

Good afternoon Madame Chair and Members of the Committee, my name is Molly Eckerle, and I am a graduate student at the University of Denver and policy intern with Chronic Care Collaborative. We proudly advocate for the over 60% of Coloradans living with chronic conditions and their caregivers. Today I testify on behalf of one of our community members who could not be here. This is her story:

My name is Rebecca Gillett. I live in Centennial, Colorado. I was diagnosed with Rheumatoid Arthritis over 22 years ago at age 26. I'm also an occupational therapist. I'm here representing myself and all patients with arthritis and other chronic diseases.

Last year, I endured extended delays in getting approval for a new medication my rheumatologist and I felt would be better for me. I was getting infusions every 4 weeks. She put in the request in January. It was initially rejected for more information and required a one-on-one call with the provider. She submitted an appeal. And then, we waited. And waited. Her staff person would call the insurance company for updates, each month before I was scheduled for the next infusion. By March, we still did not have approval. And then I lost my job and had to get my own insurance in April through Colorado Connect.

We had to resubmit the request again, under this new plan.

Why did my doctor feel I needed to switch medications? Because in 2022, I had a year of multiple health issues. My immune system, because of my RA and immunosuppressant medications, could not fight any infection. I had COVID three times that year and in between each of those COVID events, ended up in the ER with different issues - appendicitis, abdominal abscess and then eventually, sepsis. I was very lucky to catch each of these issues in the nick of time before they could have been even worse.

Waiting an additional four months for a prior authorization to come through prolonged my risks for becoming ill again. My immune system needed a reset and the new medication was supposed to help.

If a physician requests prior authorization for a new treatment the decision is not made lightly. The emotional toll I experienced in that year of illness was only worsened by dealing with prior authorization delays for four months, for what could be a solution to getting me on a healthier path.

For the record, on the new infusion treatment, I have avoided any new infections or issues to this day, so we made the right choice to switch.

This bill would have helped to limit what I experienced last year, if it were in place. Prior authorization disproportionately affects people of color with chronic diseases and I am included in that statistic, as I am Filipino. I urge you to support HB 1149 to ensure access to equitable health care for all so that other patients like me don't have to experience unnecessary delays in care.

Thank you.

House Health & Human Services

02/21/2024 01:30 PM

HB24-1149 Prior Authorization Requirements Alternatives

Typed Text of Testimony Submitted

Name, Position, Representing	Typed Text of Testimony
<p>Nathan Culberson</p> <p>For</p> <p>Colorado Association of Family Physicians</p>	<p>Feb 21, 2024</p> <p>Members of the Health and Human Services Committee.</p> <p>My name is Nathan Culberson, and I am a family physician in Pueblo. I am testifying on behalf of the Colorado Academy of Family Physicians, which represents over 2,500 family physicians, residents, and students across our state in support of Bill HB24-1149 because it will allow physicians to take better care of their patients.</p> <p>Prior authorizations have become a significant barrier to providing quality medical care to patients. I wanted to share a story from my own practice to highlight how these practices can affect patients.</p> <p>A few months ago, my office received a call from a patient that his private insurance company had denied his renewal for a home ventilator and they were coming to pick it up. The original denial had happened a month or two prior, but hadn't been communicated to my office. The patient is ventilator dependent. Documentation from his last admission clearly showed an evaluation a pulmonologist, which stated that he needed continued use of the ventilator. That afternoon, I spent an hour and a half attempting to appeal the decision, but no matter who I talked to, no one could do anything about the decision for the next 72 hours, despite the fact that it was urgent and needed to happen that day. I ended convincing the medical supply company not to pick up the ventilator until the appeal had gone through. I then had to call the insurance company back, schedule a physician-to-physician communication and re-fax the appropriate documentation. Thankfully the appeal was accepted and the patient was able to keep his ventilator for the next year. I spent over an hour and a half that day to ensure my patient wasn't in a life-threatening situation. That is an hour and a half I could have been seeing and caring for patients. On that particular day, if I wasn't able to devote this time to making multiple calls to his insurance company and medical supply company, the patient could have died.</p>

