VERMONT STEP THERAPY LAW
A Fact Sheet

WHAT IS STEP THERAPY?

Step therapy, also known as "fail first," are policies that require patients to try and fail on alternative treatments before the health plan will cover the originally prescribed treatment. Health plans implement these policies under the justification that these policies result in cost savings for the plan.[1]

WHY ARE STEP-THERAPY POLICIES HARMFUL?

Requiring an individual to take a medication picked by the plan rather than the health care provider can be unethical and inconsistent with clinical evidence and guidelines. This could be due to a lack of efficacy, lack of therapeutic equivalence, or clinical characteristics unique to the patient that necessitate one treatment over another.[2] Moreover, each patient has a unique medical history and background requiring personalized and individualized care.[3] This is why health care providers, not health plans, are best positioned to determine what treatments are most effective for each patient.[4] The time that the patient spends trying and failing on the alternative treatment may lead to disease progression, relapse, or even death.[5]

HOW DID VERMONT RESPOND?

Recognizing the need to protect prompt access to patients' treatments, Vermont passed step-therapy reform into law.[6] Effective January 2025, the law created important patient protections to reduce harms posed by step-therapy policies.[7] The law mandates specific response times, outlines situations where step therapy is prohibited, and defines circumstances that require step-therapy exemptions.[8]

Under the new law, when must a health benefit plan grant a step therapy exemption?

A patient is entitled to an exemption from a step-therapy protocol when:

1. The drug is contraindicated; will likely cause physical or mental harm or an adverse reaction; or is expected to be ineffective;
2. The patient previously tried and failed on the drug, or another prescription drug in the same pharmacologic class or with the same mechanism of action;
3. It is not in the best interest of the patient (expected to impede on patient's ability to achieve or maintain reasonable function ability, pose a barrier to adherence, or worsen a comorbid condition); or
4. The patient is currently stable on a drug.[9]

How much time does the health benefit plan have to respond to an exemption request?

Plans must respond to urgent exemption requests and acknowledge non-urgent requests within 24 hours. If the health plan requires additional information to make a decision, it must notify it must render a decision within 24 hours of receiving the additional information. Failure to meet these timelines will result in the automatic approval of the step-therapy exemption request.[10]

What if a patient's exemption request is denied?

If your insurance plan denies payment for a treatment or service, you can request an internal appeal.[11] For urgent care claims, your plan must respond within 72 hours.[12] For non-urgent care you haven't received yet, the response time is 30 days, and for services you have already received, it is 60 days.[13] [14] If the decision is upheld on appeal, you are entitled to an external review by the Vermont Department of Financial Regulation. Learn more about the appeals process, visit the **Department of Financial Regulation**. If you need additional help, you can also contact **the Office of the Health Care Advocate.** The Office of the Health Care Advocate is a special project within Vermont Legal Aid, an independent non-profit law firm, that can provie advice about how to solve a billing problem and file complaints.

Are there additional protections created by the new law?

Yes! Under the new law, health plans are also prohibited from requiring you to try-and-fail on a medication you've already failed on while enrolled in the same plan.

Additionally, the new law also requires plans to cover at least one asthma controller medication in each class and mode of administration without prior authorization; prohibits plans from imposing prior authorization on items, services, or treatments ordered by a primary care provider (as defined by the **Blueprint for Health**; and requires health plans to provide a list of all services and supplies requiring prior authorization upon the health care provider's request. Importantly the prohibition on prior authorization does not apply to prescription drugs.

The new law also requires plans to respond to urgent prior authorization requests within 24 hours. For non-urgent matters, the health plan must acknowledge receipt within 24 hours and provide an approval or denial within 2 business days. If the health plan requests additional information in order to render a decision, the plan must notify the health care provider and render a decision within 24 hours of the additional information being provided. Failure to confirm receipt of materials will result in an automatic approval of the prior authorization request.

In addition, the law requires that a prior authorization approval be upheld for the duration of the prescribed treatment or one year, whichever is longer. If a medication is taken for longer than one year, the individual will only be required to seek additional prior authorization approvals every five years.

What type of health plans does the law apply to?

The law applies to state-regulated health insurers authorized to do business in the state, such as individual and small group plans, and employer-sponsored plans that are fully funded.[15] The law does not apply to plans issued under the state Medicaid program, the federal Medicare program, or ERISA self-funded health benefit plans.[16]

WHERE CAN YOU GET MORE INFORMATION?

Visit the Department of Financial Regulation

Read the full statute.

REFERENCES

1. Sara Heath, How Does Step Therapy Impact Patient Care Access, Costs?", https://patientengagementhit.com/news/how-does-step-therapy-impact-patient-care-access-costs#:~:text=A%20separate%202010%20study%20showed,cost%20savings%20benefit%20the%20patient.
2. Id.
3. Id.
4. Patients Rising, Step Therapy: Everything You Need to Know About "Fail First" Insurance Policy, https://www.patientsrising.org/step-therapy-explained/.
5. Adrienne Chung, et al., Does A 'One-Size-Fits-All' Formulary Policy Make Sense?, https://www.healthaffairs.org/do/10.1377/forefront.20160602.055116/full/.
6. H. 766, 2023-2024 Leg. Sess. (Vt. 2024).
7. Id.
8. Id.
9. Id.
10. H. 766, supra note 9; 18 V.S.A. § 9418b(g)(4).
11. Centers for Medicare & Medicaid Services, Appealing Health Plan Decisions, https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/indexappealinghealthplandecisions/ (Sept. 6, 2023).
12. Id.
13. Id.
14. Id.
15. 18 V.S.A. § 9402.
16. Id.

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