Member of the Minnesota Council on Disability – Thank you for inviting me to share my story today.

I am a part of a group of parents who have children with a rare disease in the state of Minnesota. These children rely heavily on insurance to lead their best lives and participate in their communities. The measures that are being proposed by HF3578 (Bahner): Prior authorization and coverage of health care services requirements modified. This is important legislation for the timely diagnosis and treatment of patients with rare diseases.

First, I will share a bit about my journey with Leo

Anne & Leo

Leo was born in May of 2016 and was diagnosed with infantile Pompe disease, a rare genetic disorder. His body stores up glycogen in the muscles and the heart causing deterioration, muscle weakness, respiratory failure, cardiomyopathy, and the list goes on. Throughout his life, Leo has received support from quite a few different medical specialists and home care services. Weekly enzyme replacement infusion therapies, monthly respiratory therapy visits to check his trach and ventilator, weekly physical therapy, weekly occupational therapy, weekly speech therapy, and even nutritional support. That's not even the full list. Needless to say, he is a very complex patient, but at the end of the day he is still a kid. And he wants to play, to run, and to keep up with his older brother, just like any other kid. For that to continue, Leo needs to be granted access to care through an organization that understands the unique needs of a child like him. He needs access to care from providers that we choose and know understand our child's disease. Leo does not need to have to worry about network barriers and being told that he can't see a provider because they are out of network. As Leo continues to grow his needs will change and those doctors may change as well. The ability to be nimble and adjust to fit his needs is one of the many reasons Leo is succeeding at home today. The specialist and medical team we have worked to create to treat Leo is why we have been able to avoid hospital admissions despite his complex diagnosis and care needs.

Now that you know a little more about Leo, I'd like to share why I support this legislation and why I want you vote in favor of this legislation. I want to make sure that individuals with a rare disease have access to a provider that is knowledgeable about their disease.

I am writing to express my strong support for HF 3578 and urge you to vote in favor of this legislation. This bill is crucial for ensuring that individuals with rare diseases have access to healthcare providers who are knowledgeable about their conditions.

Rare diseases, affecting fewer than 200,000 people in the United States, pose significant challenges for patients and their families. With over 25 million Americans and more than 300 million people worldwide living with rare diseases, the impact is substantial, especially considering that more than half of those affected are children. Despite there being over 7,000 identified rare diseases, only 10% have an FDA-approved treatment. This lack of treatment options, combined with the difficulty in obtaining a diagnosis (which takes an average of seven years in the U.S.), often leads to delays in proper care, inaccurate diagnoses, and sadly, premature death, with 30% of rare disease patients not surviving past the age of 5.

One of the major challenges faced by individuals with rare diseases is navigating insurance networks. The process of obtaining prior authorizations for specialist appointments and treatments can be a significant barrier to timely care, which is often a matter of life or death. My personal experience with insurance barriers highlights the critical need for legislation like HF 3578. When my son Leo was diagnosed with Pompe disease, a rare and life-threatening condition, our insurance approval process for specialist care was agonizingly slow. Leo's diagnosis only came after he almost died, highlighting the urgent need for timely access to specialists and treatments.

Our struggle with insurance approval for Leo's care was just one example of the many challenges faced by rare disease families. Despite having good insurance and the means to pay for out-of-pocket expenses, the process was still incredibly stressful and time-consuming. We were fortunate to have access to specialists who could help us navigate the system, but many families are not as lucky.

Legislation like MN 3578 is essential for ensuring that all rare disease patients have access to the care they need. By streamlining the prior authorization process and ensuring coverage of essential health care services, this bill will help alleviate the burden faced by rare disease families and improve outcomes for patients like Leo. It will also ultimately save the state money by reducing the need for long-term care and hospitalizations.

As a parent and a concerned citizen, I urge you to support HF3578 (Bahner) and help ensure that no family has to go through what we went through. Every rare disease child deserves access to knowledgeable providers and timely care. Please do not let insurance barriers stand in the way of a child's life or future.

Thank you for your time and attention to this matter. Thank you for your time and attention to this matter.

Sincerely,

Anne St. Martin

A Concerned Parent of Children with Rare Disease

anne@pompewarriorfoundation.com

630.670.6569 - cell

Chair Liebling and Committee Members,

I am writing on behalf of the American Diabetes Association (ADA), the nation's largest voluntary health organization concerned with the health of people with diabetes to express our support for House File 3578. In particular, we want to express our support for Subdivision 5 for the treatment of chronic conditions and that an authorization for the treatment of a chronic condition does not expire unless the standard of treatment changes.

Approximately 385,569 people in Minnesota or 8.8% of the adult population have diagnosed diabetes. There are 1,441,000 people in Minnesota who have prediabetes and an estimated 33,731 people in Minnesota are diagnosed with diabetes each year.[1]

Diabetes requires continuous management and treatment, without it people are at higher risk of developing serious complications including cardiovascular disease, chronic kidney disease, foot complications, and stroke, among others. Any delay in care can be harmful for people with diabetes, who rely on their medication to live and manage the disease. Streamlining the prior authorization process will remove an unnecessary barrier for people with diabetes. The American Diabetes Association broadly supports efforts to minimize burdens put on patients and providers that hinders their ability to access the treatments that they need on an ongoing basis.

For people with diabetes, 23% reported experiencing prior authorization problems compared to 14% of other adults.[2] Eliminating the expiration for prior authorizations for people with chronic diseases will help ensure that people with diabetes, which unfortunately for so many does not go away, will not have issues with accessing their prescription medications and supplies. We respectfully urge your support on House File 3587.

Carissa Kemp
Director of State Government Affairs
American Diabetes Association

[1] https://diabetes.org/sites/default/files/2023-09/ADV_2023_State_Fact_sheets_all_rev_Minnesota.pdf
[2] https://www.kff.org/affordable-care-act/issue-brief/consumer-problems-with-prior-authorization-evidence-from-kff-survey/

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February 14, 2024

Health Finance and Policy Committee
Minnesota House of Representative
100 Rev. Dr. Martin Luther King Jr. Blvd,
Saint Paul, MN, 55155

Re: AHIP Comments Opposing HF 3578

Dear Chair Liebling, Vice Chair Bierman and members of the committee,

AHIP and our members appreciate the opportunity to respectfully express our opposition to HF 3578, legislation that, among other things, requires health insurance providers to exempt certain providers from having to complete the prior authorization (PA) process through what is known as gold carding programs and implement application programming interfaces (APIs).

We are aligned with the Committee's commitment to increase access to high-quality, affordable health care for everyone in Minnesota. However, we believe these aims are best achieved when the policies are not overly restrictive, as that could inadvertently harm patient safety and increase health care costs for all patients.

PA is a proven tool that ensures patients get the most up to date evidence-based care and prevents clinical deviations that could adversely impact patients. Health insurance providers collaborate with health care providers and other stakeholders to implement innovative solutions to improve the PA process. However, the need for PA is evident; 30% of all heath care spending in the United States may be unnecessary, and in many cases harmful to patients.[1] Every year low-value care costs the U.S. health care system $340 billion.[2] Further, 87% of doctors have reported negative impacts from low-value care.[3]

Prior authorization is critical to ensuring safe, effective, and cost-efficient health care for patients.

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[1] *Waste in the US Health Care System*. Shrank, William H. JAMA. October 2019. https://achp.pub/JAMA-LVC.
[2] *Low-Value Care*. University of Michigan V-BID Center. February 2022. https://achp.pub/VBID-Low-Value-Care.
[3] *Characteristics of Low-Value Services Identified in US Choosing Wisely Recommendations*. Ganguli, Ishani. JAMA Internal Medicine, February 1, 2022, https://achp.pub/Low-Value-Study-2022.

Health insurance providers are focused on ensuring that patients get the right care, at the right time, in the right setting, and covered at a cost that patients can afford. Insurers are uniquely positioned to have a holistic view of a patient's health care status and use prior authorization as an effective tool that helps to lower a patient's out-of-pocket costs, protects patients from overuse, misuse or unnecessary (or potentially harmful) care, and ensure care is consistent with evidence-based practices before care is delivered.

When providers and health plans work together, the patient benefits with better outcomes and less financial burden. Health insurance providers continue to innovate and collaborate with providers and other stakeholders to implement solutions to promote evidence-based care and improve the prior authorization process. Examples include:

- Streamlining prior authorization for complete courses of treatment for musculoskeletal and other conditions.
- Promoting electronic prior authorization (ePA) requests and decisions.
- Providing feedback to health care providers on their performance relative to their peers and professional society guidelines.
- Waiving prior authorization for providers with a demonstrated track record in practicing evidence-based care.

PA also promotes the appropriate use of medications and services by helping to confirm that they do not interfere with other types of medications or potentially worsen existing conditions. This includes verifying that medications are not co-prescribed in a manner that could have dangerous, even potentially fatal, interactions. Additionally, PA helps to ensure that medications and treatments are safe, effective, and appropriate. Furthermore, it provides guardrails to help ensure that drugs and devices are not used for clinical indications other than those approved by the Food and Drug Administration or those that are supported by medical evidence. And finally, it helps to ensure that patients with a newly prescribed medication or course of treatment will receive accompanying services such as counseling, peer support, or community-based support, as appropriate.

PA clinical criteria are evidence-based, developed by nationally recognized entities, and help to ensure providers are adhering to the most up-to-date evidence-based standards. The importance of utilization management tools such as PA cannot be understated, a recent study found that the amount of medical knowledge ***doubles every 73 days***.[4] And according to another study from the

[4] Densen, Peter. *Challenges and Opportunities Facing Medical Education*. Transactions of the American Clinical and Climatological Association 2011. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3116346/.

Journal of Internal Medicine, primary care providers would have to practice medicine for nearly 27 hours per day to keep up with the latest guidelines.[5]

Even with the fast-paced growth of medical knowledge, health insurance providers use PA sparingly, with the percentage of covered services, procedures, and treatments requiring PA around less than 15%.[6] Of that, health insurance providers report that up to 30% of PA requests they receive from clinicians are for unnecessary care that is not supported by medical evidence.

Health insurance providers are committed to working with providers to streamline the prior authorization process.

It is important to note that PA programs are collaborative – health insurance providers use provider input to help ensure treatment plans are protecting patient safety, improving outcomes, and controlling costs. In this spirit, in January 2018, AHIP, together with providers and hospitals, issued a joint consensus statement to cooperatively improve the PA process. [7]

Since issuing the joint consensus statement, a recent survey found that health insurance providers have increasingly waived or reduced PA requirements. Between 2019 to 2022, the percentage of plans waiving or reducing PA based on participation in risk-based contracts increased from 25% to 46% for medical services and from 5% to 8% for prescription medications.[8]

Furthermore, in January 2020, AHIP along with two technology partners and several member insurance providers, launched the Fast Prior Authorization Technology Highway (Fast PATH) initiative to better understand the impact of ePA on improving the prior authorization process.[9] An analysis of AHIP's Fast Path initiative showed:

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[5] Porter J, Boyd C, Skandari MR, Laiteerapong N. *Revisiting the Time Needed to Provide Adult Primary Care.* Journal of General Internal Medicine. January 2023. https://pubmed.ncbi.nlm.gov/35776372.
[6] *Prior Authorization: Selectively Used & Evidence-Based: Results of an Industry Survey.* America's Health Insurance Plans. https://www.ahip.org/wp-content/uploads/Prior_Authorization_Survey_Infographic.pdf.
[7] *Consensus on Improving the Prior Authorization Process.* American Hospital Association, America's Health Insurance Plans, American Medical Association, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association. Available at https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf.
[8] *Improving Prior Authorization Processes: How Health Insurance Providers Are Delivering on their Commitments.* America's Health Insurance Plans. https://www.ahip.org/documents/202207-AHIP_1P_Consensus_Statement_Actions-v02.pdf.
[9] *Prior Authorization: Helping Patients Receive Safe, Effective, and Appropriate Care.* America's Health Insurance Plans. https://www.ahip.org/prior-authorization-helping-patients-receive-safe-effective-and-appropriate-care. ,

- 71% of providers who used the technology for most or all of their patients reported that patients received care faster after providers implemented ePA.
- 60% of experienced providers said ePA made it easier to understand if prior authorization was required.
- The median time between submitting a prior authorization request and receiving a decision from the health plan was more than three times faster, falling from 18.7 hours to 5.7 hours in processing time – a 69% reduction.

