Pennsylvania Medical Society®

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March 12, 2018

Dear Representative:

During the course of patient care, a physician's moral and ethical obligation is to treat a patient in a manner that is clinically appropriate and in the best interest of that individual's well-being. These decisions come with immense personal and professional responsibility…a responsibility that physicians take very seriously.

Recently, California's Insurance Commissioner launched an investigation into how Aetna, the nation's third-largest health insurer, decides whether to approve or deny care – a process known as prior authorization. Thus far, three other states – Colorado, Washington and Connecticut – have launched similar inquiries. It is our hope that Pennsylvania's Acting Insurance Commissioner, Jessica Altman, will follow a similar path to ensure that Pennsylvania's health insurers are making appropriate and clinically sound coverage decisions.

I believe very strongly that determining how a patient is treated, and what treatment protocol is best, should be decided by a patient's physician, not by an insurance company algorithm designed only to reduce costs and ration care. While Aetna's alleged wrongdoing in California may be an isolated misstep, and a potentially large one at that, it does beg the question of exactly who is making treatment decisions…insurance executives or physicians?

Several years ago, the Pennsylvania Medical Society (PAMED) began hearing complaints from physicians regarding the expansion of prior authorizations for treatments that were considered accepted standards of care. Increasingly, as prior authorization requirements grow, physicians are having to tell patients that coverage for their surgery, diagnostic test, or therapeutic medications has been denied by their insurance company. This leaves patients frustrated and physicians scratching their heads as to why the request was rejected. More alarming is when insurers arbitrarily change prior authorization criteria that requires physicians to alter a patient's current course of treatment, jeopardizing their continuity of care.

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In recognition of this growing problem, Rep. Marguerite Quinn introduced House Bill 1293 earlier this legislative session. Rep. Quinn's proposal does not call for "scrapping" prior authorization; rather, it seeks to streamline the process by mandating transparency and other changes that will improve efficiency so that coverage decisions no longer delay patient care.

While the art of medicine continues to evolve with advances in diagnostic imaging, surgical procedures, and medication therapy, the bedrock of medical practice remains the physician-patient relationship. Unfortunately, health insurers continue to strain this relationship by dictating treatment protocols without ever having the benefit of examining the patient themselves. Passage of House Bill 1293 will go a long way in helping to ensure that our patients receive the best and most appropriate care possible and without unnecessary delays.

I urge you to support Rep. Quinn's efforts to reform insurance prior authorization so that physicians can appropriately care for your constituents.

Sincerely,

Theodore A. Christopher, MD, FACEP
President