Proponent Testimony, HB 220
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Chair Lampton, Vice Chair Craig, Ranking Member Hall and members of the Ohio House Insurance Committee, thank you for the opportunity to provide testimony in support of H.B. 220.

My name is Eric J.B. Shapiro, MD and I am a board-certified gastroenterologist and President of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO). The AMCNO is one of the oldest professional associations in Ohio and represents more than 7,200 physicians and medical students from all the contiguous counties in Northern Ohio. We are proud to be the stewards of Cleveland's medical community of the past, present and future.

Beyond being an extreme administrative burden on providers, prior authorization is simply no more than a time-delay tactic by the insurance companies to delay payments to keep their stakeholders happy. Most prior authorizations are approved on appeal, meaning the significant time spent by providers in the appeal process is unnecessary and time that could be better spent on direct patient care.

Patients also suffer the consequences of prior authorizations by having delays in receiving necessary tests, treatment, and/or medication. One Ohio patient shared online that her sister "broke her ankles and the insurance company has denied every request her doctor has made for every test. She is now unable to walk."[1] This experience is not unique considering that **94% of physicians reported care delays associated with prior authorization**.[2]

When patients are suffering from life-threatening illnesses or debilitating health conditions, physicians need to be able to deliver care that is both evidence-based and appropriate—which they are uniquely trained and educated to do, without being stalled by the insurance company whose premier motive is profit.

Specifically, H.B. 220 would ensure retroactive denial can only occur for non-covered benefits or lack of coverage at the time of service and would require prior authorization appeals to be between the healthcare provider and a clinical peer and require identification of the clinical peer (plan

[1] Patients and Physicians Speak Out. 2023. American Medical Association. https://fixpriorauth.org/stories.
[2] AMA Prior Authorization (PA) Physician Survey. 2022. American Medical Association. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

[1] Stein, J. D., Kapoor, K. G., Tootoo, J. L., Li, R., Wagner, A., Andrews, C., & Miranda, M. L. (2018). Access to Ophthalmologists in States Where Optometrists Have Expanded Scope of Practice. *JAMA Ophthalmology, 136*(1), 39. https://doi.org/10.1001/jamaophthalmol.2017.5081

clinician) making adverse determinations. This latter section is extremely important as those who question our clinical expertise should be peers who are equally qualified to make determinations.

H.B. 220 would also improve the process by prohibiting insurers from charging providers to appeal rejected claims, and it would require insurers to account for dosage adjustments in drug prior authorizations to treat chronic conditions so that the care of patients is not interrupted.

We believe that patient care and physicians' provision of such should not be impeded by the red tape of prior authorizations. H.B. 220 is an important first step in protecting our physicians and their patients.

For these reasons, we ask that you support H.B. 220. Thank you for your time.

[2] Stein, J. D., Zhao, P. Y., Andrews, C., & Skuta, G. L. (2016). Comparison of Outcomes of Laser Trabeculoplasty Performed by Optometrists vs Ophthalmologists in Oklahoma. *JAMA Ophthalmology*, *134*(10), 1095. https://doi.org/10.1001/jamaophthalmol.2016.2495