Application Programming Interfaces

Health insurance providers support interoperable exchange through APIs

Recently, the Centers for Medicare & Medicaid Services (CMS) released the Advancing Interoperability and Improving Prior Authorization Processes (Interoperability Rules) final rule which requires health plans in federal programs to build and maintain four new APIs: 1) Prior Authorization API, 2) Patient Access API, 3) Provider Access API, and 4) Payer-to-Payer API. These APIs will allow data – including data regarding prior authorizations – to be shared between parties more seamlessly.

During the rulemaking process for the Interoperability Rules, AHIP submitted comments recognizing the important role of payers in these efforts. AHIP and its members wholeheartedly support the underlying goal of moving toward a health care system in which data flow seamlessly among appropriate stakeholders to the benefit of Americans. We also support the specific objectives of achieving interoperable exchange through APIs between payers and patients, payers and providers, and payers with other payers. Furthermore, we support implementing technologies that will permit physicians to look up payer coverage and documentation requirements as well as conduct electronic prior authorization requests and responses.

Now that the Interoperability Rules are final, we have concerns that states may attempt to implement requirements that diverge from them. APIs are incredibly complicated systems to build. In order to achieve true interoperability, consistency in requirements across health care markets (including state requirements) is necessary. Should Minnesota continue to move forward with API requirements we suggest the following:

- Align the state's API implementation requirements with CMS' January 1, 2027, compliance deadline.

- Align to the required PA API functionality with 42 CFR 156.223(b). This rule requires a PA API to:
    - be populated with the payer's list of covered items and services (excluding drugs) that require prior authorization;
    - identify all documentation required for approval of any items or services that require prior authorization;
    - support a HIPAA-compliant prior authorization request and response; and
    - communicate whether the payer approves the prior authorization request (and the date or circumstance under which the authorization ends), denies the prior authorization request (with a specific reason), or requests more information.
- Exclude prescription drugs.

Commented [SB1]: @Englert, Rosemary can you review this section

Gold Carding

We are seeing many legislative approaches attempting to restrict prior authorization through gold carding programs nationally, and we caution legislative initiatives that take this approach. Section 8 of HF 3578 requires health insurers to establish gold carding programs for health care providers or groups of providers with an authorization rate in the 70th percentile over the most recent 12-month period. This is the lowest percentile exemption proposal that we have seen and are substantially concerned about its potential impact on patient safety.

Broadly waiving PA and mandating gold carding programs could lead to clinically inappropriate care, exposing patients to potential harm by using a service or drug where there is little to no evidence of clinical benefit, and could raise costs for all consumers and purchasers.

Patients should expect to receive safe and appropriate care 100% of the time, period. Prohibiting PA eliminates checks on unnecessary care – as previously mentioned, health insurance carriers report that up to 30% of PA requests they receive from clinicians are for unnecessary care that is not supported by medical evidence.[10] This in turn will significantly limit a carrier's ability to ensure health care dollars are used most efficiently to produce high quality health outcomes, effectively ending provider accountability for fraud, waste, and abuse.

Eliminating PA by mandating broad gold carding programs will significantly and negatively impact the state's health care system. Through Texas' experience with the implementation of its

[10] *Prior Authorization: Helping Patients Receive Safe, Effective, and Appropriate Care.* America's Health Insurance Plans. https://www.ahip.org/prior-authorization-helping-patients-receive-safe-effective-and-appropriate-care.

gold carding law, HB 3459 which passed in 2021, we now have a better picture of these impacts. ***The law is estimated to increase premiums for small businesses and individuals by more than $1 billion annually in the fully insured market alone.***[11] ***Just one health plan estimates that the gold carding mandate will cost consumers $500 million a year to end prior authorizations – a figure that is estimated for just its members.***[12]

Another Texas plan used back surgeries as an example of a procedure that is a high-cost intervention for medical issues that could potentially benefit from less extreme, and more affordable, care delivery approaches to highlight the cost impacts of the gold carding mandate.[13] Under the law, employers would have to pay 100% for back surgeries, even though they are inappropriate at least 10% of the time. ***The claims for this one procedure alone would cost the plan $150 million a year.***

Furthermore, a Milliman study found that eliminating PA could increase premiums by $20.1 - $29.52 PMPM – a total increase of $43 - $63 billion annually in the commercial market nationwide.[14] Another Milliman study, specific to Massachusetts, predicts that elimination of PA will increase premiums from $51.19 - $130.28 PMPM. One key factor for these huge increases is due to the elimination of the Sentinel Effect on providers.[15] When providers know they are being monitored, their performance tends to improve. Removing PA cuts out the one party that has the fullest view of patient care and that understands contraindications. As a result, health insurance providers have reported increased utilization when gold carding programs are put into place.

We are also concerned about the administrative difficulties of operationalizing gold carding programs which causes further confusion and frustration for providers and patients. Again, using Texas as an example, while the law had an effective date of January 1, 2022, implementation was delayed due to a particularly cumbersome rulemaking process.

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[11] *Veto Letter Request to Governor Abbot on HB 3459.* Texas Association of Health Plans. June 3, 2021.
[12] *Id.*
[13] *Id.*
[14] Busch, Fritz S. and Stacey V. Muller. *Potential Impacts on Commercial Costs and Premiums Related to the Elimination of Prior Authorization Requirements*. Milliman Report. March 30, 2023. https://www.milliman.com/-/media/milliman/pdfs/2023-articles/8-18-23_bcbsa-prior-authorization-impact.ashx.
[15] Busch, Fritz S. and Peter Fielek. *Potential Impacts on Costs and Premiums Related to the Elimination of Prior Authorization Requirements in Massachusetts*. Milliman Report. November 29, 2023. https://www.milliman.com/-/media/milliman/pdfs/2023-articles/11-29-23_mahp-prior-authorization-impact.ashx

Gold carding programs are most effective when provider performance is closely monitored because they are not appropriate for all providers and all services. Gold carding programs should:

- Be targeted to specific services and where provider performance can be regularly reviewed.
- Separate out prescription benefits from the medical benefits to allow for more tailored review processes and allow health plans and their PBM partners to fully utilize the safety and efficacy tools already in place to protect patients and consumers from harmful and costly drugs.
- Allow health insurance providers to monitor providers participating in these programs to ensure that the provider's standard of practice is consistent with the standard of safe, timely, evidence-based, affordable, and efficient care.
- Allow insurers to revoke a provider's participation in a gold carding program if a provider is not following those standards.[16]

These guardrails are necessary to ensure that providers who receive gold card privileges continue to deliver consistent patterns of high performance to the patients they serve. Additionally, health insurance providers need flexibility in operationalizing these programs to keep up to date with medical and safety innovations.

Sincerely,

Patrick Lobejko
Midwest Regional Director of Government Relations
AHIP

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

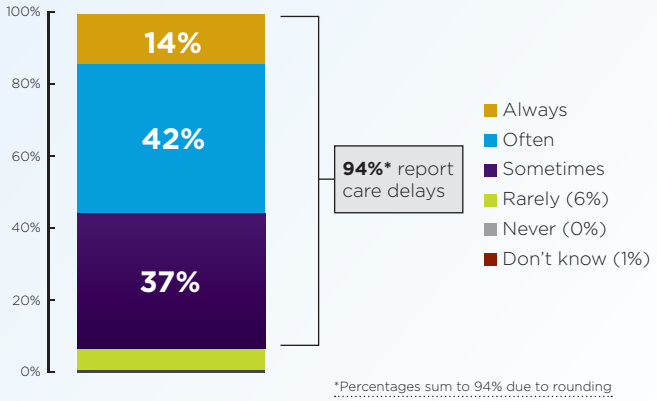
[16] *New Survey: Effective Gold Carding Programs are Based on Evidence and Value for Patients.* America's Health Insurance Plans. July 19, 2022. https://www.ahip.org/resources/new-survey-effective-gold-carding-programs-are-based-on-evidence-and-value-for-patients.

2022 AMA prior authorization (PA) physician survey

Patient impact

Care delays associated with PA

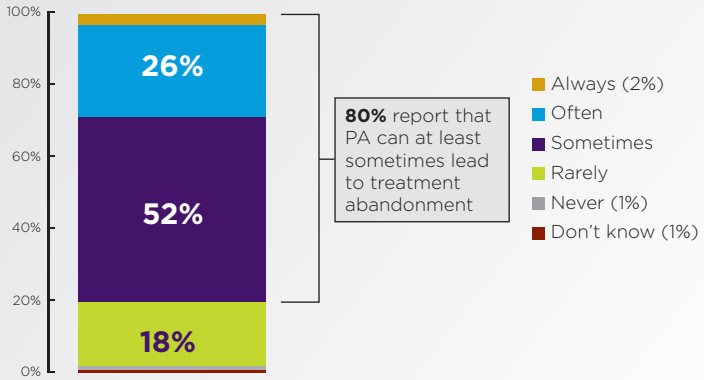
Q: For those patients whose treatment requires PA, how often does this process delay access to necessary care?



*Percentages sum to 94% due to rounding

Abandoned treatment associated with PA

Q: How often do issues related to the PA process lead to patients abandoning their recommended course of treatment?



PA and patient harm

(See below, Survey question "A.")

33% of physicians report that PA has led to a **serious adverse event** for a patient in their care.

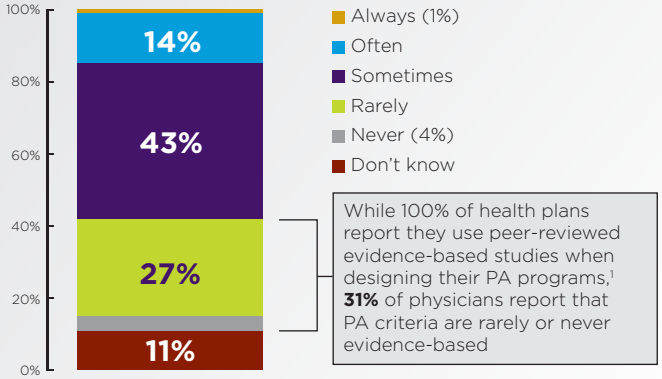
25% of physicians report that PA has led to a patient's hospitalization.

19% of physicians report that PA has led to a life-threatening event or required intervention to prevent permanent impairment or damage.

9% of physicians report that PA has led to a patient's disability/permanent bodily damage, congenital anomaly/birth defect or death.

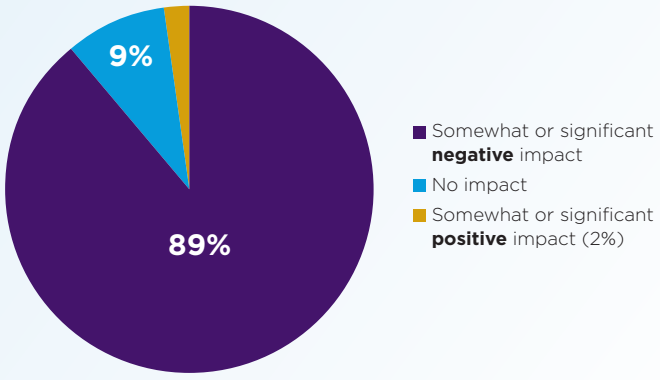
Clinical validity of PA programs

Q: How often are health plans' PA criteria based on evidence-based medicine and/or guidelines from national medical specialty societies?