	<p>This is just one of untold numbers of examples of how these practices can directly lead to harm for our patients. Medical decisions should be between a patient and their provider. This bill will establish common-sense solutions and start to remove some of the unnecessary burdens that too often come between our patients and the care they need. Because of this, we ask for your vote in support of this bill. Thank you very much for your time.</p> <p>Sincerely, Nathan Culberson</p>
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February 8, 2024

Members of the Health and Human Services Committee,

My name is Marisa Wickerath and I am a family physician in Denver. I am testifying on behalf of the Colorado Academy of Family Physicians, which represents over 2,500 family physicians, residents, and students across our state in support of HB24-1149, Prior Authorization Requirements Alternatives. I believe this bill is an important step toward reducing barriers to care for patients, improving transparency within our healthcare system, and minimizing administrative burden for providers.

Unfortunately, I experience delays in care for my patients on a regular basis due to unnecessary prior authorizations. For example, I recently received a message stating that a prescription for a very common drug had been denied by insurance. The patient's insurance had requested a prior auth which I completed, but it then was denied. I was sent the preferred formulary to order a different drug, only to find that the preferred formulary included the exact drug I had been ordering.

This system is not only incredibly frustrating, but it is also hurting our patients. 94% of physicians report that care is delayed because of prior authorizations. 25% of physicians report that prior authorizations led to patient hospitalization. This broken system also results in unnecessary administrative work. I cumulatively spend hours of my week doing needless paperwork instead of real patient care, in large part due to prior auths, and I am not alone. According to a 2022 Physician Survey by the American Medical Association, physicians and their support staff spend an average of 14 hours per week on prior authorizations. This is a poor use of our healthcare resources and is directly related to increasing administrative burden and physician burnout. We need to take a hard look at this wasteful, inefficient system that is hurting both patients and providers.

HB 24-1149 would help address these issues by streamlining and increasing transparency around insurance companies' prior authorization processes. This bill would require insurance companies to clearly communicate the number of prior authorizations approved, denied, and appealed for consumers. This bill would also eliminate unnecessary waste in the form of repeat prior auths when a previous prior auth for a treatment has already been approved in the past. Finally, this bill would help improve transparency for both patients and providers by providing a clear database of preferred formulary drugs.

We ask for you to vote in support of this bill as we believe this will help reduce barriers to necessary care while also ensuring our healthcare resources are not being wasted. Thank you for your time in considering this important legislation.

Sincerely,

Marisa Wickerath, MD
Denver

1/25/23

Members of the Health and Human Services Committee:

My name is Haley Porter and I am a family physician in Denver, Colorado. I am testifying on behalf of the Colorado Academy of Family Physicians, which represents over 2,500 family physicians, residents and students across our state in support of HB24-1149 because it will reduce burdensome bureaucratic tasks, improve patient care by decreasing wait times for needed medication, and improve transparency to prevent confusion and waste.

I can think of multiple stories that one of my patients needed a medication to improve their health that they had to wait to receive due to prior authorization. For example, one of my patients with diabetes that needed better control was a great candidate for a medication called a GLP-1. The medication has great evidence that it can help lower A1C and therefore help prevent sequelae of diabetes including heart attack, strokes, and kidney failure. This medication required a prior authorization which meant this patient could not get the medication they needed to improve their health and help prevent long term effects of uncontrolled diabetes.

This issue not only affects multiple patients and likely everyone either knows someone or has personally been affected by prior authorizations. While this is challenging, it is also important to point out that prior authorizations disproportionately impact Coloradans with disabilities or low incomes, women, and people of color. One in three patients report either delaying or forgoing needed health care because of an administrative tasks (like prior authorizations), which can become more expensive in the long run due to delayed medical care. Lastly, chronic disease patients who are Black or Hispanic experience prior authorization denials at a 19%-40% greater rate than white patients.

