Testimony before the House Health Policy Committee
on Senate Bill 247
March 3, 2022

Good morning. Thank you Chair Kahle and members of the House Health Policy Committee for the opportunity to speak to you today. My name is Dr. Jessica Heselschwerdt. I am the vice-chair of the Michigan Academy of Family Physicians' Advocacy Committee.

This testimony is being submitted today on behalf of MAFP, the state's largest specialty physician organization, which represents more than 4,200 family medicine physicians, resident physicians, and medical students. We are here to testify in strong support of Senate Bill 247, which would bring consistency, transparency, and common-sense guardrails to the prior authorization process. This bill would not only help mitigate some of the unnecessary administrative burdens that are placed on family physicians and their staff every day, but more importantly reduce delays in patients receiving critical testing, treatment, and/or necessary prescriptions.

You have heard/will hear stories today about how delays in care due to the current cumbersome prior authorization resulted in negative health outcomes for patients. I have numerous examples myself where this happened. On October 21st, I saw a patient who was experiencing significant anxiety and depression, severe enough that it was interfering with her daily function. She had tried multiple medications before, and had significant side effects from the medications we most often use for depression and anxiety. Instead, I prescribed a newer medication, called Trintellix. Because it was new and therefore expensive, it required prior authorization. The authorization was denied, and the insurance company stated that my patient had to try a medication called Viibryd first before they would approve the Trintellix. After discussing with the patient and making some other changes to her medications due to potential interactions, I prescribed the Viibryd. That also required a prior authorization. It was then denied, because I was informed that in order to prescribe the Viirbryd, my patient needed to try Trintellix- the medication I wanted in the first place. After going back and forth with the insurance company multiple times, my patient was finally allowed to receive the Trintellix on February 1, over three months after I had initially

prescribed it. It's working well for her now, but she lost three valuable months to mental illness because of these delays.

Second- I had a patient who had an MRI of her shoulder for an injury she had sustained. On the MRI, it was incidentally noted that she had a lung nodule. The radiologist was unable to determine from the shoulder imaging whether that nodule was benign or cancerous and recommended a dedicated lung scan to further investigate the nodule. Her insurance company has denied this request even after multiple appeals. They don't feel she meets criteria for imaging even though here is a chance it could be cancer. This issue still has not been resolved, weeks later. If this patient does turn out to have cancer, the delay in diagnosis resulting from the lack of insurance approval could result in a lower chance of cure.

I want to address aspects of the current prior authorization process. While prior authorization is necessary in some contexts, the increasing utilization of it over the years has led to negative consequences which place additional requirements with no additional reimbursement on physicians and the medical practice businesses that employ them. Because family physicians provide a broad range of healthcare services in the framework of their longitudinal relationships and direct interactions with patients, many of these prior authorization regulations are particularly onerous for them. Prior authorization changes outlined in this legislation will provide consistency across those insurance plans that fall within the scope of the measure and help alleviate some of the variability that exists across different plans. This change would free up more time for physicians to do what they do best, and what is needed of them – care for patients.

In Michigan, we are already experiencing a physician workforce shortage. The Robert Graham Center, which is a non-profit that compiles data on family medicine and primary care, projects Michigan will need an additional 862 primary care physicians by 2030. This represents a 12 percent increase over our current primary care workforce. Physician burnout has been a consistent problem that has led to early retirement, or leaving primary care, and the COVID-19 pandemic has exacerbated the problem. According to a recent Journal of the American Medical Association report, nearly 50 percent of the physician workforce indicated they are considering early retirement.

In light of these ongoing challenges, we must aggressively pursue commonsense reforms that help streamline administrative processes so that physicians spend less time doing paperwork and more time with patients and reduce barriers in access to the care patients need. This bill will help to do just that. It represents changes we can make now where all parties can find common ground. I request that you thoughtfully consider our testimony in support of this bill and pass it expeditiously.

Thank you for the opportunity to testify today. I am happy to answer any questions you have.