Impact of PA on clinical outcomes

Q: For those patients whose treatment requires PA, what is your perception of the overall impact of this process on patient clinical outcomes?



Physician impact

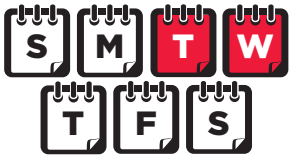
On average, practices complete

45

PAs per physician, per week

(See below, Survey question "B.")

Physicians and their staff spend an average of



almost two business days (14 hours) each week completing PAs

(See below, Survey question "C.")

Nearly **Two in five** or **35%** of physicians have staff who work exclusively on PA

(See below, Survey question "D.")

88% of physicians describe the burden associated with PA as high or extremely high

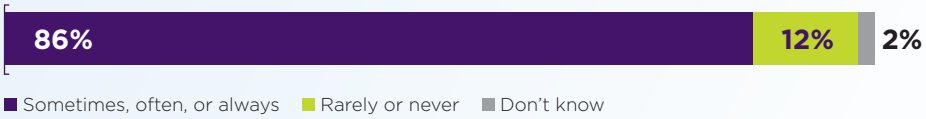
(See below, Survey question "E.")

Is PA really a bargain?

Health plans insist that PA is needed to eliminate unnecessary treatment and keep health care affordable. However, physicians report that PA can lead to overall increased health care resource utilization and can negatively impact patients' productivity at work. Which begs the question: is PA really a "bargain"?

PA and resource utilization

Q: In your experience, how often does the PA process lead to higher overall utilization of health care resources (e.g., additional office visits, initial use of less effective therapy due to step therapy requirements, emergency room visits, hospitalization)?



64% of physicians report that PA has led to **ineffective initial treatments** (i.e., step therapy)

62% of physicians report that PA has led to **additional office visits**

46% of physicians report that PA has led to **immediate care and/or ER visits**

Employer impact

58% of physicians with patients in the workforce report that PA has impacted patient job performance

(See below, Survey question "F.")

Survey questions

A. **Serious adverse event**: In your experience, has the PA process ever affected care delivery and led to a serious adverse event (e.g., death, hospitalization, disability/permanent bodily damage, or other life-threatening event) for a patient in your care?
B. **Number of PAs**: Please provide your best estimate of the number of prescription and medical services PAs completed by *you yourself and/or your staff* for your patients in the *last week*. Do not include PAs that practice staff completed for the patients of other physicians in your practice.
C. **Time to complete PAs**: Thinking about all of the PAs you and your staff completed in the last week, please provide your best estimate of the number of hours spent on processing these PAs. Do not include PAs that practice staff completed for the patients of other physicians in your practice.
D. **Practice resources for PA workload**: Do you have staff members in your practice who work exclusively on PA?
E. **Practice burden**: How would you describe the burden associated with PA in your practice?
F. **Employer impact**: Consider your patients in the workforce. Has the PA process ever interfered with a patient's ability to perform his/her job responsibilities?

Survey methodology

- Thirty-nine question, web-based survey administered in December 2022
- Sample of 1,001 practicing physicians drawn from M3 panel
- Forty percent primary care physicians/60% specialists
- Sample screened to ensure that all participating physicians:
  - Are currently practicing in the United States
  - Provide 20+ hours of patient care per week
  - Complete PAs during a typical week of practice

Reference

1. AHIP 2022 Survey on Prior Authorization Practices and Gold Carding Experiences available at https://ahiporg-production.s3.amazonaws.com/documents/2022-Prior-Auth-Survey-Results-FINAL.pdf

For information on the AMA's PA advocacy efforts, visit **ama-assn.org/prior-auth**.

AMA AMERICAN MEDICAL ASSOCIATION

CentraCare

CentraCare

1406 6 Ave N
St. Cloud MN 56301

Phone 320-251-2700

Dear Chair Liebling and Members of the Health Finance and Policy Committee:

We, CentraCare, appreciate the focus on authorizations, which delays care and creates an administrative burden. There are a few opportunities we would like the committee to consider.

CentraCare would like to see authorizations decreased, and providers worry that payers will shift prior auth requirements and denials to post-payment audits, which require the same amount of administrative burden for providers and payers.

With the change in prior authorizations for intensive services: if the provider decides to provide a less intensive service once the provider is amid the procedure the lesser service should also be covered.

CentraCare encourages the bill to be applied to all payers, understanding this could not be applied to Medicare. However, would like to apply to all commercial and Medicare Advantage and PMAP plans. This includes payers that are national plans.

CentraCare would also like to assure that with the limitations of prior auth through this bill, payers do not start denying claims for other reasons outside of prior auth. Such denials may be a medical necessity. Some of our plans, if denied for medical necessity do not allow us to appeal. CentraCare would like to assure that payers do not limit our appeal rights, due to this bill.

A few concerns we have about implementation is the timeline to implement the changes. Turning this dial may need more time to implement and we would appreciate consideration to timelines. Standardization with payers is key. It is important for clear guidelines and definitions, so the bill does not lack ambiguity and room for interpretation and results in a lack of standardization. We would request clarity to ensure that payers do not shift the burden to different denials (i.e. medical necessity instead of authorization), and we hope payers do not shift from the need for authorization on the front end to post-pay audits after the fact.

Thank you for the opportunity to weigh in on HF 3578. Decreasing authorizations is important to provide timely care and reduce the cost of providing care.

Sincerely,
Sherri Liebl, Executive Director, Revenue Cycle

Children's MINNESOTA

The Kid Experts™

February 15, 2023
House Health Finance and Policy Committee

Dear Chair Liebling and Committee Members,

On behalf of Children's Minnesota, I am writing in support of HF3578 which makes changes to prior authorization requirements that would reduce a burden that too often impacts the patients and families we serve.

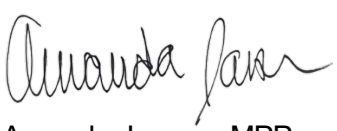
Children's Minnesota is the state's largest pediatric healthcare system, seeing more than 160,000 kids annually. In 2023, the 30 members of our prior authorization team worked to complete over 81,000 requests for nearly 58,000 individual patients. These were children suffering from cancer, heart conditions, asthma and other diseases that needed prior authorization (PA) approvals before our clinicians could treat them with the appropriate medications and health care services.

In one patient's case, an initial PA request for a cancer treatment drug was denied because the drug requested was not the preferred drug by the insurer, even though it followed the recommended standard of care. In another case a request for a liquid form of a cancer medication was denied and a tablet was suggested instead. The patient was 2 months old and the medication in tablet form could not be dosed or administered appropriately for a child of that age and size. Getting PA approvals for liquid medications that can be appropriately dosed for young children has also been a challenge for patients in hospice or those experiencing neonatal withdrawal.

Our prior authorization team and members of the care teams treating these children work tirelessly on cases like these, spending hours working on individual PA requests while also trying to protect patient families from additional worries and concerns. After going back and forth with denials and appeals on these cases, over 95% of these requests eventually do get approved, but too often the time it takes to complete the process threatens to delay patient care leaving families to make a difficult decision to move forward with their child's treatment without knowing if it will be covered by their insurance.

When a family comes to us with a sick child, they should not have to wait for cumbersome processes to be completed before being able to access the treatment their child needs to get better. I hope we can count on your support for HF3578.

Sincerely,



Amanda Jansen, MPP
Director of Public Policy
Children's Minnesota

February 13, 2024

To: Chair Liebling and Members of the House Health Finance and Policy Committee

RE: HF3578

Dear Chair Liebling and Members of the House Health Finance and Policy Committee,

The Cigna Group is a global health services company dedicated to improving the health, well-being and peace of mind of those they serve. Cigna delivers choice, predictability, affordability, and access to quality care through integrated capabilities that advance whole person health.

We respectfully oppose HF3578 as it is currently drafted. While not an exhaustive list of our issues with the bill language, I would like to highlight two primary concerns: Prior authorization exemption and potential conflicts with Federal regulations. As both a health insurer and a utilization review organization, Cigna can bring a unique perspective to the conversation.

Section 8: Prior authorization exemption process

The exemption process established in Section 8 would have several serious negative impacts, most notably it would increase inappropriate care and costs while not positively impacting patient outcomes.

The exemption process set forth in HF3578 is flawed policy that has not worked in practice, and is built on a flawed premise, which asks patients to accept that even the best providers will get their care wrong **30%** of the time and remain completely unchecked.

The State of New Jersey produced a fiscal note on their prior authorization bill (AB1255) that has both prescriptions and services is scope, similar to HF3578. While the fiscal note determined an "indeterminant" impact, Legislative Services indicated that prior authorization saves the state $177 million annually.

The actuarial firm Milliman, the same firm that produced the study on public option for Minnesota, produced a study on the elimination of prior authorization in Massachusetts. While HF3578 doesn't explicitly eliminate prior authorization, setting the exemption at the 70th percentile will effectively end prior authorization. Milliman found that commercial premiums could increase by between roughly $600 and $1,500 per member annually and Medicaid capitation rates could increase by between $270 and $1,100 per beneficiary annually if prior authorization were eliminated. This would result in an additional $5.5 billion in premium costs annually for commercial plans, and close to $3.5 billion in costs for Medicaid when applied to current enrollment in Massachusetts.

This fiscal impact should be considered prior to moving this bill forward.

Simply because a provider reaches an approval rate in the 70th percentile, does not mean they will continue to order appropriately in the absence of a utilization review program. In fact, this exemption process has been shown to be unsuccessful in encouraging long-term, positive behavior change. A study published in *The New England Journal of Medicine* found that when incentives were removed for physicians in U.K. primary care practices, there were immediate reductions in documented quality of care across 12 indicators. Conversely, there was little change in performance on the six quality measures for which incentives were maintained. In another real-world illustration, a state Medicaid program implemented an obstetric ultrasound utilization review

program, which used evidence-based guidelines to determine whether care was appropriate. After the program had been underway, it was temporarily changed to "notification only". Utilization increased 27% during the five-month hiatus in utilization review.

This is to say that in the absence of utilization review, utilization of services increases with no correlation to better patient outcomes; simply more cost to the health care system.

Potential conflicts with Federal regulations

Section 5 appears to reference the most recent CMS interoperability 2.0 final rules. These CMS rules were released in January 2024 and we look forward to the automated processes outlined in the rule. The language in HF3578 is not necessarily uniform with the CMS rule and could result in two separate systems, adding unnecessary cost and duplication to the system.

Section 6, clause 6, beginning on line 4.28, is covered by Federal regulations (147.130). The language of HF3578 removes all preventative health services recommended by USPSTF from the application of evidence-based guidelines. This goes beyond the Federal regulation. This means that we will not be able to apply any criteria or guidelines for any screening procedure covered by USPSTF such as colonoscopy, CT colonography, etc.

Section 7 does not include a definition for "chronic condition". There isn't a definition in Minnesota Statute 62M and there isn't a uniform definition among Federal agencies.

Conclusion

Utilization review plays a critical role in helping patients receive high-quality, evidence-based care, and it keeps costs down for the entire health care system. Beyond significant fiscal impact, we must consider the health and safety impact this bill will have on Minnesotans. Their well-being should be considered 100% of the time.

Consider the patient with non-small cell lung cancer (NSCLC). A form of genomic testing called molecular profiling can confirm the presence of specific cancer tumor gene mutations that are best treated with more targeted therapies. These targeted therapies are less toxic and lead to longer survival. However, up to 30% of NSCLC patients don't get the most effective treatment because they didn't get molecular profiling. We found that without utilization management, 40% of doctors were skipping this testing. Once utilization management was introduced to require the testing, about 25% patients changed to the more effective treatment based on the results, and the adherence to testing was nearly 100%.

