

**Approve Senate Bill 304**  
**Kansas State Senate testimony – 2/15/18**

My name is Tally Bell and for nearly 20 years of my 43-year nursing career, I have worked as a certified acute care nurse practitioner for Neurology Consultants of Kansas in Wichita – working directly with people with chronic neurological conditions, often conditions with no known cure, to develop individualized treatment plans that best fit their medical needs. I am here today at the request of the National Multiple Sclerosis Society as MS is the 2<sup>nd</sup> most frequent diagnosis in our 11-provider practice. We are the largest independent neurology practice in the state of Kansas, treating patients from all over Kansas, including patients from each of this Committee's cities and counties.

In every case, the physicians and nurse practitioners in our practice weigh a multitude of factors as we explore options for best treatment. What are the potential side effects of a medication and could it complicate the underlying neurological condition and other co-existing medical conditions? What treatment is the patient ultimately going to be able to be compliant with – can they manage the number of doses daily, do they have the physical and emotional strength to self-administer an injectable therapy? What underlying medical, financial, social, and psychological issues does the patient have that might be negatively impacted by a treatment choice? The treatment identification process is in-depth and requires years of ongoing education and healthcare experience to determine the best options. Our patient conversations are often hours in length and over multiple encounters to determine the best option and to achieve patient buy-in with what may be lifelong treatment, as no treatment can be effective without the patient accepting personal accountability for it. In no case is it ever “one medication fits all.”

Unfortunately, our treatment considerations often come to a screeching halt when this question is on the table — *will my patient's insurance cover this treatment?*

Through insurance companies' medication override process called “step therapy”, they can supersede our best treatment decision by forcing us to require patients fail often up to 2 other medications before they will consider allowing the patient the medication we have recommended. Their medication choices are ones that are financially more favorable for them, not ones that are “better” or more appropriate for the patient. I have no incentive to prescribe any drug, other than to follow the basic tenet of “first, do no harm” to determine to the best of my ability what is in the patient's best treatment interest. Prescribing the most appropriate treatment for a patient is not as simple as writing the prescription.

Step therapy can undermine the recommended treatment plan and interfere with the healthcare provider – patient relationship. We are forced to “defend” a treatment that was not recommended initially to a patient or in some cases, sadly, to switch them from a medication that is working well to one that might not provide the same benefit.

It is not unusual to spend weeks to months trying to get a patient on therapy because of step therapy. The only one who wins is the insurance company as they have now delayed having to pay for any medication while we are trying to appeal our medical decision on the patient's behalf. Delays in treatment might save insurance dollars in the medication bucket, but these delays can shift healthcare costs to increased physician office visits, hospitalizations, potential disability that we cannot treat, as well as decreasing the patient's productivity in society. Insurance companies have previously argued to this Committee that step therapy is necessary to provide lower-cost medications. Again, lower cost medications do not necessarily equate to lower cost healthcare when costs are shifted to other medical problems potentially created by this lower cost medication. The potential downstream healthcare costs of delayed treatment and step therapy are very real.

Financially, the costs to individual medical practices to work with patients' insurance companies are onerous and increase every year. Our costs are not reimbursed in any way, yet we must continue to increase our staff and physician non-patient time in an attempt to help the patient with their insurance's mandates. It is clear why some medical practices are saying "no" to treating conditions such as MS due to the unfavorable financial impact on their practice. Imagine you are the one diagnosed with a chronic neurological condition that can cause damage to every body system, walking, talking, thinking, feeling, seeing, toileting for your remaining years and no physician will treat you because he/she can't afford the battle as your advocate with your insurance company.

Insurance companies have also previously argued to this committee that step therapy is necessary to provide safe, high-quality medications. This is simply not true. Any medication we are requesting has FDA (Food and Drug Administration) approval for the medical condition and is backed by years, even decades, of research demonstrating safety and efficacy. Do not allow yourself to be swayed by this inaccurate argument.

Thankfully, action is being taken to help protect patients in Kansas through the introduction of Senate Bill 304. This bill puts in place stronger protections and guidelines to eliminate cost as a leading factor in implementing step therapy and defends patients who have found stability on a drug from a current or past health plan. The bill also provides greater protections for any drugs recommended due to medical necessity, allowing prescribers to make more appropriate treatment decisions.

I strongly urge the Kansas state legislators to vote for Senate Bill 304. Insurance companies should not be permitted to be the medical decision-maker through step therapy. Put medical decision-making back in physicians', nurse practitioners', and physician assistants' hands, where it belongs.

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