January 17, 2024

The Honorable Lori Houghton
Chair
House Committee on Health Care
115 State Street
Montpelier, VT 05633-5301

The Honorable Francis McFaun
Vice Chair
House Committee on Health Care
97 Sunset Road
Barre Town, VT 05641

The Honorable Alyssa Black
Ranking Member
House Committee on Health Care
115 State Street
Montpelier, VT 05633-5301

Re: Support for H. 766 – Utilization Management Reform

Dear Chair Houghton, Vice Chair McFaun and Ranking Member Black:

On behalf of the Alliance for Patient Access (AfPA), I am writing in support of H. 766, a bill that would reform utilization management practices in the state of Vermont, including copay accumulators, step therapy and prior authorization.

About AfPA

Founded in 2006, AfPA is a national network of policy-minded health care providers who advocate for patient-centered care. AfPA supports health policies that reinforce clinical decision making, promote personalized care and protect the clinician-patient relationship. Motivated by these principles, AfPA members participate in clinician working groups, advocacy initiatives, stakeholder coalitions and the creation of educational materials.

Copay Accumulator Programs

Copay assistance is often of critical importance for patients, particularly those with chronic or rare diseases. The assistance provides payment toward a patient's prescription copay requirements, helping increase access to treatment options. However, in recent years, many health plans have instituted a practice in which patient payments made using copay coupons are allowed for payment but then excluded from being counted towards a patient's annual deductible, or out-of-pocket cost limit.

These practices are known as copay accumulator programs, and they can hinder patient care by increasing out-of-pocket costs for patients, leading to patients – regardless of their health status – switching medications based on unforeseen expense. Patients may also abandon their medication altogether, as these programs can leave patients with unanticipated medical bills of hundreds or even thousands of dollars. These consequences put patients at risk for re-emerging symptoms and new side effects and place an undue burden on patients already managing complex conditions. Re-emerging symptoms and new side effects can lead to worsening conditions, leading to increased costs to the health care system via increased need for clinician and emergency room visits.

Nineteen states and Puerto Rico have already passed copay accumulator reform legislation to help their residents. H. 766 will protect access by ensuring that all payments made on behalf of a patient – including those made using copay coupons – count toward that patient's out-of-pocket maximum. These reforms will

protect patients from the surprise out-of-pocket costs associated with copay accumulator programs, support optimal patient health, and ensure the clinician-patient relationship remains intact.

Step Therapy

Step therapy is a utilization management tool used by insurers to dictate a specific course of care, often as a way to contain health care costs. Sometimes referred to as "fail first," step therapy protocols require patients to try and fail on one or more medications, usually lower cost medications, before the patient can access the medication prescribed by their health care provider. This leads to delays in accessing treatment for many patients and can prevent patients from getting the care their clinicians order, leading to negative health outcomes and increased burden on both patients and clinicians.

H. 766 would improve patient access through the establishment of a clear and accessible process ensuring patients and providers can understand how to secure an exemption from the formulary step requirements. Further, the legislation would require exception requests (to override the step protocol) to be granted in a timely manner when the formulary-preferred medicine: (1) is contraindicated, (2) is expected to be ineffectual based on a specific patient, (3) is not in the best interest of the patient based on medical necessity, (4) has already been tried and found ineffective, or (5) when the patient is stable on another medicine.

Prior Authorization

Prior authorization requires a clinician office to first request permission from an insurer before he or she may order a medical service or prescribe certain medications, a process that can serve as a barrier and frequently leads to delays in appropriate treatment. Studies show that these types of delays in treatment can lead to higher health care costs due to increased hospital visits. An article published by the American Medical Association (AMA) cites a survey in which 16% of clinician respondents said they had a patient who ended up in the hospital due to PA-related delays.[1] Another study conducted by the Cleveland Clinic found that patients' mortality rates increase between 1.2 and 3.2 percent for each week that they are denied treatment.[2]

H. 766 would require standardized response times, which are important in ensuring timely resolutions to prior authorizations requests. Long delays in response to prior authorization requests only increase the possibility of adverse events occurring. In the AMA survey, 28% of clinician respondents reported that their patients experienced a serious adverse event while waiting on a prior authorization response.[4] Patients deserve timely responses to these requests to ensure they can access the items and services that are prescribed to them by their clinician. For these reasons, AfPA supports implementing required response times of 24 hours for urgent and 2 calendar days for non-urgent prior authorization requests.

On behalf of Vermont patients and the Alliance for Patient Access, we urge your support for H. 766 throughout the legislative process to ensure patients can access the treatments they need.

Sincerely,

Josie Cooper
Executive Director
Alliance for Patient Access