HF3578 would dramatically curtail those benefits for patients. We believe there are several ways to streamline utilization review that create a better experience for providers without sacrificing patient care.

Sincerely,

Margaret Reynolds
Senior Director, State Government Affairs
margaret.reynolds@cignahealthcare.com

February 14, 2024

Dear Chair Liebling and Members of the House Health Finance and Policy Committee,

We write in support of HF 3578 (Bahner): Prior authorization and coverage of health care services requirements modified, and are grateful for the hearing on this important issue that is relevant for so many of the patients and families Gillette Children's serves.

Gillette Children's operates an independent, nonprofit, specialty care, 60-bed pediatric hospital in St. Paul along with pediatric specialty clinics across Minnesota, including clinics in Burnsville, Maple Grove, St. Paul, Baxter, Bemidji, Duluth, Willmar and Mankato.

We serve children with complex disabilities, rare conditions, and traumatic injuries with a focus on brain, bone and movement conditions needing specialized expertise. Each year, we treat patients from all 87 Minnesota counties.

This legislation provides for meaningful reform that will remove some of the many barriers the children we serve face in obtaining access to needed and timely health care services.

One example is the language in Section 7, lines 5.13 - 5.15

Subd. 5. **Treatment of a chronic condition.** An authorization for treatment of a health condition that an enrollee is expected to have for longer than one year does not expire unless the standard of treatment for that health condition changes.

The largest single diagnosis we see in patients at Gillette Childrens is cerebral palsy - a group of disorders that affect a person's ability to move and maintain balance and posture. Cerebral palsy is a lifelong condition and would meet the definition of a chronic condition. It is caused by brain injury or atypical brain development that happens around the time of birth or early in life. It is a complex condition that can affect many parts of the body, including muscles. Muscle spasticity - the presence of overly tight muscle – is a common symptom of cerebral palsy.

There is no cure for spasticity. Treatment, however, often lessens the severity of spasticity's effects on everyday activities. One of the treatments available is botulinum toxin (Botox) injections.

Gillette Children's employs 14 FTE's whose sole role is processing prior authorizations. Two of our employees only process prior authorizations for Botox. One of our employees works on Medicaid Botox prior authorizations and one employee focuses on commercial insurance Botox prior authorizations.

In 2023 we submitted 1,485 prior authorizations for Botox. Of those, only 14 were initially denied – approximately 1%. As of our most recent records, 1,200 of these prior authorizations have been approved, and the remainder are either currently going through the prior authorization process or have been approved in 2024 but are not yet reflected in our reports.

With passage of this legislation, once a Botox prior authorization for a child with cerebral palsy has been approved, the prior authorization would remain in place unless the standard of treatment changes. This is just one example of a provision in this bill that will positively impact the patients and families we serve at Gillette Children's while removing a significant administrative burden. We urge your support, and we are grateful for your time.

Sincerely,

Paula Montgomery
Executive Vice President
Chief Administrative Officer

Oppose One-Size-Fits-All Prior Authorization "Gold Carding" Programs

Health plans use prior authorization (PA) to evaluate provider requests for tests, treatments, and procedures against evidence-based guidelines to ensure that patients get appropriate care, at the right time, and in the right setting. At the request of health plans, pharmacy benefit companies may administer PA programs for prescription drugs that are tailored to the needs of the health plan.

"Gold card" programs allow physicians with high rates of PA approvals over a specified time frame to be exempt from PA requirements. While gold carding has been used in some unique circumstances, with strict limitations, it is not appropriate for all types of provider services or prescribing practices. To maintain the highest level of safety and appropriate care for each patient, gold carding programs cannot be statutorily mandated.

Prior authorization programs protect patients and save money.

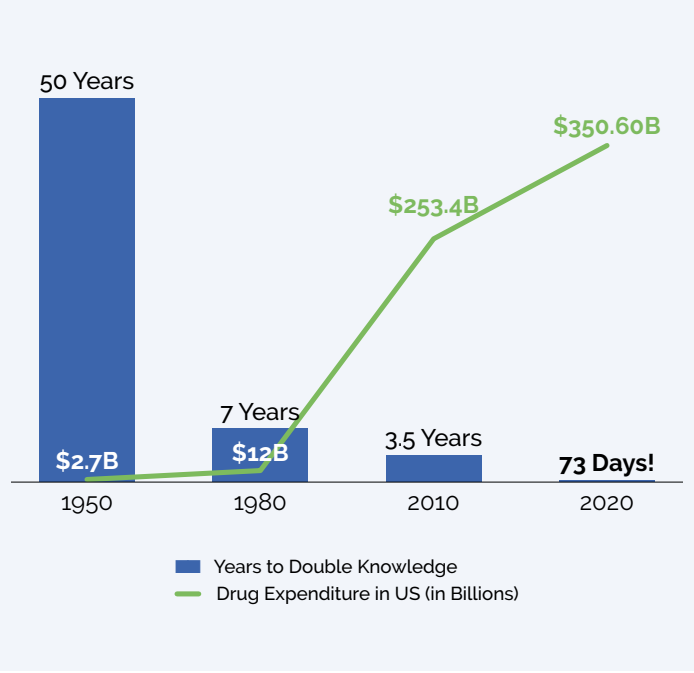
Prior authorization is an important tool to ensure appropriate dispensing and administration of prescription medications, helping plans assess risks to patients and protecting against inappropriate utilization and waste.[1] Plans and pharmacy benefit companies have clinical teams that evaluate prescriptions for drugs that:

- Are intended for certain age groups or conditions only;
- Are used for cosmetic or therapeutic reasons, to ensure the drug is being used therapeutically;
- Have potentially harmful side effects, dangerous interactions, or risks for abuse or misuse;
- Aren't covered by insurance but are deemed medically necessary by the prescriber; or
- Are brand-name drugs with an affordable generic equivalent.[2]

The U.S. Federal Trade Commission and the National Academy of Sciences, Engineering, and Medicine (NASEM) have stated that cost savings are associated with plan PA programs; NASEM noted that without formulary controls, "insurance premiums would rise."[3]

PBMs are equipped to manage cost based on the current evidence-based guidelines.

With so much clinical data, prescribers struggle to stay informed about new guidelines. As the chart below demonstrates, medical knowledge now doubles every 73 days,[4] and drug costs continue to skyrocket. CMS reported that total drug expenditures hit $350B in 2020.[5] PBM clinical teams are equipped to regularly review current evidence-based guidelines and identify more cost-effective, safer, or equally efficacious alternatives, such as generics or more affordable brand-name drugs.



Pharmacy benefit companies should not be mandated to implement gold carding programs.

While "gold card" programs appear to beneficially reduce administrative burdens on prescribers, "gold carding" can create significant challenges, including the following:[6]

- Provider performance tends to slip once the provider has gold card status.
- An individual's performance typically varies across services, so it is difficult to confer gold card status on a provider across all services (i.e., prescriptions, diagnostic tests, etc.).
- Providers within the same clinic or group often perform differently, creating potential confusion for providers, their staffs, and patients.
- Gold carding removes pharmacy benefit companies' ability to provide insights into clinical concerns, duplications in therapy, and potential drug interactions.
- Laws designed to ensure all patients are treated fairly require PA standards to be applied equally for all patients. Granting gold card status potentially puts certain patients at a disadvantage.

Real-Time Benefit Tools (RTBT) and electronic prior authorization are the solution.

In a survey of plans with gold carding programs, America's Health Insurance Plans (AHIP) found that **73% of plans with gold carding programs reported problems, such as difficult implementation, higher costs, and reduced quality of care.**[7] In an earlier survey, AHIP found "performance tends to slip once [a provider has been] gold carded."[8]

Instead of forgoing PA and its associated benefits, using RTBT to better understand the formulary requirements and electronic prior authorization (e-PA) can increase transparency, **shorten review times by 13 days**[9] and ease providers' administrative burden.[10] AHIP found that ePA leads to "faster time to patient care, faster time to a decision, lower burden from phone calls and faxes, and improved information for providers."[11]

Policymakers should focus on increasing access to technology that improves clinical outcomes instead of policies, like gold carding, that eliminate patient protection.

1 GoodRx. 2020. "What is Prior Authorization? A Look at the Process and Tips for Approval. https://www.goodrx.com/insurance/health-insurance/prior-authorization-what-you-need-to-know. Visante. 2020. "Increased Costs Associated with State Legislation Impacting PBM Tools." https://www.pcmanet.org/wp-content/uploads/2020/04/Visante-Study-on-the-Increased-Costs-Associated-With-State-Legislation-Impacting-PBM-Tools-April-2020.pdf. PA can generate 50% savings for targeted drugs or categories (p. 8), and multiple studies find savings in PA programs (p. 17). Visante. 2020. https://www.pcmanet.org/wp-content/uploads/2020/04/Visante-Study-on-the-Increased-Costs-Associated-With-State-Legislation-Impacting-PBM-Tools-April-2020.pdf.

2 Id.; Visante p. 8

3 Visante, p. 9.

4 Jensen, P., MD (2011). Challenges and Opportunities Facing Medical Education. *Trans Am Clin Climatol Assoc.*, 122, 48–58. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3116346/#:~:text=It%20is%20estimated%20that%20the,0.2%20years%E2%80%94just%2073%20days.

5 Mikulic, M. (n.d.). *Prescription drug expenditure in the U.S.* Statista, 2023. https://www.statista.com/statistics/184914/prescription-drug-expenditures-in-the-us-since-1960/.

6 Berry K. "Prior Authorization." Presentation to Health Information Technology Advisory Committee Office of the National Coordinator for Health Information Technology. March 2019.

7 Visante. 2020. https://www.pcmanet.org/wp-content/uploads/2020/04/Visante-Study-on-the-Increased-Costs-Associated-With-State-Legislation-Impacting-PBM-Tools-April-2020.pdf, p.9.

8 Reporting on a study of an ePA initiative that began in January 2020. AHIP. 2019. "Presentation to the Health Information Technology Advisory Committee, Office of the National Coordinator for Health Information Technology." https://www.healthit.gov/sites/default/files/facas/2019-03-20_Public_and_Private_Payer_Perspective_AHIP_Kate_Berry.pdf.

9 *2020 Electronic Prior Authorization Report*. Cover My Meds, 2020. https://assets.ctfassets.net/2in405srp47m/4uzia8m4YQy3mBplpyBuqF/9af9cefa63bba76566aa3e8595751e45/CMM_36664_ePAExecutiveSummary_Digital.pdf.

10 PCMA. 2023. "Patient Care." https://www.pcmanet.org/patient-care/. Journal of the American Pharmacists Association. 2022. "Evaluation of the Fact Prior Authorization Technology Highway." The article indicates that there was a reduction in time to process PA requests due to using electronic PA (18 hours to 5.7 hours), and a drop in the number of phone calls and faxes it took to resolve the PA request. https://www.sciencedirect.com/science/article/abs/pii/S1544319122002394?dgcid=coauthor.

11 AHIP. 2022. "Effective Gold Carding Programs are Based on Evidence and Value for Patients." https://www.ahip.org/documents/202207-AHIP_1P_Gold_Carding_Survey_Results.pdf.

ACOG
Minnesota Section

February 14, 2024

Madame Chair and Members of the Health Finance and Policy Committee,

The Minnesota Section of the American College of Obstetricians and Gynecologists (ACOG) supports HF3578 for prior authorization reform.

Too often, prior authorization – which is truly intended as a checkpoint prior to provision of unique or experimental medical care that can be particularly expensive – stands in the way of patients receiving standard, evidence-based medical management for preventative and therapeutic care. This may prevent patients from accessing consistent contraception, mental health medications, pain management for menstrual cycles, chemotherapy for gynecologic cancers, genetic screening in pregnancy or as related to hereditary cancer syndromes, procedures for the work-up or management of concerning symptoms or conditions, and countless other components of necessary OB/Gyn care. This can become especially frustrating and dangerous in cases in which patients have been stable on one medication or therapy and a change in health insurance carrier or policy type creates new requirements for accessing it.