Passing this bill will not only improve access to care for all Coloradans but will further help close the gap of disparities when seeing how prior authorizations disproportionately affect many members of our society. It will prevent disruptions in care, improve transparency with drug costs, and reward great care with fewer barriers.

Thank you for your time. Your consideration of these matters and solutions is very much appreciated and we ask you for your vote in support of this bill.

Sincerely,

Haley Porter, MD MPH
Denver, CO



February 13, 2024

Representative Lindsey Daugherty, Chair
House Health and Human Services Committee
HCR 107
200 E Colfax Avenue
Denver, CO 80203

Dear Chair Daugherty and Members of the House Health and Human Services Committee,

The Rocky Mountain Oncology Society (RMOS) and the Association for Clinical Oncology (ASCO) are pleased to provide our strong support for HB 1149, which would exempt providers with a high rate of approvals from prior authorization requirements.

Formed in 1991, RMOS is a diverse community of oncology professionals whose mission is to promote the highest professional standards of oncology, research and exchange information and ideas leading to improvements in oncology. ASCO is a national organization representing physicians who care for people with cancer. With nearly 50,000 members, our core mission is to ensure that cancer patients have meaningful access to high quality, equitable cancer care.

Prior authorization, which requires patients or their clinicians to secure pre-approval as a condition of payment or insurance coverage of services, is consistently identified as the largest barrier to care for insured patients. In a recent ASCO survey, 80% of respondents said that a patient has experienced significant impacts on their health, such as disease progression, because of prior authorization processes. The most common harms to patients include delays in treatment (95%) and diagnostic imaging (94%), patients being forced onto second-choice therapy (93%) or denied therapy (87%) and increased out-of-pocket costs (88%). These survey results confirm that the administrative burdens associated with prior authorization contribute to major delays and denials of necessary, appropriate, and in many cases, lifesaving care.

RMOS and ASCO are committed to supporting policies that reduce cost while preserving quality of cancer care; however, it is important that these policies are developed and implemented in a way that does not undermine patient access. Payer utilization management approaches like prior authorization are of particular concern because they represent greater likelihood of raising barriers to appropriate and timely care for patients with cancer. While many treatments preferred by payers cost less, they may not be the best treatment available for the patient.

HB 1149 requires insurers to review the list of procedures, diagnostic tests, prescription drugs, and other services that require prior authorization and eliminate requirements for those services that have a

high frequency of approval. This would reduce administrative burden, allowing physicians to spend more time with patients.

Patients forced to interrupt ongoing treatment due to health plan utilization management restrictions can experience negative health outcomes. This measure promotes continuity of care by prohibiting an insurer from denying a claim for a health-care procedure that a clinician provides related to an already-approved surgical procedure. The bill also extends the duration of an approved prior authorization for a health care service or prescription drug to a calendar year.

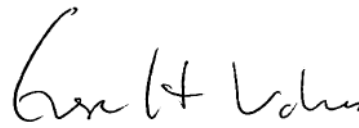
Finally, this legislation requires insurers to make available certain statistics regarding the number of prior authorization requests that are approved, denied, or appealed. This information would enable lawmakers to evaluate the effectiveness, potential impact, and cost of prior authorization processes on patients, physicians, insurers, and the system as a whole.

RMOS and ASCO support HB 1149 and encourage the Committee to pass this legislation to ensure that physicians most familiar with their patients' health care needs can provide timely care. For a more detailed understanding of our policy recommendations on this issue, we invite you to read the [ASCO Position Statement: Prior Authorization](#). Please contact Sarah Lanford at ASCO at Sarah.Lanford@asco.org if you have any questions or if we can be of assistance.

Sincerely,



Tejas Patil, MD
President
Rocky Mountain Oncology Society



Everett Vokes, MD, FASCO
Chair of the Board
Association for Clinical Oncology