The National Organization of Rheumatology Management (NORM) is a nonprofit organization that promotes education, expertise, and advocacy for rheumatology managers and their practices. We are focused on supporting our patients and pursuing excellence in medical practice management.

Utilization Management

Because most rheumatology medications are expensive biologics, NORM members help patients navigate some of the most burdensome utilization management requirements in the entire healthcare system. A recent study on prior authorizations for infusible medications prescribed for rheumatologic conditions found that 71% of patients had to seek prior authorization for their prescribed medications. Almost all of the prior authorizations, including the ones initially denied, were ultimately approved. Such a high eventual approval rate indicates that prior authorization serves as a delay tactic above all else, which is unacceptable for a progressive and irreversible disease such as rheumatoid arthritis. Additionally, this issue affects even the most vulnerable beneficiaries: a review by the Office of the Inspector General (OIG) found such alarming rates of prior authorization in Medicaid managed care that the OIG raised concerns about access to care for the beneficiaries covered by those plans. The problem with utilization management is not limited to prior authorization. In the case of step therapy, patients are often required to "step through" medications they have already tried in the past to no effect. Many patients simply give up as a result of confusing, frustrating, and opaque utilization management protocols.

NORM supports legislation that would improve the current utilization management landscape for patients in federally regulated plans:

- The bipartisan ***Safe Step Act*** **(S.652/H.R.2630)** would apply to employer-sponsored plans. The legislation would codify five commonsense exceptions to step therapy, including an exception for patients switching plans who are already stable on a different medication or for situations in which the step therapy protocol would require the patient to try a treatment that is contraindicated or expected to be ineffective. The legislation also requires plans to establish a clear and transparent exceptions process, with a timeline for appeals.
- The bipartisan ***Improving Seniors Timely Access to Care Act*** would modernize prior authorization processes in Medicare Advantage (MA). More specifically, it would require that MA plans establish electronic prior authorization processes meeting standards set by the Department of Health and Human Services, establish transparency requirements related to the use of prior authorization in MA, and establish patient protection standards related to prior authorization.

Drug Affordability

Increasingly, patients who need expensive specialty medications are subject to so-called "copay accumulators," which means the insurance company or its pharmacy benefit manager will allow the

use of copay assistance to reduce coinsurance, but will not count the value of that copay assistance towards the patient's deductible or out -of-pocket cost. When copay assistance runs out for the year, the patient suddenly discovers that they still owe almost their entire deductible. Given the prevalence of high-deductible plans and the out-of-pocket costs of specialty medications, that can leave patients responsible for thousands of dollars for a single prescription. Practically speaking, this means that patients no longer have access to the medication they need, since only very few patients can afford such surprise costs.

In the *2021 Notice of Benefit and Payment Parameters (NBPP)*, CMS finalized a policy that allowed insurers to use accumulators in the Affordable Care Act exchange markets. Last year, a federal court struck down that regulation and the Administration has stated that it will not appeal that ruling. Now is the time to codify a prohibition on the use of these harmful programs.

NORM supports legislation to prohibit the use of copay accumulators in federally regulated plans. The bipartisan *Help Ensure Lower Patient (HELP) Copays Act* (H.R.830/S.1375) would prohibit the use of copay accumulators in the Affordable Care Act exchanges.

Reimbursement Stability

Independent medical practices are under incredible financial pressure, which has contributed to consolidation trends and created access challenges for patients. Increasingly, Medicare is no longer viewed as a stable payer, because its Physician Fee Schedule continues to result in compounding reimbursement cuts. According to the American Medical Association, inflation-adjusted reimbursement for physicians from Medicare declined by 26% from 2001 to 2023. A major driver of the downward trend is the fact that, unlike all other major Medicare payment systems, the Fee Schedule lacks a mechanism to reflect inflationary cost increases into its reimbursement rates. Thus, there is a widening gap between the cost of the care delivered to Medicare beneficiaries and the program's reimbursement for that care.

In addition to declining reimbursement rates, practices are subject to "death by a thousand cuts." For example, a poll by the Medical Group Management Association (MGMA) found that 60% of responding practices were being charged fees to receive electronic payment by insurers. Approximately a third of respondents (32%) carried fees as high as 3% on every electronic reimbursement. This is akin to charging employees for receiving their paycheck via direct deposit. Often, the process for opting out of electronic payment is cumbersome and unclear. Additionally, many practices are not comfortable being left dependent on paper check reimbursement. There must be an option for medical practices to be electronically paid for the services they provide to patients without being charged for their own reimbursement.

To help alleviate the financial pressure on medical practices, NORM supports the following legislation:

- The bipartisan ***Strengthening Medicare for Patients and Providers Act*** **(H.R.2474)** would provide an annual Fee Schedule update based on the Medicare Economic Index (MEI).
- The bipartisan ***No Fees for EFTs Act*** **(H.R.6487/S.3805)** would prohibit health plans and entities acting on their behalf from imposing fees on healthcare providers for electronic funds transfers and healthcare payment and remittance advice.