by 2030 with most of them being primary care.¹⁷

Perhaps more important than the costs to doctors and businesses are the costs to patients. These costs are not always monetary but can directly cost patients' health and time. Approximately 74 percent of physicians say prior authorization can take between 2 and 14 days, with 15 percent saying it can take from 15 to more than 31 days.¹⁸ This means that patients are being delayed necessary medical care because of the paperwork formalities of prior authorization. For patients needing to be treated as soon as possible, this is an unreasonable burden. In many cases the delay of treatment can cause adverse health consequences. One survey found that 87 percent of physicians report that prior authorization has a negative impact on clinical outcomes and 82 percent reported patients abandoning treatment altogether.¹⁹ Instead of patients receiving the directed care in a timely matter upon diagnosis, they must endure delays that can cause their condition to worsen.

¹³ Lawrence P. Casalino et al., *What Does it Cost Physician Practices to Interact with Health Insurance Plans?*, HEALTH AFFAIRS, (2009), <https://www.healthaffairs.org/doi/10.1377/hlthaff.28.4.w533>.

¹⁴ Advisory Board. *Physician Burnout in 2019, Charted*. <https://www.advisory.com/daily-briefing/2019/01/18/burnout-report> (last visited Sep. 4, 2019).

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ ASS'N OF AM. MED. COLL., *New Findings Confirm Predictions on Physician Shortage*, <https://news.aamc.org/press-releases/article/2019-workforce-projections-update/> (last visited Sep. 4, 2019).

¹⁸ *Supra*, note 7.

¹⁹ *Id.*

This is a serious problem in patient cases that need immediate medical attention. For instance, radiation oncologists need to immediately start treatment on rapidly spreading tumors. With cancer, time is not on your side, and delays due to prior authorization can cost someone their potential recovery. In fact, 90 percent of radiation oncologists report treatment delays.²⁰ While insurance companies and health care providers grapple with the paperwork of the prior authorization process, patients' health is at stake. Prior authorization is distracting from the primary purpose of health care providers, and in no scenario should its cost-saving benefits take priority over patients' wellbeing.

Policy Considerations

While it is intended to provide a cost control for health care providers, there is consensus among doctors that prior authorization is being over used and the current process presents significant administrative burdens ultimately impacting patient health. Below are potential reforms to address this very important issue.

Clinical Validity

A legitimate reason to require prior authorization on certain prescription drugs and medical procedures is to ensure the patient is receiving evidence-based treatment. However, this does not always align with its use for certain treatments by prioritizing cost-containment measures over what is clinically appropriate. Every patient is not the same, therefore treatments that may be generally appropriate for certain conditions, may not be in the best interests of a particular patient. For example, the presence of comorbidities (two simultaneous chronic illnesses) or taking into account a patient's reaction to multiple drugs for treatment. One way to ensure patient care is at the forefront is to ensure that any utilization management program be flexible to meet the patients' needs and to allow for timely review of treatments that are denied. Finally, physicians should be making the final decision of what is right for patients, not their clinical review entity.²¹

Continuity of Care

Patients are sometimes forced to interrupt ongoing treatment due to a health plan utilization management coverage restriction. Often, this comes from a change in the formula, treatment coverage, or health plan. Disruption in the treatment process can have a negative impact on the health of the patient. In such a case, utilization review entities should offer a grace period for those stabilized on a certain treatment upon enrollment in a new plan or change to a current one. Furthermore, if a plan changes during the course of a year, plans should continue to cover patients who are using the treatments that were taken off the coverage.²²

²⁰ AM. SOC'Y FOR RADIATION ONCOLOGY, *Prior Authorization and Cancer Patient Care*, <https://www.astro.org/ASTRO/media/ASTRO/News%20and%20Publications/PDFs/ASTROPriorAuthorizationPhysician-SurveyBrief.pdf> (last visited Sep.4, 2019).

²¹ AM. MED. ASS'N, *Prior Authorization and Utilization Management Reform Principles*, <https://www.ama-assn.org/system/files/2019-06/principles-with-signatory-page-for-slsr.pdf> (last visited Sep. 4, 2019); AHA, AHIP, AMA, APHA, BLUECROSS BLUESHIELD, MGMA, *Consensus Statement on Improving the Prior Authorization Process*, <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf> (last visited Sep. 4, 2019).

²² AM. MED. ASS'N, *supra* note 21.

Transparency, Automation, and Electronic Prior Authorization

Traditionally, prior authorization is submitted via fax, requiring physicians and staff to manually fill out patient health information to prove medical necessity. Additionally, certain guidelines to prove medical necessity are not fully available from the health plan, thus requiring medical professionals to do duplicative work in the event of a denial.

Another reason physicians are frustrated is that the reason for the denial of a treatment by a health insurance plan is not always clear. Patients often proactively and carefully review formularies (deductibles, percentage paid out of pocket by the health plan) and coverage restrictions prior to purchasing their health plan. Patients do this to ensure they are selecting the best health plan that meets their medical needs. However, health insurance plans are making changes to formularies and coverage restrictions throughout the plan year. Changes made by health insurance plans regarding formulary and coverage restrictions lack clarity from utilization review entities to doctors and patients, further leading to confusion, delay, and denial of treatment.²³ One potential solution is to require health insurance companies to cover drugs or treatments for the entire benefit year.

One way to mitigate confusion, maximize transparency, and make the health care system more efficient is to incorporate Electronic Health Records (EHRs) into the review process. EHRs provide accurate, up-to-date, and complete information about patients and allow for a more coordinated health care system. As such, there should be coordination and communication of up-to-date prior authorization and step-therapy requirements, coverage criteria and restrictions, drug tiers, relative costs, and covered alternatives among (1) EHR, pharmacy system, and other vendors to promote accessibility of this information to providers at the point-of-care via integration into ordering and dispensing technology interfaces and (2) via websites easily accessible to contracted health care providers.²⁴

This could involve moving toward an industry-wide adoption of electronic prior authorization transaction based on national standards, which has the potential for streamlining the process for all stakeholders. Additionally, including all this information electronically in EHR systems will improve process efficiencies, reduce time to treatment, and potentially result in fewer prior authorization requests because health care providers will have the coverage information they need when making treatment decisions.²⁵

Conclusion

The prior authorization process, while sometimes necessary to promote clinical standards and disincentivize unnecessary care, creates an administrative burden that costs time, money, and resources to physicians and their staff. It often delays routine care for patients and takes clinical autonomy away from physicians. It can put patients in danger and threaten the ability of a physician to run their own practice. This hearing will allow Members of the Committee to hear about an ongoing issue within the current health care system and discuss policies to reduce the administrative burdens so that doctors can treat more patients in a timely manner which will lead to better health outcomes.

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.*