OHIO ACADEMY OF FAMILY PHYSICIANS

Proponent Testimony for Senate Bill 56
Presented by Sarah Sams, MD on behalf of the
Ohio Academy of Family Physicians
Senate Health, Human Services and Medicaid Committee
Tuesday, March 7, 2017

Chairman Burke, members of the Senate Health, Human Services and Medicaid Committee, thank you for allowing me to testify in support of SB 56, a proposal that seeks to minimize barriers to treatment by improving the step therapy process. Last session, I testified on behalf of myself and the Ohio Academy of Family Physicians in strong support of Senate Bill 243. I feel so strongly about the need for this legislation that I am here again to show my support. I thank you for giving me that opportunity.

My name is Dr. Sarah Sams. As medical director at Grant Family Medicine in Grove City and associate director of the Grant Family Medicine Residency Program, I am a past president of the Ohio Academy of Family Physicians and vice chair of their Public Policy Committee. I am also completing a term as chair of the Commission for Governmental Advocacy for the American 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 across Ohio. 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.

Step therapy is a tool insurers use to limit how much they spend covering patients' medications. Under step therapy, a patient must try one or more drugs chosen by their insurer – usually based on financial, not medical, considerations – before coverage is granted for the drug prescribed by the patient's physician. Patients may be required to try one or more alternative prescription drugs that are of lower cost to the insurer, but may not be the best therapy for some patients.

SB 56 seeks to improve the step therapy process by:

- Requiring that an insurer's process for requesting a step therapy override is transparent and available to the physician and patient.
- Allowing automatic exceptions to step therapy requirements when:
    - The required prescription drug is contraindicated or will likely cause an adverse reaction
    - The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen.
    - The patient has previously tried the required drug or a drug in the same pharmacologic class and the drug was ineffective or caused an adverse event
    - The required prescription drug is not in the best interest of the patient based on medical appropriateness
    - The patient is stable on a prescription drug for the medical condition under consideration.
- Ensuring that step therapy programs are based on clinical guidelines developed by independent experts.

Step therapy requirements vary from insurer to insurer and change frequently even within the same insurance company. These requirements result in physicians and other practice staff spending hours each week on the phone attempting to obtain permission to get appropriate, needed medications for patients. The American Academy of Family Physicians 2014 Practice Profile report indicates that family physicians spend 1.8 hours per week on prior authorization of insurance coverage, 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. 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 to seek to override the insurance company's step therapy requirement. After spending 45 minutes on the phone, being transferred from

department to department, my request 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 permission from the insurer to waive the step therapy requirement to keep her on the medication she had been on for the past 9 years.

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.

I could tell you countless stories of where my medical judgment and the safety of the patient have been disregarded due to step therapy and formulary decisions. Every physician could write a book about the frustration and time wasted because of these 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 take 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 choose 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 step therapy requirements is one of the 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 Senate Bill 56 as a means to improve patient care in Ohio. Thank you for allowing me to testify and for your consideration.

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