OHIO ACADEMY OF FAMILY PHYSICIANS

Proponent Testimony for Senate Bill 129

Presented by Sarah Sams, MD on behalf of the

Ohio Academy of Family Physicians

House Insurance Committee Hearing - Tuesday, May 17, 2016

Chairwoman Sears, Vice Chairman Brinkman, Ranking Minority Member Bishoff, members of the House Insurance Committee -

Thank you for allowing me to submit written testimony in strong support of Senate Bill 129, a proposal that seeks to reform and simplify the prior authorization processes used by insurance companies. My name is Dr. Sarah Sams. I am the medical director at Grant Family Medicine in Grove City and associate director of the Grant Family Medicine Residency Program here in Columbus. I am submitting this testimony on behalf of myself and the Ohio Academy of Family Physicians.

The Ohio Academy of Family Physicians is a statewide professional association with 4,800 family physician, family medicine resident and medical student members. Family physicians are dedicated to treating the whole person. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focusing on integrated care. Unlike other specialties that are limited to a particular organ or disease, family medicine integrates care for patients of all genders and every age, and advocates for the patient in a complex health care system.

The prior authorization process is an enormous burden for those on the front lines of delivering patient care. Prior authorization forms have evolved away from just cost considerations into a review of treatment practices in general. As a result, prior authorization forms sometimes request attachment of pertinent medical history and include questions regarding diagnoses, risk and benefit, alternatives, effectiveness, stability of symptoms, side effects, and other considerations.

Not only do physician practices face increased numbers of prior authorization requests, the complexity of these requests creates a huge administrative burden for the physician and the physician's practice team. Prior authorizations cause immense frustration for patients and physicians. And they can delay much needed treatment and in some cases result in inappropriate care for patients.

The American Academy of Family Physicians 2014 Practice Profile report indicates that family physicians spend 1.8 hours per week dealing with prior authorization requests, 7.7 hours per week on non face-to-face patient care issues, and 3.8 hours per week on other non-patient care tasks. Just think how many additional patients could be seen and cared for in that time each week. That fact that physicians and other practice staff spend hours attempting to obtain permission to provide appropriate, needed medical care and medications for patients is just crazy. I will provide you with just a couple of examples.

I have an 85 year-old patient who previously had a stroke. She has high blood pressure and diabetes and is on many medications, four for blood pressure control. It took me and a nephrologist multiple medication adjustments to find the combination of four medications that controlled her blood pressure (an important component if reducing recurrent stroke) and that she tolerated without side effects. She has not been hospitalized in several years. Her health insurance was provided through her previous employer's pension plan and they chose to change insurance carriers. The new insurance plan wanted her to try their preferred medication. I was concerned about any change in medication as an elevation of her blood pressure could put her at serious risk. I called for the prior authorization. After spending 45 minutes on the phone, being transferred from department to department, the prior authorization was denied because she had never tried and failed "their preferred medication". I hung up in frustration. My nurse manager then called back and spent another 90 minutes on the phone with the appeals department and finally, after a total of 2 hours 15 minutes we got prior authorization to keep her on the medication she had been on for the past 9 years.

This was a year ago. Last week I received a request for the SAME medication switch for this patient and we had to go through the entire prior authorization process again for the same medication that we spent 2 hours on last year. Nothing has changed with the patient, yet I am required to provide them the same documentation and reasons for why I STILL don't feel it is in the best interest of my patient to change to a different medication.

Here is another example. I had a child who was diagnosed with Attention Deficit Disorder. There are different treatment options for this condition including stimulant

medications (forms of amphetamines such as Adderal, Concerta, Ritalin) and a non-stimulant medication, Strattera. The child had a family member in the household who was in recovery from substance abuse. I felt the safest medication to treat the child and avoid the risk of drug diversion was the Strattera. But the insurance company required step therapy for this medication. I was REQUIRED to prescribe a controlled substance, an amphetamine, before being allowed to prescribe the Strattera. I explained the circumstances of the family member with substance abuse but was still denied.

Senate Bill 129 seeks to speed up the turnaround time on prior authorization requests – the request might be for authorization of health care services, medications and/or needed medical devices. Through amendment, insurers continue to seek extensions of the timeframes stated in the bill. For example, they want to have one business day to make a decision on requested urgent care services. Well, people get sick and need health care 24 hours a day/ seven days a week/365 days a year – they don't decide to get sick only on "business" days.

Insurers want to have five business days to make decisions on non-urgent care services. Five business days is too long; 72 hours is much more appropriate. There is federal precedent to support that 72 hour timeframe as Medicare Part D has a 72 hour review determination limit for non-urgent matters and a 24 hour limit for expedited review of urgent and emergency situations. Medicaid fee-for-service has similar requirements.

Managed care companies argue that they don't want terms of prior authorization legislated. They will tell you they consider these matters to be a subject for contract negotiation, but in reality, physicians individually do not have much ability to negotiate terms that are favorable to their patients or to them. Physicians often feel powerless when advocating with payers on behalf of their patients.

The bottom line – this is about patients and a physician's ability to advocate for the care that a patient needs. What we have now is the insurance companies putting their bottom line before my medical judgement about want a patient needs. Every physician could write a book about the frustration and time wasted because of these prior authorization requirements – requirements that often put the patient at risk.

Let me take this a step further. More and more administrative hassles and the overwhelming burden of paperwork imposed on physicians and their practice teams not only takes physicians away from patient care but are resulting in physician burnout. According to a 2013 Medscape survey, more than 40% of U.S. physicians reported experiencing at least one symptom of burnout (loss of enthusiasm for work, feelings of cynicism, and a low sense of personal

accomplishment). A 2012 study in *JAMA Internal Medicine* found that more than one-third of physicians were burned out.

Primary care physicians chose their specialty in order to be on the front lines of delivering comprehensive, continuous, coordinated care to patients. Insurance requirements and interference into the practice of medicine have become so burdensome that physicians are burned out. A recent survey of our members indicated the severity of this problem – physicians are starting to hate what medicine has become because it is so far from why they chose to go into medicine in the first place. The joy they experienced when they actually had the time and energy to interact and care for patients is diminishing – and the burden of prior authorization requirements is one of the major contributing factors. We have to start addressing these administrative hassles in medicine or we are going to have a greater problem in achieving and maintaining a sufficient primary care workforce to provide care to an aging population.

The Ohio Academy of Family Physicians strongly supports passage of a strong version of Senate Bill 129 as a means to improve patient care in Ohio. For the good of patients, the playing field between insurance companies and physicians needs to be leveled. Please do not weaken this bill through the amendment process.

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