Alliance of Specialty Medicine

Sound Policy. Quality Care.

PRIOR AUTHORIZATION & STEP THERAPY REFORMS

H.R. 3514/S. 1816, *Improving Seniors' Timely Access to Care Act (Seniors' Act)*

H.R. 5509/S. 2903, Safe Step Act

REQUESTS

The Alliance of Specialty Medicine (Alliance) urges members of Congress to **cosponsor and advance** bipartisan reform utilization management practices to improve patient access to care, including:

- ***Improving Seniors' Timely Access to Care Act* (Seniors' Act) (H.R. 3514/S. 1816)** introduced in the House of Representatives by Reps. Mike Kelly (R-PA), Suzan DelBene (D-WA), John Joyce, MD (R-PA), and Ami Bera, MD (D-CA), and in the Senate by Sens. Roger Marshall, MD (R-KS) and Mark Warner (D-VA).
- ***Safe Step Act* (H.R. 5509/S. 2903)** introduced in the House by Reps. Rick Allen (R-GA) and Lucy McBath (D-GA), and in the Senate by Sens. Lisa Murkowski (R-AK) and Maggie Hassan (D-NH).

BILL SUMMARIES

The ***Seniors' Act* (H.R.3514/S.1816)** builds upon the *Centers for Medicare and Medicaid Services (CMS) Interoperability and Prior Authorization* final rule[1] to streamline and modernize the prior authorization (PA) process in the Medicare Advantage (MA) program. On June 25, the House Energy and Commerce Subcommittee on Health favorably reported the bill to the full committee. The legislation has the support of more than 300 organizations.[2] More than two-thirds of the House and Senate are cosponsors. The legislation received a preliminary "no cost" score from the Congressional Budget Office. The legislation:

- **Establishes electronic-PA (e-PA) for MA plans** including standardization of transactions and clinical attachments.
- **Increases transparency** around MA prior authorization requirements and their use.
- **Clarifies CMS authority** to establish timeframes for e-PA requests including expedited determinations, real-time decisions for routinely approved items and services, and any other PA request.
- **Expands beneficiary protections** to improve enrollee experiences and outcomes.
- **Requires reporting to Congress** on program integrity efforts and ways to further improve the e-PA process.

The ***Safe Step Act* (H.R. 5509/S. 2903)** provides a clear and timely appeals process when a patient is subjected to step therapy. During the 118th Congress, the legislation was advanced by the Senate Committee on Health, Education, Labor, and Pensions (HELP) as part of the *Pharmacy Benefit Manager Reform Act*. The legislation:

- **Establishes a clear exemption process**: Requires insurers to implement a clear and transparent process for physicians or patients to request an exception to a step therapy protocol.
- **Outlines exceptions to fail first protocols**. Requires insurers to grant an exception if an appeal clearly demonstrates any of the following:
  - Patient has already tried and failed on the required drug.
  - Insurer-preferred treatment will cause irreversible consequences.
  - Required treatment is contraindicated and will/is likely to cause an adverse reaction.
  - Required treatment will/is expected to prevent a patient from working or fulfilling activities of daily living.
  - Patient is stable on their current medication.
- **Requires timely response:** An insurer is required to respond to an exemption request within 72 hours under normal circumstances, and within 24 hours if life threatening.

[1] https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-prior-authorization-final-rule-cms-0057-f

[2] https://docs.google.com/document/d/19OqthcWUvWTjWqefB6WaRHIK-KlqDpad_NjRc5kwnl0/edit?usp=sharing

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 this 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 are now experiencing significant barriers to medically necessary care due to prior authorization requirements for items and services that are eventually routinely approved.

Specialty physicians and their patients are often subject to prior authorizations and other utilization management tactics in the MA program. Generally, utilization management processes delay enrollee access to medically necessary care and treatments and create considerable, unnecessary administrative burdens for specialty physicians. Equally concerning, these tactics are a leading cause of physician burnout, forcing many to retire early or leave the practice of medicine. While utilization management processes, such as prior authorization, may be appropriate in some situations, the HHS Office of Inspector General has found that MA plans use prior authorizations to deny medically necessary care that meets coverage requirements under traditional Medicare and is supported by the enrollee's medical records.[3]

Step-therapy protocols establish 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.

ALLIANCE SURVEY & KEY FINDINGS

In the fall of 2022, the Alliance conducted a survey of over 800 specialty physicians on the topic of utilization management. The findings underscore the burden of utilization management protocols on the practice of medicine, both in terms of the negative impact on patient care and the increased administrative onus on medical practices.[4] Respondents overwhelmingly indicated that the use of prior authorization has increased across all categories of services and treatments:

- Over 93% of respondents answered that prior authorization has increased for procedures;
- More than 83% answered that prior authorization has increased for diagnostic tools, such as labs and even basic imaging; and
- Two-thirds (66%) responded that prior authorization has increased for prescription drugs, with physicians noting that even many generic medications now require pre-approvals.

Given these significant problems, the Alliance supports opportunities to meaningfully improve utilization management practices, such as prior authorization, to reduce administrative burdens and ensure safe, timely and affordable access to care for patients.

