HOUSE HEALTH CARE COMMITTEE

H.766: STEP THERAPY & PRIOR AUTHORIZATION

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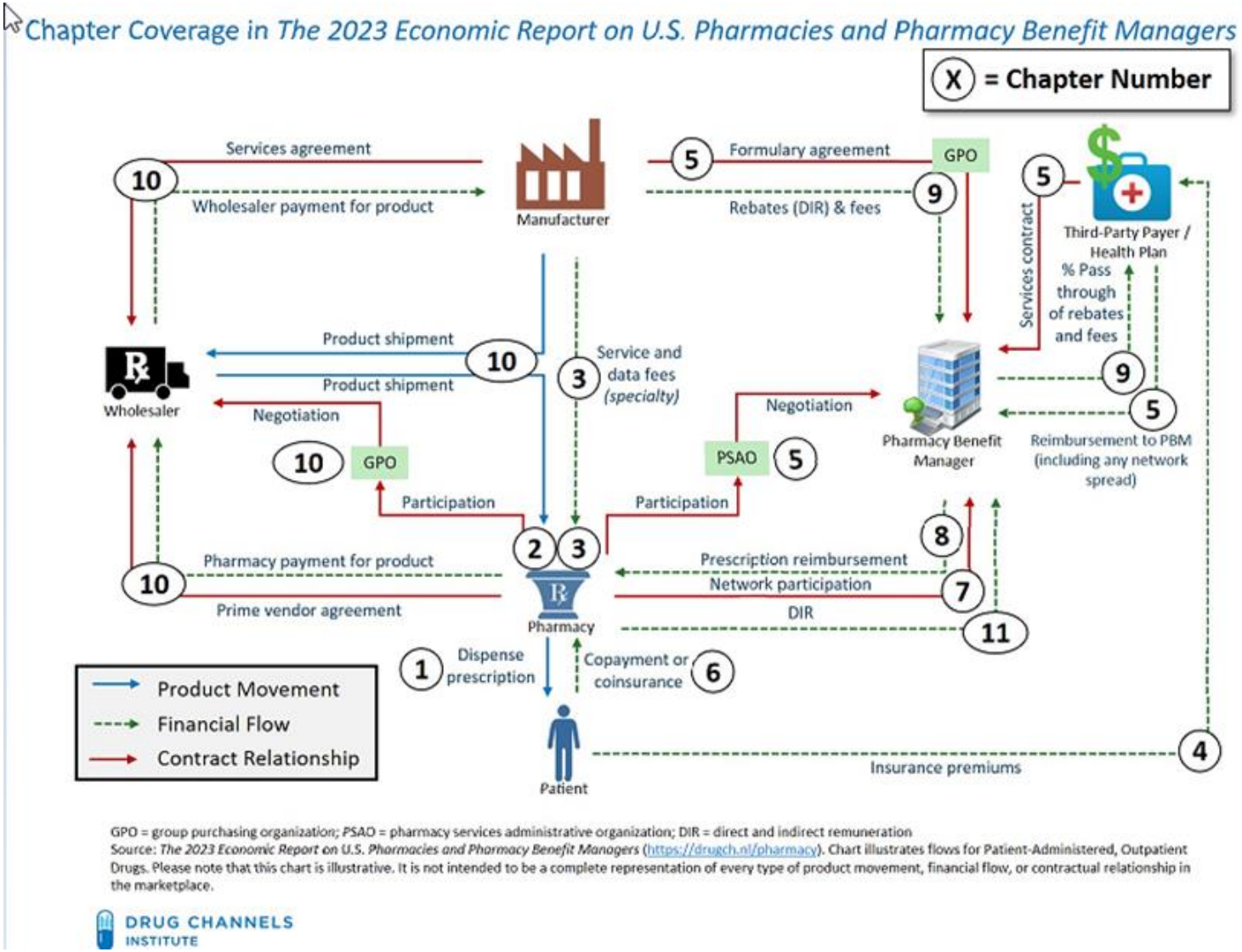
2023 VS. 2022 DRUG COSTS AND TRENDS