Prior authorization reform is included within the legislative priorities for national ACOG for 2024. ACOG supports consistent access to contraception, access to genetic screening without need for approval, removal of the ability for retroactive denials of already authorized care, ensuring authorizations are valid for at least one year or for the length of treatment for chronic conditions, reductions in the administrative burdens of prior authorizations, improving efficiency of the prior authorization process to prevent delays in access to necessary care, and collaboration between specialty groups and government bodies to identify care that should never require prior authorization.

Minnesotans deserve consistent access to healthcare and the therapies that are deemed appropriate and safe by their trusted healthcare providers without interference from insurance carriers. Please join us in supporting HF3578.

Erin Stevens, MD

Legislative Chair for MN ACOG

COALITION OF RECOVERY INVESTMENT

Rep. Kristin Bahner
525 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd
Saint Paul, MN 55155

Senator Kelly Morrison
3205 Minnesota Senate Building
95 University Avenue W.
St. Paul, MN 55155

February 15, 2024

Dear Rep. Richardson and Sen. Morrison:

The Coalition of Recovery Investment (CORI) is dedicated to reducing the harm caused by chemical dependency and improving the health of our families, communities, and state and that starts with fighting for timely access to substance use disorder (SUD) treatment.

CORI and our member organizations support HF3578/SF3532 that would establish new regulatory rules around the frustrating process of prior authorization that we are told impacts timely access to substance use disorder treatment.

We are specifically very supportive of provisions in your bill that prohibit prior authorization for medication to treat a substance use disorder, outpatient mental health treatment or outpatient substance use disorder treatment, and treatment delivered through a neonatal abstinence program operated by pediatric pain or palliative care subspecialists.

Prior authorization processes often delay patient care and SUD treatment frequently involves urgent care needs due to the acute nature of addiction. Prior authorization requirements can delay or impede timely access to critical treatment, exacerbating health risks and potential overdoses.

Research consistently demonstrates the effectiveness of early intervention and continuous care in treating SUD. Prior authorization adds unnecessary administrative hurdles, interfering with the implementation of evidence-based treatment protocols and best practices.

Reforms to prior authorization processes in Minnesota will streamline administrative tasks for providers, reduce delays in care, and improve patient access to timely and appropriate treatments, ultimately enhancing the overall quality of healthcare delivery. CORI is happy to support the provider community in streamlining this process and thank you for authoring this important legislation.

If CORI can be of help or if you have questions, please reach out to CORI's consultant, Sarah Erickson, at sarah.erickson@unitedstrategiesllc.com.

Sincerely,

Bill Messinger
Chair, Coalition of Recovery Investment

HF - 3578 - email of support from parent of child with rare disease

I am writing to express my support for Minnesota legislation **HF 3578 -** A bill for an act relating to health care, modifying requirements for prior authorization and coverage of health care services. As a citizen and as a supporter of a family with a young child with a rare disease I know that this legislation is needed here in our state. Helping the rare disease community starts with ensuring that these patients and their families have access to doctors and treatments that are not restricted by insurance providers. I also know that they need to have a voice in our government.

According to the National Institutes of Health (NIH), a rare disease is defined as a condition affecting fewer than 200,000 people in the United States. Over 25 million Americans and more than 300 million people around the world are living with a rare disease. More than half are children. There are over 7,000 identified rare diseases. Of those defined as a rare disease only 10% have an approved FDA treatment. Furthermore, of those rare disease patients 30% will die before the age of 5 of these many life-threatening diseases. On average, it takes seven years for people with a rare disease to get a diagnosis in the U.S. In general clinicians are likely to be very unfamiliar with most of the 7,000 identified rare diseases, and a limited number of healthcare professionals specialize in each rare disorder. Lack of appropriate disease-specific care contributes to delays and inaccuracies in diagnosis, delays in proper treatments, and sometimes death. **On top of all that, navigating your insurance networks can be yet another barrier in a patient's journey to a rare disease diagnosis and getting the proper treatment which is literally a matter of life or death the longer you wait.**

Often, the responsibility of finding the right doctors and treatments falls to the impacted families and their friends. I have seen firsthand how these rare disease families are already stretched thin in time and resources. Why make their lives harder by restricting them with insurance barriers? HF 3578 would ensure that these brave families are not restricted by their insurance providers and can access the care and treatment they desperately need in a timely manner. **I urge you to support HF 3578 and ensure that Minnesota remains a state known for our innovation, protection, and dedication to medical advancement for all patients, including the 1 in 10 Americans living with a rare disease.**

--

Anne St Martin

Email - anne@pompewarriorfoundation.com
Cell - 630-670-6569
www.pompewarriorfoundation.com

MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

1400 Van Buren St NE
Suite 215
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952-542-0130
office@mafp.org
www.mafp.org

February 14, 2024

Dear Health Finance and Policy Committee Members,

On behalf of the Minnesota Academy of Family Physicians (MAFP), the largest physician specialty society in Minnesota representing over 3,100 family physicians and physicians in training, I strongly encourage your support for House File 3578. The prior authorizations addressed in HF 3578 pose an unacceptable barrier to essential care for our patients and present a burdensome administrative challenge, diverting our members and their teams from direct patient care.

Family physicians play an important role in caring for Minnesotans throughout their lifespan. As leaders in primary care, we collaborate with our teams to maintain our patients' health and manage chronic conditions. Every family physician has countless stories of the detrimental delays caused by prior authorizations, and it is a major driver of physician as well as health care team burnout. These delays result in patients being denied access to vital medications for managing conditions such as diabetes and substance use disorders in addition to delaying discovery of life altering diagnoses.

The excessive use of prior authorizations, even for generic and cost-effective medications and treatments, is concerning. It is perplexing that these barriers persist, particularly for well-established options that have proven to be evidence-based and first-line treatments for the patient. Utilizing prior authorization as an obstacle between a patient suffering from substance use disorder and the life-saving treatment Suboxone is both counterproductive and unacceptable. Using prior authorization to delay a CT scan after an x-ray showed an abnormality thereby delaying a cancer diagnosis can literally cost a patient their life. Instances where patients are unable to fill their prescriptions and receive needed imaging or tests promptly, particularly in crisis situations, underscore the urgent need for reform.

Prior authorizations are an ineffective strategy for controlling health care costs. The resulting delays in care are unacceptable for patients and the convoluted processes associated with addressing prior authorizations are further burdening our already strained health care workforce. Please support HF 3578 as an important step in addressing prior authorizations to help ensure access to care for our patients.

Sincerely,

Bob Jeske, MD
President, MAFP

February 14, 2024

RE: SF 3532/HF 3578 – Prior Authorization Reforms

Dear Senator Morrison and Representative Bahner

Thank you for authoring legislation aimed at reforming the complex and excessively cumbersome prior authorization (PA) process. The Minnesota Ambulatory Surgery Center Association (MNASCA) and Healthcare Leaders Association of Minnesota (HLAMN formerly MMGMA) join other stakeholders, including the Minnesota Medical Association, the Minnesota Hospital Association, and many specialty clinics and provider groups in supporting SF 3532/HF 3578.

MNASCA, a statewide association representing Minnesota's Ambulatory Surgery Centers (ASCs), promotes high-quality, value-driven surgical services to provide the best possible care to patients. Healthcare Leaders Association of Minnesota is an organization of healthcare business leaders and executives who work together to improve the health status of the community and patients they serve. However, in recent years, the PA process has significantly hindered our members' ability to provide effective therapies to patients, consequently leading to compromised health outcomes in certain instances. As the legislature considers prior authorization reforms, we would like to highlight two critical issues with the existing PA system:

Prior authorization is time-consuming and overly burdensome. The current system requires doctors to jump through multiple hoops to obtain an insurer's approval before it will agree to pay for a prescription medication, medical test, or procedure. Prior authorization requirements and submission processes also vary widely among insurers, often requiring providers to expend valuable staff time and resources completing manual forms and furnishing additional information. Finally, our doctors are often working with insurer physicians who lack specialized knowledge of our surgery centers' specialties and recommended therapies and, therefore, do not have the expertise to make informed decisions regarding patient care.

Overuse of prior authorization is also harmful to patients. The PA review process frequently forces patients to wait days for insurers to issue approvals, and weeks or months to resolve denials. Minnesota doctors report that prior authorization has led to care delays, treatment abandonment, and even serious adverse events for patients.

Without legislative action, the overuse of prior authorization will continue to delay needed patient care, increase administrative costs, and contribute to physician burnout. MNASCA and HLAMN support legislative changes that will:

- Prohibit insurers from retrospectively denying coverage of a healthcare service for which prior authorization was not required by the health carrier.
- Require insurers to create and maintain an interface to streamline the prior authorization process and facilitate the exchange of information between providers and insurers.

- Prohibit prior authorization for critical services by expanding Minnesota Statutes 2022, section 62M.07, subdivision 2 to include additional services.
- Limit the use of prior authorization for chronic conditions to one-time only approvals.
- Require insurers to annually report prior authorization frequency, denial rates, and approval rates.
- Implement a "gold card" program for physicians attaining prior authorization approval rates exceeding the 70th percentile.

MNASCA and HLAMN greatly appreciate the legislature's consideration of these prior authorization reforms.

Sincerely,

Tracy Mills, President
Minnesota Ambulatory Surgery Centers Association

Melissa Larson, President
Healthcare Leaders Association of Minnesota

Representative Tina Liebling, Chair
Representative Robert Bierman, Vice Chair
House Health Finance and Policy Committee
75 Rev Dr. Martin Luther King Jr. Boulevard
St. Paul, MN 55155

MINNESOTA ONCOLOGY

February 15, 2022

Support for HF 3578: Modification to Prior Authorization in Minnesota

Honorable Chair Liebling and Members of the House Committee,

Thank you for the opportunity to submit testimony in support of HF 3578: improving prior authorization and coverage of health services.

For over 40 years, Minnesota Oncology (MNO) has delivered patient-centered, comprehensive, and compassionate cancer care in community cancer centers using best practices, state-of the-art therapies and research which has made us the premier independent provider for patients in Minnesota. We have over 100 physicians and advanced practice providers at 12 different locations across the greater twin city metro area.

We believe that the passage of HF 3578 is critical to preserving access to timely, personalized, community-based cancer treatment**.** Among other common-sense reforms, passage of this bill would place guardrails around the processes of prior authorization by:

- Preventing health carriers from retrospectively requiring prior authorization or limit coverage for a service based on the lack of prior authorization if that service would be otherwise covered;
- Creating a comprehensive automated program that will better support providers when going through the prior authorization process and bring increased transparency from carriers;
- Not requiring prior authorization for antineoplastic cancer treatment based on National Comprehensive Cancer Network guidelines;
- Creating an improved exemption process;
- And increasing state reporting requirements for carriers regarding prior authorization.

Utilization management processes like prior authorization were originally intended to be a check and balance for high cost and uncommon procedures; however, it is now used commonly to restrict access to care. More recently, prior authorization requirements for cancer treatments have significantly increased, leading to delays in needed care, adverse outcomes for patients, interference with the physician-patient relationship, and increases in overall health care costs.

Since we are treating so many individuals in our communities, our practice has a full team dedicated to processing prior authorization requests to ensure that our patients receive the most appropriate care. These proposed improvements to prior authorization in Minnesota will have a marked impact on our team's ability to process these administrative requests in a timely manner.

