F I S C A L I M P A C T R E P O R T

SPONSOR Stefanics **ORIGINAL DATE** 02/06/17 **LAST UPDATED** 03/02/17 **HB**

SHORT TITLE Prescription Drug Coverage Step Therapy **SB** 179/aSCORC

ANALYST Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY17	FY18	FY19	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	Minimal*	Minimal*	Minimal*	Minimal*	Recurring	Various

(Parenthesis ( ) Indicate Expenditure Decreases) *But see fiscal implications below.

Duplicates House Bill 244

SOURCES OF INFORMATION
LFC Files

Responses Received From
Public School Insurance Authority (PSIA)
Retiree Health Care Authority (RHCA)
Human Services Department (HSD)
Department of Health (DOH)
General Services Department (GSD) provided to HAFC only

SUMMARY

Synopsis of SCORC Amendment

The Senate Corporations and Transportation Committee amendment to Senate Bill 179 adds the words "providing for delayed repeal" to the title, and inserts a section specifying a delayed repeal date of July 1, 2021.

Synopsis of Original Bill

Step therapy involves the requirement by health insurers that their enrollees be treated with a less expensive drug or device before moving to a more expensive one if the lower-cost therapy proves ineffective. It is used to attempt to reduce the cost of care. Senate Bill 179 would regulate the use of step therapy and establish review procedures both before an insurer would institute step therapy for a given disorder, and to resolve complaints by insured patients subject to step therapy.

Insurers would have to base their step therapy protocols on recommendations of "an interdisciplinary panel of experts," who would use analytical and methodological experts to help with data analysis and interpretation of high-quality research studies in recommending the steps patients would be required to take. Transparency of the process would be required, and opportunities for public input would be available. If published guidelines were not available, expert opinion could be used. Patients and prescribers would have access to a method to request an exception to a given step therapy determination, and insurers would have to respond within 72 hours, or 24 hours in an urgent situation. Exceptions would be mandated in the following cases:

- The drug indicated in the step therapy protocol is contraindicated in that patient's case or could cause physical or mental harm in that patient.
- The patients particular circumstances make it appear the indicated step therapy drug will be ineffective in the given patient.
- The patient has used the drug before (under the same or a previous insurer), and found it either ineffective or causing an adverse effect.
- The patient is stable on the desired medication, whether it is currently covered by the insurer or by a previous insurer.

Patients could appeal the insurer's decisions through the Patient Protection Act.

Plans could still require the use of a generic version of a patented drug.

Separate sections of Senate Bill 179 makes the same requirements in a number of insurer types as indicated in the table below:

Section of House Bill 139	Type of insurance affected
1	Group health plans
2	Medical assistance plans
3	Individual health insurance policies, health care plans or certificates of insurance
4	Group or blanket health insurance policies, health care plans or certificates of health insurance
5	Individual or group health maintenance organizations
6	Individual or group nonprofit health care plans

FISCAL IMPLICATIONS

GSD's Risk Management Division reported that step therapy management saved the group benefits fund $1.7 million in FY16 and without the benefit of step therapy management, prescription drug costs would increase by at least $6.4 million over the next three years. GSD went on to further explain that its plan participants already have the right to get prescription drugs paid for "as written" once their provider provides the appropriate medical justification.

Responding agencies indicated that there would probably be little change in expenditures resulting from this legislation, although OSI noted that its staffing needs might increase if

required to handle complaints or investigate insurers' compliance with the provisions of the bill. PSIA and HSD both indicated the possibility that medication costs might go up if there were many exceptions requested and granted.

HSD also noted that

> The bill would require significantly more time and work to implement and maintain a step therapy program than currently exists, including providing for public comment, the make-up of committees, etc. This level of effort may reduce the number of step therapy protocols that are implemented even though such protocols may be economically reasonable and may even provide some protections to the recipient by requiring the use of more known standard therapies before using very expensive newly marketed drugs.
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> The high level of effort without any additional funding to support such efforts may have unanticipated consequences. The Texas Medication Algorithm Project attempted something similar which was focused on behavioral health prescribing. The Texas behavioral health authority collaborated with UT Southwestern to develop a system of clinical practice guidelines which made recommendations regarding first line medications and subsequent steps. The whole endeavor was comprehensive but required a fair amount of funding to make it work. They received funding from a variety of sources - NIH, foundations, the VA, and a number of pharmaceutical companies. Although the pharmaceutical companies were not authors on the final guidelines, there has been some controversy that the guidelines were overly influenced by the pharmaceutical companies and when there were gray areas in the decision making process, expensive, newer generation medications were emphasized.

SB 179 might have a major impact on prescription costs if step therapy protocols were to be too easily circumvented. Step therapy programs require that patients try less expensive medications first before "stepping up" to drugs that cost more. These programs are in place to hold down drug costs for insurance plans and out-of-pocket costs for consumers. Insurance plans with transparent step therapy programs provide a clear appeals process for providers who feel the standard treatment is contraindicated or will not help their patients. There are some insurance plans that do not have transparent step therapy programs, making it quite difficult to make the case that a given patient should go immediately to a higher "rung" on the "step ladder." Some insurance companies will not honor a patient's previous insurance company's step therapy program after the patient has switched companies, requiring again that the patient start at the "lowest step." Because some drugs are extremely costly, starting with a less expensive drug may provide a patient with adequate therapy at a lower cost to the insurer and/or to the patient. Making it too easy to circumvent step therapy protocols may increase costs for plans and consumers alike.

SIGNIFICANT ISSUES

In each section, there appears to be a discrepancy between subsection A2, which mandates an "interdisciplinary panel of experts" to develop step therapy protocols, and subsection D, stating that no new entities are required in order to develop review criteria. In addition, it seems difficult to imagine one group being knowledgeable about all the possible step therapy protocols (e.g., drugs for gastro-esophageal reflux and drugs for psychosis).

DUPLICATION

Senate Bill 179.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Insurers would continue to pursue step therapy in their own ways, and prescribers and patients would not have a set appeal mechanism when they believe step therapy was not in the patient's best interest.

LAC/sb/jle/al