- Increase in total drug costs were 24.9%
- Utilization increased by 8.6%
- Traditional (non-specialty) drug costs up by 18.5%
- **Specialty spending is 55% of all drug costs, but only 1.7% of prescriptions**

Pharmacy Costs	2022	2023	% Change
Total Drug Cost	$ 183,441,600	$ 229,193,944	24.9%
Total # Prescriptions	862,208	936,197	8.6%
Avg Drug Cost / Rx-ALL	$ 212.76	$ 244.81	15.1%
Avg Drug Cost / Rx- NON SPECIALTY	$ 94.33	$ 111.75	18.5%
Avg Drug Cost / Rx SPECIALY	$ 6,588	$ 8,045	22.1%
Total Specialty Drug Cost	$ 103,588,459	$ 126,325,004	21.9%
% Specialty of Total Drug Cost	56.5%	55.1%	-2.4%
% Specialty Rxs	1.8%	1.7%	-6.8%
% Generic Rxs	80.8%	81.7%	1.2%

DRUG DISTRIBUTION SYSTEM

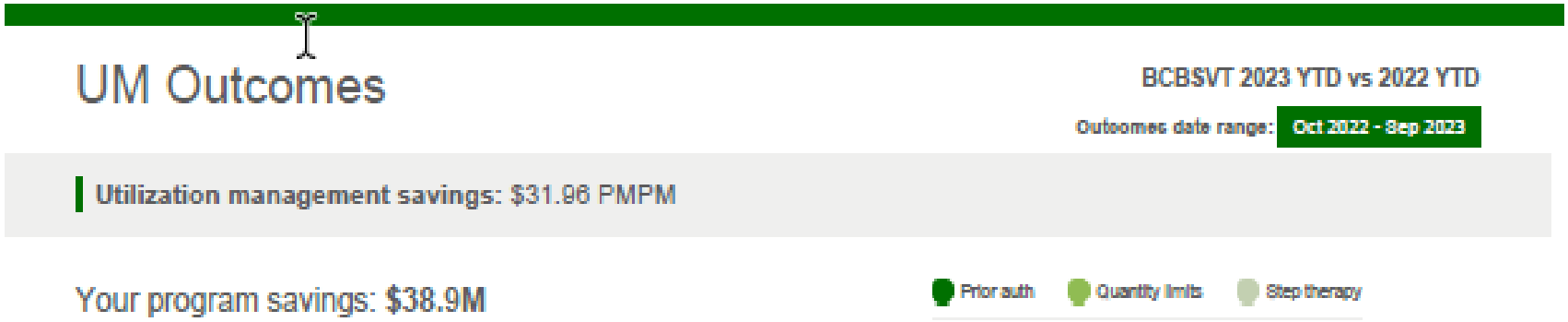


GPO = group purchasing organization; PSAO = pharmacy services administrative organization; DIR = direct and indirect remuneration