Without guardrails to protect the patient, these protocols take clinical decision making out of the physician's hands and give it directly to the insurance company. In many instances, those reviewing the prior authorization requests have no direct knowledge of the patient, insufficient training in the most up to date clinical evidence, and/or lack specialized expertise in cancer care.

On behalf of MNO, I urge you to support HF 3578. I am happy to answer any questions related to this important issue the committee may have.

Best Regards,

Paul Thurmes

Dr. Paul Thurmes, MD
Practice President, Minnesota Oncology

February 15, 2024

Health Plan Partnership of Minnesota - HF 3578 Concerns

Chair Liebling, Representative Bahner and Committee Members,

Thank you for the opportunity to share our concerns regarding HF 3578. The Health Plan Partnership of Minnesota (HPPM) shares the goal of accessible, inclusive, high quality, and affordable health care across Minnesota.

Members of HPPM have concerns about HF3578 as presented today, and while the topics addressed here are not a complete list of concerns, we would like to highlight the risk of conflict with emerging Federal standards and blanket prior authorization exemptions.

Conflict with Federal regulations

The Centers for Medicare & Medicaid Services (CMS) finalized the CMS Interoperability and Prior Authorization Final Rule to begin implementation in 2026. The goal is to improve the electronic exchange of health information and streamline prior authorization processes for medical items and services. These policies aim to reduce burden on patients, providers, and payers, resulting in approximately $15 billion (about $46 per person in the US) of estimated savings nationwide over ten years. If the State of Minnesota adopts prior authorization on a different timeline or with different criteria, the patchwork of regulations may increase costs in the system and may increase complexity for patients, providers, and payors.

The fiscal impact of a patchwork approach will not appear on a fiscal note; however, it may reduce the savings that could be gained by aligning with emerging Federal rules. We request caution moving a disparate set of prior authorization requirements.

Prior Authorization Exemption and Gold Carding

Prior authorization exemptions – including "Gold Carding" – are designed to engage providers who have a very low rate of prior authorization rejections, to streamline

prescribing, and improve patient access. Building successful relationships between providers and payors for the benefit of patients is a goal we all share. Health plans work with providers to streamline prescribing while containing costs and protecting patient safety. A step-by-step approach based on quality outcomes is the most prudent way to streamline process and protect patient safety. A blanket 70% threshold does not match the high-quality standard adopted in other states and may put patient safety at risk.

Additionally, without interoperability of electronic health records, even this low threshold may be difficult to achieve. An AHIP survey indicates that 80% of medical prior authorization and 39% of prescription prior authorizations were submitted manually.

Conclusion

We ask the committee members to consider prior authorization in the context of Minnesota's innovative, rapidly evolving care model. As therapies and medical devices become more patient specific, a deliberate, quality-focused, step by step approach to streamlining prior authorization will protect patients, improve access, and focus on the best value for care.

Sincerely,

Michelle Benson
Health Plan Partnership of Minnesota
Mbenson@healthplansmn.org

We welcome additional health plans and other related entities to join as we advocate for accessible, inclusive, high quality, and affordable health care across Minnesota.

Minnesota Hospital Association

161 Saint Anthony Ave., Ste. 915
Saint Paul, MN 55103-2382
www.mnhospitals.org

February 15, 2024

Chair Liebling and Members of the House Health Finance and Policy Committee,

On behalf of the Minnesota Hospital Association (MHA) and the patients our 141 hospital and health system members across the state serve, we write to you today to share our strong support for HF 3578 (Bahner) to strengthen Minnesota's current Prior Authorization (PA) laws.

In the 2020 Legislative Session, lawmakers passed a bill making overdue changes to the Prior Authorization process. That law shortened most PA response timelines and required like or similar physician specialties to conduct the PAs. These were certainly much needed improvements but unfortunately problems still remain which are creating hardships for our patients.

Patients across Minnesota are having their care delayed waiting for their insurer to approve payment for a procedure or medication that has been prescribed by their physician or other licensed provider AND it is part of their current benefit set. HF 3578 establishes much-needed guardrails to Minnesota's Prior Authorization process so that our patients can receive timely and needed health care.

Highlights of the bill which will benefit patient care:

- Prohibits Prior Authorizations for certain care services beyond emergency services: Substance Abuse Treatment, some generic drugs, outpatient mental health and chemical dependency, chemotherapy cancer treatments, immunizations, preventative services, pediatric hospice, Neonatal Abstinence Syndrome treatments, others.
- Calls for Prior Authorizations not to expire after one year for treatment of chronic conditions unless standards of care change in order to have patients with these conditions receive uninterrupted health care.
- Prohibits retrospective denials for Prior Authorizations where a PA was not required.
- Prohibits denials of services where Prior Authorization was required based solely on the lack of a PA – if the service would have normally been covered.
- Requires utilization review organizations to develop new systems to: Automate the process to determine if a Prior Authorization is needed, support automated PA requests and responses, indicate if a PA denial is appealable – in order to make the PA process faster and more efficient to reduce wait times for our patients.
- Requires (annually by Sept. 1) the Department of Commerce to publish a report documenting the following: the number of Prior Authorizations required, the number of PAs authorized vs. adverse determinations, the number of adverse determinations reversed on appeal, the 25 codes with highest number of PA requests and authorizations. The report is required to provide this data by

certain patient service lines. Transparency of this data will serve Minnesotans across the state by identifying areas that need to be further improved to help even more patients receive care.

In addition to Prior Authorization reform being of significant benefit to patients, this bill will undoubtedly help reduce provider burnout. Minnesota, like most other states, is facing a physician shortage – and we need to allow physicians to spend more time on patient care and not administrative tasks – to the greatest extent possible. Unnecessary Prior Authorizations should be eliminated, and the process should be more streamlined. This will serve our patients and reduce instances of interrupted care and wait times for them. This will also improve physician job satisfaction.

These challenges are not unique to Minnesota. The American Medical Association reports a record number of more than 70 Prior Authorization Reform bills being introduced in 28 different states. We hope that Minnesota will join a list of states passing this needed Prior Authorization reform in service of Minnesota patients.

Sincerely,

Mary Krinkie
Vice President of Government Relations
mkrinkie@mnhospitals.org

Danny Ackert
Director of State Government Relations
dackert@mnhospitals.org

ACOG
Minnesota Section

February 14, 2024

Madame Chair and Members of the Health Finance and Policy Committee,

The Minnesota Section of the American College of Obstetricians and Gynecologists (ACOG) supports HF3578 for prior authorization reform.

Too often, prior authorization – which is truly intended as a checkpoint prior to provision of unique or experimental medical care that can be particularly expensive – stands in the way of patients receiving standard, evidence-based medical management for preventative and therapeutic care. This may prevent patients from accessing consistent contraception, mental health medications, pain management for menstrual cycles, chemotherapy for gynecologic cancers, genetic screening in pregnancy or as related to hereditary cancer syndromes, procedures for the work-up or management of concerning symptoms or conditions, and countless other components of necessary OB/Gyn care. This can become especially frustrating and dangerous in cases in which patients have been stable on one medication or therapy and a change in health insurance carrier or policy type creates new requirements for accessing it.

Prior authorization reform is included within the legislative priorities for national ACOG for 2024. ACOG supports consistent access to contraception, access to genetic screening without need for approval, removal of the ability for retroactive denials of already authorized care, ensuring authorizations are valid for at least one year or for the length of treatment for chronic conditions, reductions in the administrative burdens of prior authorizations, improving efficiency of the prior authorization process to prevent delays in access to necessary care, and collaboration between specialty groups and government bodies to identify care that should never require prior authorization.

Minnesotans deserve consistent access to healthcare and the therapies that are deemed appropriate and safe by their trusted healthcare providers without interference from insurance carriers. Please join us in supporting HF3578.

Erin Stevens, MD

Legislative Chair for MN ACOG

February 14, 2024

The Honorable Tina Liebling, Chair, House Health Finance and Policy Committee
The Honorable Robert Bierman, Vice Chair, House Health Finance and Policy Committee
Minnesota House Health Finance and Policy Committee Members
Minnesota House of Representatives
477 State Office Building
St. Paul, MN 55155

Re: **PCMA Comments Opposing HF 3578 – Prior authorization and coverage of health care services requirements modified, ground for disciplinary action against physicians modified, reports to the commissioner of commerce and the legislature required, data classified, and rulemaking authorized.**

Dear Chair Liebling, Vice Chair Bierman, and Members of the Health Finance and Policy Committee:

My name is Michelle Mack and I represent the Pharmaceutical Care Management Association, commonly referred to as PCMA. PCMA is the national trade association for pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 275 million Americans with health coverage provided by large and small employers, health insurers, labor unions, and federal and state-sponsored health programs.

PCMA appreciates the opportunity to provide written testimony and I apologize I am not able to be there in person. We respectfully submit the following comments for consideration in opposition to HF 3578, given our industry has significant concerns about the bill. PBMs exist to make drug coverage more affordable by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. PBMs help consumers obtain lower prices for prescription drugs through price discounts from retail pharmacies, rebates from pharmaceutical manufacturers, and using lower-cost dispensing channels. Though employers, health plans, and public programs are not required to use PBMs, most choose to because PBMs help lower the costs of prescription drug coverage.

Prior Authorization

Prior authorization is a requirement that a health plan pre-approves a prescription drug before a pharmacy can dispense it to an enrollee as a covered benefit. The primary goals of prior authorization are one, to ensure the appropriateness and suitability of the prescribed medication for the specific patient; two, safety; and three, to control costs. Health plans and PBMs rely on independent Pharmacy & Therapeutics Committees, comprised of experts that include physicians, pharmacists, and other medical professionals, to develop evidence-based guidelines used in drug management programs—including prior authorization—and to ensure that these management

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

controls do not impair the quality of clinical care. Prior authorization is a tool used for drugs with the following characteristics:

- Dangerous side effects
- Harmful when combined with other drugs
- Should only be used for specific health conditions
- Are often misused or abused
- Have equally, more effective, or more affordable drugs that would work for the majority of patients based on evidence-based drug therapy standards of care

Every health plan has a prior authorization appeals process. According to the National Academies of Sciences, Engineering, and Medicine (NASEM), "Every plan, whether Part D or an employer-sponsored pharmacy benefit, has an exception process that permits coverage of a drug not on formulary or reduces out-of-pocket cost if a prescriber provides information about side effects the patient has experienced from a lower-tiered drug or offers another medical reason for switching."[1] This process safeguards against the use of prior authorization being too restrictive.

Inappropriate use of medicines can harm patients and result in unnecessary healthcare expenditures. Additionally, there are potential unintended cost impacts of proposals to limit or prohibit utilization management tools such as prior authorization.

In 2020, when prior authorization language was enacted in Minnesota, the language was heavily negotiated, and the negotiations took place during the height of the pandemic. A mere four (4) years later, the issue is again at the forefront. Among other things, we are concerned that the language in HF 3578 is changing "emergency" exemptions to "certain" exemptions, such as not being able to use prior authorization for: "medication to treat a substance use disorder," "generic drug…or a biologic drug", "services covered through a value-based arrangement", etc. In addition, and equally concerning is the requirement that an authorization would not expire if it is for the treatment of a chronic condition. Finally, in 2008, Minnesota was one of the first states to enact electronic prior authorization language for prescription drugs, which can be found in §62J.497. The language in HF 3578 does not address this long-standing requirement and appears to set forth a new standard and process.

Gold Carding

HF 3578 also intends to create a gold carding program, which would allow providers to skip prior authorization requirements if they qualify by meeting an authorization rate in the 70th percentile over the most recent 12-month period. This is a standard that has not been enacted in any other state. Once this exemption is applied, payment can only be withheld for limited reasons that do not include the service being later found not medically necessary in whole or in part. Gold carding

[1] Making Medicines Affordable: A National Imperative," National Academies of Sciences, Engineering, and Medicine (NASEM), Nov. 2017.

programs may not be appropriate for a pharmacy benefit. Because multiple unaffiliated providers could be prescribing to the same patient, PBMs are uniquely positioned to identify dangerous drug interactions that may not be visible to the prescriber or pharmacist. Also, PBMs are uniquely positioned to identify more cost-effective, safer, or equally efficacious alternatives, such as generics or more affordable brand-name drugs.