CONTACTS

Seniors' Act

To cosponsor **H.R. 3514**, please contact:
JP.Moreland@mail.house.gov (Rep. Kelly)
Julia.Grabo@mail.house.gov (Rep. DelBene)

To cosponsor **S. 1816**, please contact:
Max_Seltzer@marshall.senate.gov (Sen. Marshall)
Colleen_Nguyen@warner.senate.gov (Sen. Warner)

Safe Step Act

To cosponsor **H.R. 5509**, please contact:
Tre.Lind@mail.house.gov (Rep. Allen)
Suny.Chen@mail.house.gov (Rep. McBath)

To cosponsor **S. 2903**, please contact:
Cassidy_Hobbs@murkowski.senate.gov (Sen. Murkowski)
Jasmine_Masand@hassan.senate.gov (Sen. Hassan)

[3] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp
[4] https://specialtydocs.org/wp-content/uploads/2022/12/ASM-2022-Survey-Summary-Findings-.pdf

Alliance of Specialty Medicine

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STABILIZE MEDICARE PHYSICIAN PAYMENT
H.R. 6160, *Strengthening Medicare for Patients and Providers Act*
H.R. 8163, *Provider Reimbursement Stability Act*

REQUESTS

The Alliance of Specialty Medicine (Alliance) recognizes that Congress provided a 2.5% increase to the Medicare conversion factor in 2026 but calls on Congress to embrace long term reforms to **prevent recurring annual Medicare cuts** and **enact permanent solutions to stabilize Medicare physician payments and improve Medicare physician quality programs.** The Alliance urges members of the House of Representatives to **cosponsor and advance the bipartisan *Strengthening Medicare for Patients and Providers Act* (H.R. 6160)** and ***Provider Reimbursement Stability Act* (H.R. 8163)** and urges Senators to introduce companion legislation.

Additionally, the Alliance urges Congress to **reform the Medicare physician payment system and Quality Payment Program (QPP) that were revised and established under the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA)**. Earlier this year, the Alliance submitted substantive comments to the U.S. House Republican and Democratic Doctors Caucuses on Modernizing MACRA[1] and to the House Energy and Commerce Committee as part of their May 20, 2026 hearing to examine opportunities for Medicare physician payment reform.[2]

BILL SUMMARIES

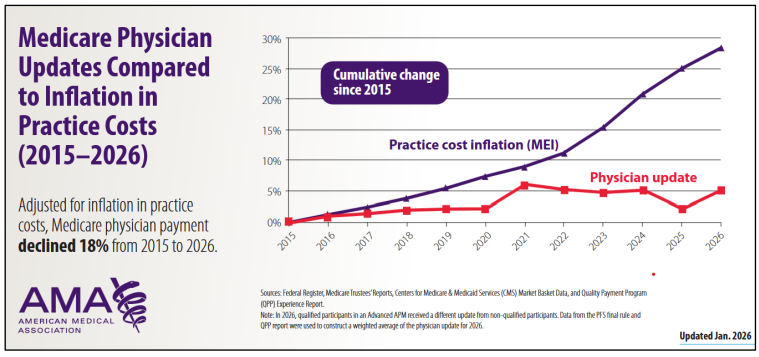
The ***Strengthening Medicare for Patients and Providers Act* (H.R. 6160**) replaces the separate conversion factors for qualifying APM participants and other physicians with a single conversion factor and provides for an update that is equal to the annual percentage increase in the Medicare Economic Index (MEI).

The ***Provider Reimbursement Stability Act* (H.R. 8163)** seeks to modernize and update the budget neutrality mechanism of the Medicare Physician Fee Schedule (MPFS) to improve stability for physician reimbursement and patient access by:

- **Increasing the payment threshold** to present day values and indexing it to inflation.
- **Improving transparency and accountability** by requiring the Centers for Medicare and Medicaid Services (CMS) to compare policy change cost estimates with actual utilization data and provide correction adjustments.
- **Providing payment predictability** by preventing CMS from making changes to the MPFS that would result in year-to-year changes greater than 2.5%.
- **Promoting payment accuracy** by requiring CMS to incorporate more frequent and accurate cost inputs when determining the value of services.

BACKGROUND

Lack of Inflationary Update – As shown in the chart to the right, physician practice costs were on the rise prior to the enactment of the *Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).* The price of medical supplies, equipment, and clinical and administrative labor was at substantial levels, as demonstrated by Medicare Economic Index (MEI).[3] MACRA established physician payment updates



[1] https://specialtydocs.org/wp-content/uploads/2026/01/Alliance-of-Specialty-Medicine-MACRA-Modernization-response-to-House-Doctors-Caucuses-01.16.2026.pdf

[2] https://specialtydocs.org/wp-content/uploads/2026/05/Alliance-of-Specialty-Medicine-Letter-to-House-EC-for-MACRA-Hearing-Record-05.20.2026.pdf

[3] https://fixmedicarenow.org/sites/default/files/2025-06/25-1349100 Medicare-inflation-phy-cost %281%29.pdf

without a yearly automatic inflation adjustment, which is what other Medicare providers receive through their annual payment updates based on an inflation proxy, such as the Consumer Price Index (CPI). Given the lack of an automatic payment update, Medicare physician payments declined 18% from 2015 to 2026 when adjusted for inflation in practice costs.[4] While Congress anticipated that physicians would receive value-based incentives and differential payment updates through their participation in the QPP – either through the Merit-based Incentive Payment System (MIPS) or the Advanced Alternative Payment Model (APM) tracks – many factors have led to insufficient payment updates, particularly when compared to the effort and resources physicians must devote to participate.