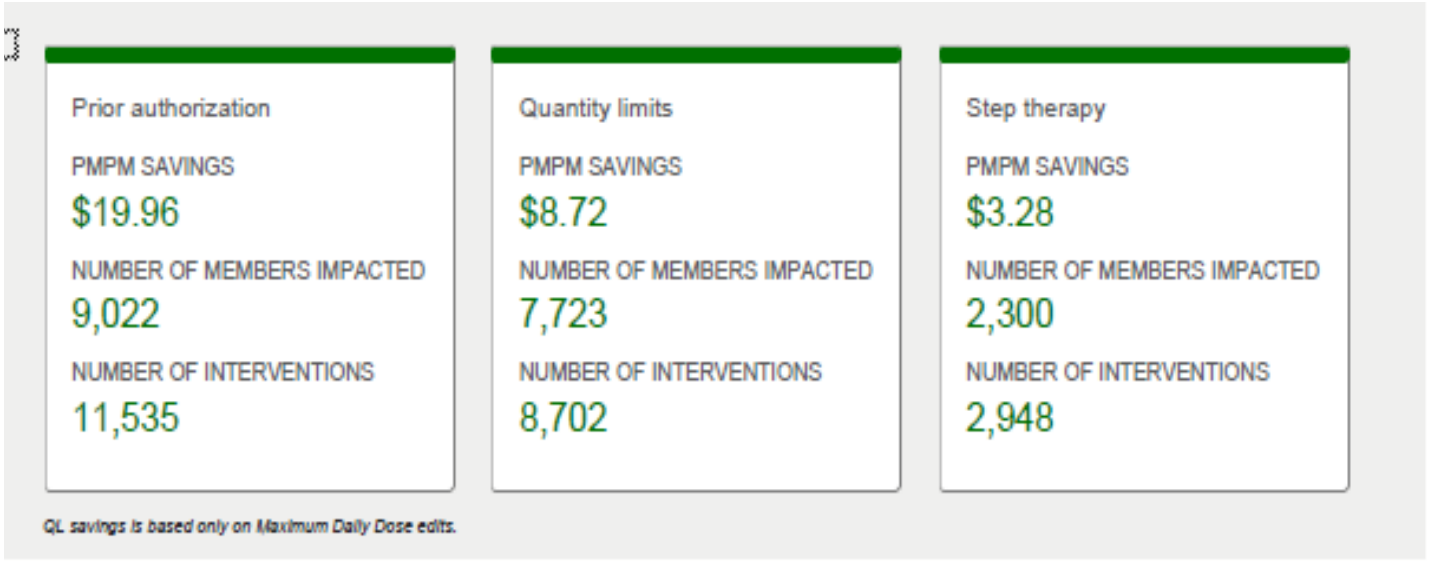
Source: *The 2023 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers* (https://drugch.nl/pharmacy). Chart illustrates flows for Patient-Administered, Outpatient Drugs. Please note that this chart is illustrative. It is not intended to be a complete representation of every type of product movement, financial flow, or contractual relationship in the marketplace.

DRUG CHANNELS INSTITUTE

DRUG UTILIZATION MANAGEMENT



Drug Utilization Management-Savings



SECTION 3: PRIOR AUTHORIZATIONS

- 2023 Prior Authorization Activity:

2023 PA Activity	Blue Cross VT	DVHA
Total # PAs	15254	30067
# Approved	11534	21639
# Denied	3720	8428
Denial Rate	24.39%	28.03%

SECTION 3: PRIOR AUTHORIZATIONS

- Purpose of Drug Prior Authorization:
  - ❖ Assures clinical appropriateness and patient safety
  - ❖ Satisfies requirements for manufacturer rebates, usually through preferred status and step therapy
- PA Development:
  - ❖ Thorough review of available literature, manufacturer information, consultation with panel of physician and pharmacist experts
- PA Turn Around Times:

PA TYPE	Turn-Around Time
URGENT CONCURRENT PA	24 Hours
STANDARD POST-SERVICE PA (DMR)	30 Calendar Days
URGENT PRE-SERVICE PA	24 Hours
STANDARD PRE-SERVICE PA	2 Calendar Days

SECTION 3: PRIOR AUTHORIZATIONS

- *Page 11, Lines 16-18:*
- *(D) Sec. 3. 18 V.S.A. § 9418b(g)(4) is amended to read:*
    - *Prior authorization approval for a prescribed treatment, service, or course of medication shall be valid for the duration of a prescribed or ordered course of treatment or one year, whichever is longer.*

- **Oppose:** This essentially means a lifetime PA for most maintenance drugs. The duration of a prescribed course of treatment can be a patient's lifetime for many medications. Most but not all PAs are one year in length, some are 3 or 6 months and reauthorization criteria is based on efficacy of drug and medical necessity to continue.
- Prescription regimens should be re-evaluated each year as alternate (more cost-effective and/or clinically appropriate) medications become available.
- Restricts movement to lower net cost drugs. Restricts use of clinically comparable drugs with lower ingredient cost and higher rebates.