As stated earlier, gold carding programs may not be appropriate for a pharmacy benefit, and we suggest that this provision not apply to the pharmacy benefit. For your reference, two documents describing gold carding are included.

In the interest of Minnesota patients and payers, it is due to these problematic provisions noted above that we must respectfully oppose HF 3578.

Thank you for your time and consideration. Please feel free to contact me should you have any questions.

Sincerely,

Michelle Mack
Senior Director, State Affairs
Phone: (202) 579-3190
Email: mmack@pcmanet.org

February 13, 2024

Re: HF 3578 – Prior Authorization Modernization

Dear Chair Liebling and Members of the House Health Finance and Policy Committee:

On behalf of RAYUS Radiology, a network of multi-modality diagnostic imaging centers, that operates 23 advanced imaging centers across Minnesota, we are writing you today in strong support of the provision of HF 3578 which looks to further reform and modernize the state's prior authorization statutes. Prior authorization or utilization review is a process used by insurers to limit costs by requiring providers to qualify for payment coverage by obtaining advanced approval from the insurer prior to providing the service to the patient. In many circumstances, this results in delays in needed care and continues to place an increased administrative burden on clinicians, who are looking to treat patients in a timely manner to increase patient health outcomes.

The bill before your committee would further clarify that health plans may not limit or deny coverage for a service solely bases on the lack of prior authorization being obtained. From a radiologist's perspective, a diagnosis of a patient may change based on the findings of an imaging report, and that new diagnosis may have different prior authorization requirements than what was initially suspected. Still the patient must be seen to receive an accurate diagnosis.

Similarly to what other states have done, this bill looks to establish automation guidelines for health plan's interfaces. We believe this will result in less administrative work from both the provider and health plan, and this will ensure a more streamlined process for patients seeking care. Additional functionality between providers and payers will greatly help modernize these processes.

Further, we are supportive of the "gold carding" language in the bill and consideration should be given to ensure this language applies to both the ordering and rendering physician. This again will prove to reduce speedbumps in the process of patients receiving essential care.

Please let us know if you have any questions, and we appreciate your consideration of the bill.

Sincerely yours,

Dr. Blake Johnson, FACR	Dr. James Sullivan	Dr. Derek Weldon
National Medical Director	Twin Cities Medical Director	St. Cloud Medical Director

Minnesota Chapter

INCORPORATED IN MINNESOTA

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Minnesota Chapter of the American Academy of Pediatrics
1609 County Road 42 W #305,
Burnsville, MN 55306

February 15, 2024

Dear Members of the Health Finance and Policy Committee,

On behalf of the over 1,000 members of the Minnesota Chapter of the American Academy of Pediatrics (MNAAP), I am writing in strong support of H.F. 3578.

Prior authorization requirements are dangerous for patients. It is the primary cause for deferred or delayed care, leads to severe negative health outcomes, and must be limited.

This legislation would prohibit prior authorization for services where deferred or delayed care leads to serious negative health outcomes for children, youth, and adolescents. Our patients – Minnesota's children – are often forced to defer important care due to prior authorization requirements. When care for these services is put off, or discontinued entirely, our patients suffer immensely. Treatments for conditions such as substance-use disorder, mental health, cancer, chronic conditions, and others, if deferred or delayed, can lead to severe negative health outcomes, including death. Insurance companies denying important care do not know what is best for patients. Pediatricians who diagnose and treat patients, do.

H.F. 3578 would go far to reducing burdens for services that, when undergo prior authorization, are almost always approved, and do nothing except force patients to either delay treatment or give up on pursuing treatment altogether.

Almost every health expert agrees – prior authorization is bad for patients. Survey data from the American Medical Association in 2022 found that 94% of physicians reported that prior authorization has led to delays in care and 89% of physicians said that prior authorization has had negative effects on patient health outcomes.

I greatly appreciate this committee taking up the important issue of prior authorization reform early in the legislative session. MNAAP urges the Health Finance and Policy Committee to pass H.F. 3578. It will save lives.

Sincerely,

Eileen Crespo, MD, FAAP
President, Minnesota Chapter of the American Academy of Pediatrics

MINNESOTA
ORTHOPAEDIC
SOCIETY

February 15, 2024

Madame Chair and Members,

On behalf of the Minnesota Orthopaedic Society, I am writing in support of HF 3578.

This bill directly addresses the negative experiences felt by too many patients in Minnesota due to prior authorization requirements.

According to data from the American Medical Association, 94% of physicians report that prior authorization has led to delays in care for their patients. In that survey, 1 in 3 physicians reported that prior authorization has led to serious adverse events for patients. Additionally, while 100% of health plans report using peer-reviewed evidence-based studies when designing prior authorization programs, 31% of physicians polled report that prior authorization criteria are rarely or never evidence-based.

This reflects what we are hearing from our own members. According to data gathered among the state's orthopedic physicians, over 90% of prior authorization requests were ultimately approved, most of which following first application.

These numbers suggest that services that are evidently not overutilized still undergo frequent prior authorization review. This does not benefit the patient. This does not benefit the provider. This does not benefit anyone except health plans that save money when patients give up on pursuing treatment due to prior authorization.

Our patients and providers deserve better. This bill would eliminate prior authorization for services we can all agree, we want to encourage patients to get. These include treatments for substance-use disorder, outpatient mental health, cancer, chronic conditions, and preventative health services. For other services not included in Section 6 or Section 7 of this bill, Section 8 aims to limit the use of prior authorization for those services that are almost always approved. These sections will drastically improve patient health in Minnesota.

I greatly appreciate the time dedicated to this important issue. HF3578 prioritizes patient care by reducing the burden of prior authorization and I urge members to support it.

Sincerely,

Paul Lafferty, MD
President, Minnesota Orthopaedic Society

February 15th, 2024

Chair Tina Liebling and Members
House Health Finance & Policy Committee
St. Paul MN

Re: The Minnesota Pharmacy Alliance Support for Prior Authorization Reform - HF3578

Dear Representative Liebling:

The Minnesota Pharmacy Alliance (MPA) represents over 1500 retail and health system pharmacists, pharmacy technicians, and student pharmacists across the state of Minnesota. Pharmacists and pharmacy staff care for patients in all healthcare settings throughout Minnesota. Pharmacies are where an overwhelming number of Minnesotans get their health care needs met every day in Minnesota. We are the health care provider a patient will see the most throughout the year and are the closest point of access for health care services for Minnesota patients. Pharmacies and pharmacists are also represented by the Minnesota Retailer's Association and grocery store-based pharmacies are also represented by the Minnesota Grocers Association.

We are writing to you today to convey our strong support for Representative Bahner and Senator Morrison's legislation, HF3578, that will reform the prior authorization system and process in Minnesota. It will prioritize a provider's choice of treatment and therapy and the patient, who may have complicating factors, over payer barriers to medications that greatly impact and save lives every day in Minnesota. The legislation will also positively impact the gross burden and real costs that prior authorizations have for pharmacies in Minnesota every day.

Assuming the legislative language that specificizes a provider also includes a pharmacist, we support all provisions in the bill language.

With each patient medication interaction there is almost always a transaction fulfillment that occurs and often a health insurance or pharmacy benefit manager requires a prescription to go through a prior authorization before the patient's provider prescribed medication is dispensed, delivered or administered in the State of Minnesota. For 1.4 million Minnesotans who receive their health insurance from the Department of Human Services Medical Assistance program, they too could benefit from this legislation. The DHS Formulary and drug benefit administration also employs a fairly robust prior authorization process.

Health plans collectively represent 3,165,144 individuals covered by health carriers licensed in Minnesota as of December 31, 2020. This includes fully and self-insured health insurance markets, but excludes state and federal public programs. Commercial fully-insured enrollees represent 38% of these enrollees, and self-insured represent 62%. For these enrollees, the health plans collectively received 114,879 drug prior authorization requests in 2020, for an average of 0.036 requests per enrollee. The health plans received notably more prior authorization requests per enrollee for the commercial fully-insured (0.071) than for self-insured enrollees (0.033).
Minnesota Department of Health Report, 2021

The legislation takes a practical approach to protecting patients with diagnosis and medication therapy prescribed by a provider for substance use disorder, mental health treatment, antineoplastic cancer, immunizations, health screenings for woman, pediatric hospice, neonatal abstinence for pediatric pain, generic drug or multisource brand name drugs rate d as therapeutically equivalent, biologic drugs rated as interchangeable and services covered through a value-based arrangement. Often medication therapies prescribed for these diagnosis and conditions are quite specific and need to be administered to the patient in a very timely manner. Every day in Minnesota we see patient care denied or their care substantially delayed due to prior authorizations. This is not just a problem in Minnesota.

A 2022 AMA survey found that for patients whose treatment required prior authorization, 94% of physician respondents said the process led to delays in care for patients. 80% reported that delays due to prior authorization resulted in patients abandoning their recommended course of treatment either sometimes or more often. Of the physicians surveyed, 33% had seen a prior authorization requirement led to a serious adverse event for a patient, including 25% who reported prior authorization leading to a patient's hospitalization. Overall, 89% of respondents perceived prior authorization to have a somewhat or significantly negative impact on patient clinical outcomes.
American College of Physicians – 2/2024

Barriers within the existing system impede pharmacists' abilities to receive prior authorizations, disrupt workflows, and delay the dispensing of needed medications and the provision of pharmacists' patient care services to patients. Pharmacists need a means to have real-time access to information about prior authorizations and from providers' systems, which they currently do not have. Many prior authorization processes are time consuming, use extra staff to make sure payment is authorized and done, costly, and a burden to pharmacy providers.

These processes often involve unreasonable wait times to receive the prior authorization (some have taken one month or longer). For critically ill patients and those patients suffering from mental illness or substance abuse, such wait times could be onerous and potentially life altering.

However, this only describes the impact to care. The financial, systems and daily burden that prior authorization pose to Minnesota pharmacies has grown substantially in recent years. Minnesota pharmacies need real reform and this legislation will go a long way to help.

Despite widespread recognition of the problem, progress has been slow. In 2019, the Council for Affordable Quality Healthcare (CAQH) reported that PA's time per manual transaction increased from 16 minutes the previous year to 21 minutes, with a corresponding increase in cost from $6.60 to $10.92. In 2020, total spending on prior authorization increased to $767 million, with 86% of the expenditure incurred by providers and pharmacies. PA requirements often undermine clinical decision-making and can negatively impact patient outcomes. This comes at a high cost for small and independent practices with limited administrative resources, particularly those in communities that may have reduced access to care.[2]

Whether a community independent, regional chain or big box chain, prior authorizations in these medication categories are having a negative impact for patients, providers and pharmacies across Minnesota. We urge you to pass HF3578 so that the health care provider and the patient are the primary consideration.

Sincerely,

Jason Miller, PharmD
Public Affairs Committee Co-Chair
Minnesota Pharmacists Association

Tamara Bezdicek, PharmD, BCPS
Co-Chair, Minnesota Pharmacy Alliance
Minnesota Society of Health-System Pharmacists

Deborah Keaveny, RPh
Minnesota Independent Pharmacists

February 14, 2024

Representative Tina Liebling, Chair
House Committee on Health Finance and Policy
75 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, Minnesota 55155

Dear Representative Liebling and Members of the House Committee on Health Finance and Policy,

The Minnesota Society Clinical Oncology Society (MSCO) and the Association for Clinical Oncology (ASCO) strongly support HF 3578, a bill that would improve prior authorization processes in the state, and we urge the Committee to vote in favor of the measure.