The Medicare Trustees[5] and other policy experts have raised concerns about the lack of an inflation measure in the Medicare Physician Fee Schedule (MPFS). In its June 2025 report[6], the Medicare Payment Advisory Commission (MedPAC) recommended replacing current-law MPFS updates "with an annual update based on a portion of the growth in inflation, as measured by the MEI," and for CMS to use timely cost data to refine relative value units (RVUs). While these steps are positive, a full-MEI update is essential to stabilize the Medicare payment system over the long term.

***Budget Neutrality* –** Beyond the challenges in physician payment created under MACRA, the MPFS is plagued by other challenges, including requirements to maintain budget neutrality and irregularly timed updates to practice expense data used to set payments. In fact, physicians spent many years "paying down" the significant budget neutrality adjustment prompted by CMS' 2021 and 2023 implementation of increased relative values for office and outpatient evaluation and management (E/M) services and inpatient and other E/M services, respectively. For 2024, CMS commenced paying for a new E/M add-on payment that Congress previously prohibited CMS from implementing, prompting yet another substantial budget neutrality adjustment and concomitant reduction to the MPFS conversion factor (CF). Similarly, CMS' 2022 implementation of revised clinical labor prices – the first comprehensive update in nearly two decades – resulted in budget-neutrality payment reductions for many procedures within the practice expense pool. We appreciate congressional efforts to reduce CF cuts temporarily; however, Congress has still allowed year after year of cuts to the MPFS CF, and this pattern is unsustainable. The 2026 MPFS CF equals $33.40[7]. In 2016, it was almost $36.00. The *Provider Reimbursement Stability Act* (H.R.8163) seeks to reform budget neutrality calculations, which is one of various factors plaguing the MPFS.

***Barriers to Participating in Value-based Care Programs* –** Many specialty physicians also face major barriers under MACRA's QPP, including MIPS and Advanced APMs. Both tracks of the QPP have been implemented in a manner that limits meaningful participation among many specialists. For example, MIPS remains overly complex, and program rules change from year to year. It also relies on siloed assessments of quality and cost rather than a more comprehensive approach to value and disincentivizes investments in the development and use of more meaningful specialty-specific quality measures and clinical data registries. At the same time, APMs remain largely focused on primary care. Even when specialists participate in more focused, episode-based models, high APM participation thresholds under the QPP make this track inaccessible to many specialists. As a result, many specialists have struggled to shift to value-based payment models and to qualify for the QPP's 5% APM incentive payment, which expired after the 2024 payment year. Therefore, the Alliance urges Congress to work with CMS to ensure that the QPP offers specialists more clinically relevant participation pathways; and restore and extend the full 5% APM incentive payment and maintain or lower the QPP's APM thresholds to incentivize specialty physician movement into APMs, including more relevant models that have not yet materialized.

CONTACTS

Strengthening Medicare for Patients & Providers Act
To cosponsor H.R. 6160, please contact:
Jamie.Truax@mail.house.gov (Rep. Ruiz)
Huntley.Campbell@mail.house.gov (Rep. Bilirakis)

Provider Reimbursement Stability Act
To cosponsor H.R. 8163, please contact:
Marisa.Burleson@mail.house.gov (Rep. Murphy)
Julia.Brunner@mail.house.gov (Rep. Schneider)

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[4] https://www.ama-assn.org/system/files/medicare-updates-inflation-2015-2026-chart.pdf
[5] https://www.cms.gov/oact/tr/2024
[6] https://www.medpac.gov/document/june-2025-report-to-the-congress-medicare-and-the-health-care-delivery-system/
[7] As established under MACRA, CMS sets two conversion factors for 2026: one for clinicians who are not Qualifying Participants (QPs) in Advanced APMs (shown above), and a separate, higher conversion factor for QPs.

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REPRESENTING MORE THAN 100,000 SPECIALTY PHYSICIANS

American Academy of Facial Plastic & Reconstructive Surgery

American Academy of Otolaryngology–Head and Neck Surgery

American Association of Neurological Surgeons

American College of Mohs Surgery

American Gastroenterological Association

American Society for Dermatologic Surgery Association (ASDSA)

American Society of Cataract and Refractive Surgery

American Society of Echocardiography

American Society of Plastic Surgeons

American Society of Retina Specialists

American Urological Association

Coalition of State Rheumatology Organizations

Congress of Neurological Surgeons

National Association of Spine Specialists

The Society of Interventional Radiology (SIR)

www.specialtydocs.org info@specialtydocs.org