SECTION 3: PRIOR AUTHORIZATIONS

- *Paragraph under (E), Page 11/12, lines 19-21,1-2 :*
  - *For an insured who is stable on a treatment, service, or course of medication, as determined by a health care provider, that was approved for coverage under a previous health plan, a health plan shall not restrict coverage of that treatment, service, or course of medication for at least 90 days upon the insured's enrollment in the new health plan.*

- Not clinically necessary in most cases. If it is clinically indicated, PA is approved. Currently, a continuation for 14 days is allowed if PA is denied, and appeal is being pursued; can be extended if needed.
- Not operationally feasible for the new health plan to know whether a prior health plan approved a PA for a new member. This would require the development of a new system to bring PA information in from other payers.
- Allowing 90 days would significantly lower our rebate collections (these lead to lower premium costs) due to the inability to switch patients to lower net cost drugs for 90 days.
- In addition, allowing 90-day supply would then tie back to Step Therapy, *line 15 on page 3 (iv: the insured is stable on a prescription drug selected by the insured's treating health care professional for the medical condition under consideration*), allowing new members to the health plan to stay on their existing medications as they would be considered "stable." This bypasses PA and would not allow movement to a clinically appropriate, lower net cost product. Also has a significant impact on rebates.
- **Change to "for at least 14 days"**

SECTION 4: PRIOR AUTHORIZATIONS

- *Sec. 4. 18 V.S.A. § 9418b(i) is added to read:*
  - *(i)(1) The Department of Financial Regulation shall adopt rules, bulletins, or other guidance that prohibits carriers from imposing prior authorization requirements for any generic medication or for any admission, item, service, treatment, procedure, or medication, or for any category of these, that have low variation across health care providers and denial rates of less than 10 percent across carriers.*

- Historically generic medications were inexpensive but now some generic medications are more expensive than other equivalent medications. CivicaRx was formed as a company to combat high-cost generics. Abiraterone=$161/30DS, savings per Rx as much as $2800 per Rx.
- **Remove "any generic medication"**

SECTION 1: STEP THERAPY

- *Sec. 1. 8 V.S.A. § 4089i(e)-Step Therapy*
- *Page 3, lines 9-13:*
  - *(iii) the insured has already tried the prescription drugs on the protocol, or other prescription drugs in the same pharmacologic class or with the same mechanism of action, which have been discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event, regardless of whether the insured was covered at the time on a plan offered by the current insurer or its pharmacy benefit manager;*

- Another drug within same pharmacological class may be effective for an individual when the first product tried was not effective. Efficacy is patient-specific in many cases and does not necessarily mean a drug in the same class would be ineffective.
- **Remove: "or other prescription drugs in the same pharmacologic class or with the same mechanism of action"**

- It is clinically appropriate to expect reasonable evidence of a trial, not just word of mouth. Getting information from other providers or health plans is not something we do today and would require development.
- **Remove: "regardless of whether the insured was covered at the time on a plan offered by the current insurer or its pharmacy benefit manager";**

SECTION 1: STEP THERAPY

- *Page 3, lines 14-17: (B) grant an exception to its step-therapy protocols..*
  - *(iv) the insured is stable on a prescription drug selected by the insured's treating health care professional for the medical condition under consideration;*

➢ Most drugs can be switched without harm, very few cannot

➢ Allows pharma manufacturer to use "patient assistance programs" to stabilize and circumvent PA

- *Page 3, Line 18-21:*
  - *(v) the step-therapy protocol or a prescription drug required under the protocol is not in the patient's best interests because it will:*
    - *(I) pose a barrier to adherence;*
    - *(II) likely worsen a comorbid condition; or*

➢ This should be demonstrated via PA request and is the purpose of the PA