MSCO is a professional organization whose mission is to facilitate improvements for Minnesota physician specialties in both hematology and oncology. MSCO members are a community of hematologists, oncologists, and other physicians who specialize in cancer care. 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.

MSCO and ASCO are committed to supporting policies that reduce cost while preserving quality of cancer care; however, it is critical that such policies be 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 care for individuals with cancer.

MSCO and ASCO are pleased that HF 3578:

- **Alleviates administrative burden on physicians** by requiring utilization review organizations to establish and maintain an electronic prior authorization platform that automates certain elements of the process for in-network clinicians;

- **Accommodates the needs of specialized patient populations** by prohibiting prior authorization for antineoplastic cancer treatment consistent with National Comprehensive Cancer Network guidelines; and
- **Improves transparency** by implementing prior authorization statistic reporting requirements.

HF 3578 would also require the Commissioner of Commerce to adopt rules establishing requirements for a prior authorization exemption process that would grant an exemption to doctors with a strong track record of prior authorization approvals. This will allow clinicians to skip the burdensome prior authorization process, ultimately resulting in more-timely delivery of care to patients.

MSCO and ASCO are encouraged by the steps HF 3578 takes toward improving prior authorization in Minnesota, and we welcome the opportunity to be a resource for you. 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,

Amrit Singh

Amrit Singh, MD
President
Minnesota Society of Clinical Oncology

Everett Vokes

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

NAMI
National Alliance on Mental Illness
MINNESOTA

February 13, 2024

Members of the Health Finance and Policy Committee:

On behalf of NAMI Minnesota, we are writing in strong support of HF 3578. It has been almost 20 years since the first federal mental health parity law passed. One of the provisions is for plans to document use of prior authorization for both medical care and mental health care services. Many studies have shown that prior authorization is used much for mental health care than health care. The Kaiser Family Foundation found that 84% of Medicare Advantage enrollees are in plans that apply prior authorization to a mental health service. Some states, due to parity violations, have banned prior authorization for mental health care. Data transparency for prior authorizations should be a part of enforcing mental health parity.

Too often, prior authorization slows down or completely impedes access to care. Outpatient care, such as therapy, is one of the least expensive modes of care. Requiring prior authorization, and the subsequent delays, can lead to someone requiring a higher and more expensive level of care. We have seen some plans require prior authorization for sessions longer than 30 minutes. For people with serious mental illnesses or when in a crisis, 30 minutes is not long enough. The same is true for requiring prior authorization for prevention care such as depression screening. Eliminating prior authorization for medication treatment for substance use disorder when we have an increasing number of people dying from opioids simply makes sense.

When people are retroactively denied coverage for services, it can create fear to reach out for help next time. This is especially significant during our current mental health crisis. Parents cannot afford to hesitate to seek care when their children are experiencing symptoms. Early intervention and prevention are some of the most effective tools we have in improving the lives of people with mental illnesses, and we must do all we can to protect access.

We believe HF 3578 strikes a good balance automating processes, encouraging high quality care, and holding health carriers accountable. Please vote to support this bill and improve access to mental health care for Minnesotans.

Sincerely,

Sue Abderholden, MPH
Executive Director

Elliot Butay
Senior Policy Coordinator

Minnesota Society of Interventional Pain Physicians

The Voice of Interventional Pain Medicine in Minnesota

February 14, 2024

Chair Tina Liebling
477 State Office Building
St. Paul, MN 55155

Dear Chair Liebling and members of the Health Finance and Policy Committee,

The Minnesota Society of Interventional Pain Physicians (MSIPP) thanks you for prioritizing a hearing on HF3578 which would modify the prior authorization requirements.

As physicians trained in the medical subspecialty of interventional pain management, we know all too well the hurdles that prior authorization causes to our practices and more importantly to our patients. Using the most effective therapies and medications are objectives healthcare providers and insurers both share however, we believe prior authorization is used more to cut insurer costs than to protect patients.

Section 7, Subdivision 5 states that an authorization for treatment of a health condition that an enrollee is expected to have for a longer than one year does not expire unless the standard of treatment for that health condition changes. Nearly every therapy and medication our members prescribe for our patients, who are suffering with chronic pain, require prior authorization. What causes frustration, is that most prior authorizations for chronic pain are eventually approved. For our patients facing chronic conditions, and their doctors, prior authorizations serve as a reoccurring headache which ultimately delays their care.

As pain physicians, we want to spend our time seeing patients and managing their care plans. HF3578 will make a significant difference for us and our patients because we will not have to continually do prior authorizations for patients with chronic conditions allowing us to see more patients.

Thank you for your consideration of HF3578. I am available for questions at andrewwillmd@yahoo.com.

Sincerely,

Dr. Andrew Will
President
MSIPP

2104 Northdale Boulevard NW, Suite 220 | Minneapolis, MN 55433
(763) 767-8000 | (763) 537-6666 | msipp.org

PHYSICIANS
UNIVERSITY OF MINNESOTA

720 Washington Ave SE
Suite 200
Minneapolis, MN 55414
Executive Offices

February 15, 2024

Sen. Kelly Morrison
3205 Minnesota Senate Building
95 University Ave West
St. Paul, MN 55155

Rep. Kristin Bahner
525 State Office Building
100 Rev. Dr. Martin King Jr. Blvd.
St. Paul, MN 55155

Dear Rep. Bahner and Sen. Morrison,

I am the CEO of the University of Minnesota Physicians (UMP). Thank you for chief authoring SF3532/HF3578 which would regulate the burdensome prior authorization (PA) process.

UMP is the multi-specialty academic physician practice of the University of Minnesota. We are dedicated to serving all Minnesotans, the upper Midwest and beyond. We understand that complicated prior authorization processes often delay patient care and negatively impact patient outcomes, particularly for those with urgent or serious medical conditions where timely access to care is crucial.

The administrative burden of prior authorization consumes significant time and resources for healthcare providers, diverting their focus from direct patient care and leading to increased burnout and dissatisfaction among medical professionals. Prior authorization also can lead to unnecessary treatment interruptions or changes, disrupting established treatment plans and potentially compromising patient well-being.

A problem with the current prior authorization process is that the requirements vary widely from one insurer to another, each of which also has a different process for submitting prior authorization requests. UMP believes a standardized process will benefit not only patient care but help the streamline this labor intensive work for clinicians statewide.

We are thankful that there is a larger coalition this year led by the Minnesota Medical Association, the Minnesota Hospital Association and many specialty clinics and provider groups and we are happy to support this important legislation.

Thank you for taking the time to listen to our concerns. I would be happy to speak to you if you have any questions.

Sincerely,

Bevan Yueh, MD, MPH
CEO
University of Minnesota Physicians
byueh@umn.edu

February 14, 2024

Chair Liebling and Members of the House Health Policy and Finance Committee:

I write on behalf of OutFront Minnesota, our state's largest LGBTQ+ advocacy organization, in support of HF 3578 (Bahner) addressing prior authorization in this state.

This bill is an opportunity to continue to ensure that Minnesota's medical care remains world-class and that patients and their care providers are not faced with unnecessary barriers to best-practice care.

The current landscape around prior authorizations is something that has unfortunately impacted many Minnesotans. As the Minnesota Medical Association notes, this is having direct impacts on both patients and providers[1]: "94% of physicians report that prior authorization has led to care delays, 80% report that prior authorization can and has led to treatment abandonment by patients, and 33% report that prior authorization has led to a serious adverse event for their patients." These numbers are particularly concerning when the majority of those seeking approvals ultimately receive them. There are legitimate reasons to support prior authorization for specialized services, where appropriate; but, when broadly applied, they create delays and burdens that are not in the best interests of patients or the providers who serve them.

The concerns addressed by this bill are not unique to our state's 2SLGBTQIA+ populations, but we know that the prior authorization barriers can compound existing barriers[2] to seek or receive necessary care.

HF 3578 would help our state to better track and limit the negative impacts of prior authorization for *everyone* seeking care; and it would help to alleviate burdens to our health care providers who can spend more of their time serving patients.

OutFront Minnesota supports HF 3578 and we encourage committee members to support this legislation.

Sincerely,
Kat Rohn
Executive Director
OutFront Minnesota

[1] https://www.mnmed.org/advocacy/key-initiatives/prior-authorization
[2] https://www.kff.org/report-section/lgbt-peoples-health-status-and-access-to-care-issue-brief/

What Is "Gold Carding"?

"Gold Carding" is a program used by some health plans that waives, on a limited basis, prior authorization (PA) rules for certain services provided by clinicians who are deemed "high-performing." The clinician's "gold card" exemption from prior authorization is effective for a limited service or set of services, for a defined period, and is reviewed regularly to ensure the clinician continues providing appropriate care.

What is prior authorization and why is it used?

Prior authorization is used by plan sponsors to improve clinical safety, decrease inappropriate utilization and waste,[1] and help ensure appropriate use of high-risk and/or high-cost drugs. In the pharmacy benefit, a PA helps ensure the appropriateness of medication prescribed for patients and promotes the most cost-effective therapies.[2] It is often used to evaluate prescriptions for drugs that are intended for certain age groups or conditions only; drugs used for both cosmetic or therapeutic reasons, to ensure the drug is being prescribed for therapeutic treatment; drugs that have potentially harmful side effects, dangerous interactions, or risks for abuse or misuse; drugs that aren't covered by insurance but are deemed medically necessary by the prescriber; or brand-name drugs that have a more affordable generic equivalent.[3]

What sort of factors determine whether a provider achieves "gold card" status?

Programs vary from plan to plan, but eligibility for a gold carding program is typically conditioned upon the provider having a demonstrated history following appropriate plan and medical evidence-based protocol. America's Health Insurance Plans (AHIP) found in a survey of its member health plans using gold carding programs that "low prior authorization denial rates, minimal prior authorization requests, and risk-based contract participation" were three important qualities of a provider in determining eligibility.[4]

Is gold carding widely used for pharmacy benefits?

In a survey of health plan members, AHIP reported that 21% of the responding members used a gold carding program for prescription medications in 2022. Unlike medical claims, the pharmacy benefit payments are determined in real time.

Is gold carding the only way to streamline prior authorization for medications?

Electronic prescribing ("e-prescribing"), "real-time benefits tools," and electronic prior authorization (e-PA) are three tools that reduce the time and paperwork for PAs. Prescribers e-prescribing send prescriptions instantly to patients' pharmacies; real-time benefits tools inform prescribers about medications' formulary placements and cost sharing at the time of prescribing, guiding patients toward the safest, most cost-effective drugs; and electronically submitting a PA can reduce the time needed to complete the request.[5] AHIP found, when it studied a new e-PA initiative that began in January 2020, that e-PA led to "faster time to patient care, faster time to a decision, lower burden from phone calls and faxes, and improved information for providers."[6] In AHIP's 2022 survey, 75 percent of health plans responding indicated that they used e-PA to help streamline the process of PA.

1 Visante (citing PBMI). 2023. "PBMs: Generating Savings for Plan Sponsors and Consumers. 2023," p. 19.
2 GoodRx. 2022. "What is Prior Authorization? A Look at the Process and Tips for Approval."
3 Id.; Visante p. 8
4 Health Payer Intelligence. "Gold Carding Has Mixed Effects on Streamlining Prior Authorization Processes." Nov. 2022.
5 PCMA. 2023. "Patient Care."
6 AHIP. 2022. "Effective Gold Carding Programs are Based on Evidence and Value for Patients."

ABOUT PCMA

PCMA is the national association representing America's pharmacy benefit companies. Pharmacy benefit companies are working every day to secure savings, enable better health outcomes, and support access to quality prescription drug coverage for more than 275 million patients. Learn more at www.pcmanet.org.

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