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SUPPORT **HB711 THE PRIOR AUTHORIZATION REFORM ACT** TO ENSURE THAT PATIENTS GET THE NECESSARY CARE THEY NEED

Current prior authorization requirements instituted by health insurance entities are forcing patients to wait too long for medically necessary and appropriate treatments. According to surveys from the Illinois State Medical Society (ISMS) and other medical organizations, these prior authorization requirements are causing critical patient care delays and adverse patient safety events.

More than 91% of Illinois physicians responding to a 2019 survey reported that the burden of prior authorization has significantly increased in the past five years. Survey comments reveal that this burden is resulting in **longer wait time for patients, less successful patient outcomes, rising costs for medical practices, and increasing physician burnout.**

To address these issues, **House Bill 711** will create a system to reduce long term health care costs by **eliminating or reducing inefficiencies and by keeping people healthy on the front end.** Our important initiative does the following:

- Increases transparency. The bills will require payers to maintain and publicly post a list of services for which prior authorization is required. Finding out what treatments require prior authorization is often a challenge in itself, and often is not known until after the treatment is prescribed, exacerbating delays in care.

- Establishes important maximum timelines for urgent and non-urgent prior authorization requests. Currently there are no standard timelines, forcing patients to wait an excessive amount of time, often weeks, before care can be initiated. **Illinois oncologists, for example, note that their patients often have to wait 30 days before cancer treatments are approved and can be scheduled to begin.**

- Defines qualifications of individuals designated to review and make prior authorization determinations. Too often treatment plans are reviewed and determined by individuals who are not trained in the area of medicine they are reviewing. Setting forth specific qualifications required of these individuals will streamline the process with quicker, educated decisions.

- Ensures that if prior authorization is requested and approved for a given procedure, reasonably related supplies or services are considered to have also received authorization. **Surgeons are registering complaints that while a surgery is approved, a separate prior authorization is required for the anesthesia and has not come through, delaying the surgery.**

- Provides for continuity of care for patients with long-term or chronic conditions by requiring that prior authorization approvals remain in effect for the lesser of 12 months or the course of treatment as recommended by the patient's health care professional or provider. Approvals would generally remain in effect for 6 months for treatments for non-chronic conditions.

- Ensures that a prior authorization determination confirms medical necessity requirements and requirements for payment for the delivery of the health care service. All too often a physician spends hours dealing with payers to get a treatment approved, only to experience non-payments after the care is rendered.

This legislation does not seek to eliminate prior authorization; instead, the goal is to realign what has become a very broken system by requiring transparency, appropriate peer-to-peer review, medically appropriate timelines for both urgent and non-urgent care, and ensuring continuity of care.

The Your Care Can't Wait Coalition members urge you to vote yes on House Bill 711 to ensure that patients get the care they need.