



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 24, 2016

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

Thank you for allowing me to testify before you 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. I provided written testimony last week but I am so passionate about this issue that when another hearing was scheduled where I could be present I wanted to take the opportunity to share a bit more information and be available to answer any questions you might have.

The Ohio Academy of Family Physicians is a statewide professional association with 4,900 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. And trust me – this is a complex health system for our patients to navigate.

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. However, these prior authorizations are seldom seen by medical personnel unless it proceeds to an appeal process. The authorizations are often handled by algorithms that do not take into consideration the very specific, individual needs and complexity of patients. They are simply determined by “has this patient ever been on “Drug X”, our formulary choice”. Even in the appeals process it is difficult, if not impossible, to speak with a pharmacist or medical director who might understand the complexity of my individual patient. This process can delay much needed treatment and in some cases result in inappropriate care for patients.

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.

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. This physician time spent on prior authorizations equates to about 8 patient care visits that I could have performed. The 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 81 year-old patient who previously had a stroke. She has high blood pressure and diabetes and is on many medications, five for blood pressure control. (I did not have her chart in front of me when writing the written testimony last week so please forgive the age correction from my previous testimony). It took me and a nephrologist multiple medication adjustments to find the combination of five medications that controlled her blood pressure (an important component of reducing recurrent stroke) and that she tolerated without side effects and that don’t interfere with the multiple other medications that she is on for other disease processes such as diabetes. 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. Several years ago 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 filled out the prior authorization. It was denied, appealed and then approved. That was four years ago. Each year since, I have had to go through the same process – providing the same information. And each time the authorization has been denied on initial request and I have had to appeal. Last year after spending 45

minutes on the phone, being transferred from department to department, the prior authorization was again 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 has been on for the past 9 years.

I have gone through this prior authorization process for this patient for the last 4 years in a row and I still have to wait 72 hours for them to review and decide. I had to make the request with documentation again last week. 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. My nurse, having the previous documentation in front of her from last year's battle, still spent 50 minutes on the phone and was told they would have an answer within 3 business days.

Often times the "three business days" is a delay that not only is not medically acceptable but can lead to greater health care costs. A patient presenting to the emergency room with a blood clot, (we call that a DVT or deep vein thrombosis), needs to be on blood thinning medication to prevent spread of the clot and to decrease the chance that a piece of that clot will break off and move to the lungs (Pulmonary Embolis), brain (causing a stroke) or the heart (causing a heart attack). The medication that is most commonly used long term for this is Coumadin, an oral medication that requires getting a therapeutic blood level to be effective. While waiting for the Coumadin to build up in the system and be effective another medication needs to be used. In the past this was typically heparin, and IV medication, that requires hospitalization to administer and monitor. However, several years ago a low molecular weight heparin, Lovenox, that can be given to the patient or by the patient themselves, as shots (similar to how a patient takes insulin) was developed. That medication can safely be used as the "bridge" until the Coumadin is therapeutic. However, many times the Lovenox requires prior authorization. While this is taking place the only option is for the patient to be admitted to the hospital incurring expensive hospital bills. Often times, by the time the Lovenox is authorized, the patient is now therapeutic on the Coumadin and no longer needs the Lovenox. In the meantime, however, they had to be hospitalized instead of in their own home and racked up expensive bills that increase the overall cost to the health care system.

One last 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. While there is a separate piece of legislation dealing with the specifics of step therapy, the prior authorization process and timeframe still apply and are part of the overall burden of the prior authorization process.

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. This is not acceptable. For example, they want to have one business day to make a decision on requested urgent care services and there is discussion of lengthening that timeframe. 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 and the extended wait could lead to a need for hospitalization.

Insurers want to have five to ten business days to make decisions on non-urgent care services. Five business days is too long; 72 hours is much more appropriate for non urgent requests, but keep in mind that the 72 hours applies for an appeal AFTER the medication may have already been denied the first time, resulting in up to 6 or more days from the time that the doctor initially started the process. 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 financial bottom line before my medical judgement about what 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.

The administrative hassles and the overwhelming burden of paperwork imposed on physicians and their practice teams, not only take physicians away from patient care, but are also resulting in physician burnout. Yet I continue to fill out these forms and make these phone calls because it is the right thing to do for my patient. 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 some physicians are leaving the practice of medicine. 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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