

PATIENT ACCESS/UTILIZATION MANAGEMENT
H.R. 3107, Improving Seniors' Timely Access to Care Act
H.R. 2279 / S. 2546, Safe Step Act

REQUEST

The Alliance of Specialty Medicine urges representatives to **cosponsor and advance the bipartisan *Improving Seniors' Timely Access to Care Act (H.R. 3107)* and the bipartisan *Safe Step Act (H.R. 2279/S. 2546)*** before the end of the 116th Congress. H.R. 3107 was introduced by Representatives Suzan DelBene (D-WA), Mike Kelly (R-PA), Roger Marshall, MD (R-KS), and Ami Bera, MD (D-CA). H.R. 2279 was introduced in the House by Representatives Raul Ruiz, MD (D-CA) and Brad Wenstrup, DPM (R-OH). S. 2546 was introduced in the Senate by Senators Lisa Murkowski (R-AK) and Doug Jones (D-AL).

BILL SUMMARIES

To increase transparency and accountability and to reduce the burdens of prior authorization, the ***Improving Seniors' Timely Access to Care Act*** would streamline prior authorization in the Medicare Advantage (MA) program by:

- Establishing an electronic prior authorization process;
- Minimizing the use of prior authorization for services that are routinely approved;
- Prohibiting additional prior authorization for medically-necessary services performed during a surgical or invasive procedure that already received, or did not initially require prior authorization;
- Requiring plans to report on the extent of their use of prior authorization and the rate of delays and denials;
- Ensuring prior authorization requests are reviewed by qualified medical personnel; and
- Ensuring that plans adhere to evidence-based medicine guidelines.

The ***Safe Step Act (H.R. 2279)*** amends the Employee Retirement Income Security Act of 1974 (ERISA) to require a group health plan to establish an exception process to medication step-therapy protocol when the treatment is contraindicated, expected to be ineffective, likely to cause an adverse reaction, expected to decrease the individual's ability to perform daily activities or occupational responsibilities, or if the individual is stable based on the prescription drugs already selected. H.R. 2279 would require that requests be granted in a timely manner, within three days after receipt of the request or 24 hours where the life, health, and ability of the individual are jeopardized by the protocol.

BACKGROUND

Prior authorization is a cumbersome process that requires physicians to obtain pre-approval for medical treatments or tests before rendering care to their patients. The process for obtaining approval is lengthy and typically requires physicians or their staff to spend the equivalent of two or more days each week negotiating with insurance companies — time that would better be spent taking care of patients. Patients experience significant barriers to medically necessary care due to prior authorization requirements for items and services that are eventually routinely approved. Recent surveys of specialty physicians have found that:

- Nearly 90% have delayed or avoided prescribing a treatment due to the prior authorization process;
- 95% report that this increased administrative burden has influenced their ability to practice medicine;
- 82% state that prior authorization either always (37%) or often (45%) delays access to necessary care;
- Prior authorization causes patients to abandon treatment altogether with 32% reporting that patients often abandon treatment and 50% reporting that patients sometimes abandon treatment;

- Nearly two-thirds report having staff who work exclusively on prior authorizations, with one-half estimating that staff spend 10-20 hours/week dedicated to fulfilling prior authorization requests and another 13% spending 21-40 hours/week; and
- Ultimately, the majority of services are approved (71%), with one-third of physicians getting approved 90% or more of the time.

A medication **step-therapy protocol** establishes a specific sequence in which prescription drugs are covered by a group health plan or a health insurance issuer. Step-therapy protocols may require patients to try and fail an insurer-preferred medication before being covered by the physician-prescribed medication. Many insurers have instituted this practice to help control the costs of expensive medications. However, while this practice may initially reduce insurer costs, it can have devastating health consequences for patients and ultimately lead to more expensive health care costs in the long run. Patients who are denied first coverage of medications recommended by their physicians can end up with poor health outcomes due to adverse health events which can lead to costly hospitalizations. In the era of personalized medicine, patients with chronic diseases such as inflammatory bowel disease, rheumatoid arthritis, cancer, psoriasis, or age-related macular degeneration may respond differently to various medications used to treat these diseases. In 2017, the Alliance conducted a survey of specialists, finding:

- More than 85% have experienced an occasion during which a stable patient was asked to switch from his or her medication by the insurer even though there was no medical reason to do so.
- 70% reported that their patients were unable to follow recommended treatment plans due to out-of-pocket costs.
- Nearly 95% report needing to change a prescription to a different medication due to delay tactics from insurers related to the original prescription.
- More than half reported that it took longer than 3 days to get a patient the proper medication.

CONTACT

To cosponsor the ***Improving Seniors' Timely Access to Care Act (H.R. 3107)***, please contact Kyle.Hill@mail.house.gov (Rep. Suzan DelBene) or Kevin.Dawson@mail.house.gov (Rep. Mike Kelly).

To cosponsor the ***Safe Step Act (H.R. 2279)***, please contact Erin.Doty@mail.house.gov (Rep. Ruiz) or Greg.Brooks@mail.house.gov (Rep. Wenstrup).

To cosponsor the ***Safe Step Act (S. 2546)***, please contact Anna_Dietderich@murkowski.senate.gov (Sen. Murkowski) or Katie_Campbell@jones.senate.gov (Sen. Jones).