Alliance of Specialty Medicine

Sound Policy. Quality Care.

March 15, 2024

The Honorable Virginia Foxx
Chair
Committee on Education and the Workforce
2176 Rayburn House Office Building
Washington, DC 20515

The Honorable Bobby Scott
Ranking Member
Committee on Education and the Workforce
2101 Rayburn House Office Building
Washington, DC 20515

Submitted electronically to EdandWorkforceRFI@mail.house.gov

RE: Reforms to Increase Affordability and Quality in Employer-Sponsored Health Coverage

Dear Chairwoman Foxx, Ranking Member Scott, and members of the House Committee on Education and Workforce:

The Alliance of Specialty Medicine (Alliance) represents more than 100,000 specialty physicians and surgeons across 16 specialty and subspecialty societies. The Alliance is deeply committed to fostering patient access to the highest quality specialty care by advancing sound health care policy. As patient and physician advocates, the undersigned organizations appreciate the opportunity to respond to the House Education and Workforce Committee's Request for Information on ways to build upon and strengthen the *Employee Retirement Income Security Act* (ERISA).

The Alliance makes several recommendations below on ways to strengthen and clarify ERISA preemption so that our members can focus on providing high quality patient care rather than utilization management requirements.

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 processes for obtaining these approvals are lengthy and administratively burdensome, requiring physicians and 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. Given the complex health conditions managed by specialty physicians, their patients are subject to prior authorization and other utilization management tactics more frequently, which delays access to medically necessary care and treatments. These tactics are a leading cause of physician burnout, forcing many to retire early or leave the practice of medicine. Even more frustrating, prior authorization requirements for medically necessary items and services are eventually routinely approved, which indicates that these processes are merely a delay tactic by the insurers.

In the fall of 2022, the Alliance of Specialty Medicine surveyed 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. Respondents overwhelmingly indicated that the use of prior authorization has increased in the last five years 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.

The Alliance supports efforts to reduce administrative burdens and ensure safe, timely, and affordable access to care for patients. In the 117th Congress, we endorsed the *Improving Seniors' Timely Access to Care Act* (H.R. 3173/S. 3018), which unanimously passed the House of Representatives and garnered 380 bipartisan co-sponsors. As you may know, the legislation would streamline prior authorization in the Medicare Advantage 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.

We urge you to enact similar reforms for ERISA-governed health coverage to rein in the overreaches of employer-sponsored health plans that delay and deny care through utilization management tools and ultimately increase costs to the health care system. Such reforms would go a long way to ensuring that patients get the care they need when they need it.

The Alliance also supports the *Safe Step Act* (H.R. 2630), which seeks to amend ERISA to reduce barriers to care and improve patient outcomes. A medication step-therapy protocol establishes a specific sequence in which a group health plan or a health insurance issuer covers prescription drugs. 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 costs by limiting the use or dosage 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, leading 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. Health care costs increase when patients are forced to fail first on a treatment and experience adverse events that can lead to hospitalization or other interventions.

As you may know, the Senate Health, Education, Labor, and Pensions (HELP) Committee included the *Safe Step Act* as an amendment to the *Pharmacy Benefit Manager Reform Act* (S. 1339) as reported out of

committee. The legislation will help patients and physicians by requiring insurers to implement a clear and fair appeals process that is easily accessible on the plan's website and allows step therapy to be bypassed in medically necessary circumstances, such as when a patient is already stable on a therapy. The bill would also establish a time frame in which insurers must respond to appeals to ensure that patients can receive appropriate treatment in a timely manner.

Thank you for considering our feedback as you develop legislation to increase affordability and quality in employer-sponsored health coverage. Please contact us at info@specialtydocs.org if you have any questions or would like to discuss these issues in greater detail.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American College of Osteopathic Surgeons
American Gastroenterological Association
American Society for Dermatologic Surgery Association
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
North American Spine Society
Society of Interventional Radiology