Trends

Statistics and Strategies for Health Plan Sponsors

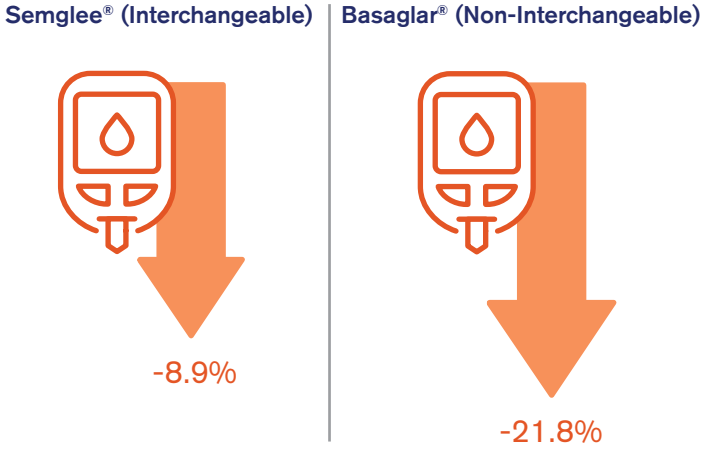
Second Quarter 2023

Key statistics

Biosimilars

Interchangeable biosimilars may be automatically substituted by a pharmacist for the original biologic or reference product, like generic substitution for brand-name medications, while non-interchangeable biosimilars require prescriber approval.

Average Cost Difference for Interchangeable and Non-Interchangeable Biologics Compared to Lantus®*



* Excluding manufacturer rebates

Source: Segal's SHAPE data warehouse

Strategies for promoting use of biosimilars

A biosimilar is like a generic version of a biologic drug. However, a generic drug is an exact copy of a brand drug. A biosimilar is a near-replica of another biologic medication that is already licensed by the FDA (the reference product) and is close enough that it leads to similar clinical outcomes.

Biosimilars will change the treatment landscape by increasing access for patients who need specialty drugs. Additionally, the availability of biosimilars presents an excellent opportunity for plan sponsors to lower costs.

Evolving landscape of autoimmune biosimilars

Humira® (adalimumab) is the top-selling anti-inflammatory prescription drug in the world and is often the top drug cost for plan sponsors. The first Humira biosimilar, Amjevita™, was launched at the end of January. There are at least seven additional biosimilars for Humira in the pipeline that are expected to be approved this year. More biosimilars to treat autoimmune conditions are expected to enter the market, including one for Stelara® (ustekinumab) in early 2024.

Adoption has been slow

Biosimilar uptake has been slow for many reasons, including:

- Providers may be hesitant to convert to biosimilars due to efficacy concerns and often find inconsistency in insurers' policies.
- Historically, pharmacists have not dispensed biosimilars via retail.
- Patients may be reluctant to switch because they don't understand biosimilars, including their safety, efficacy and potential cost savings.
- How biosimilars are positioned within the formulary and represented in the pharmacy benefit manager (PBM) contract may discourage their use.
- PBMs and insurers may favor the more expensive brand reference products over the lower-cost biosimilars to maximize rebates. Major PBMs such as CVS Caremark (CVS) and Express Scripts, Inc. have already done this with generic drug releases. Each of these PBMs has a strategy that prefers a brand product over an equivalent generic, with the brand drug available to members for the generic copayment.
- Plan sponsors may wish to avoid disrupting participants' treatments.

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Savings opportunities

While biosimilar uptake has been slow, increasingly, its availability and adoption bring the potential to produce significant savings for plan sponsors.

Brand-name drugs, including specialty medications, account for the vast majority of prescription drug spending, with specialty medications representing 55 percent of total drug costs.

For example, two pricing models have been reported for Amjevita: a non-rebate-eligible option that is 55 percent lower than Humira's list price and a rebate-eligible option that is 5 percent lower.

How to encourage adoption

Plan sponsors can use several strategies to encourage use of biosimilars:

- Educate stakeholders, including providers, pharmacies and participants, about the increased availability and safety of interchangeable options.
- Revise the plan design to include incentives to encourage adoption and utilization management, such as step therapy, to require patients to try lower-cost options first.
- Introduce provider incentives, either through a direct contracting arrangement or by working with the insurer or third-party administrator (TPA) to ensure that the contracted providers are aware of and are considering biosimilars as a treatment option.

Consider these questions when developing strategies to promote biosimilars:

- Should they be added as a preferred or non-preferred formulary option?
- Does a brand or generic copayment apply?
- If the plan offers copayment assistance, how will that impact costs?
- Should it be added only for new patients?
- What is my PBM's strategy and how flexible is it in adopting biosimilars?

Transparency in Coverage (TiC) rule

On March 4, 2023, U.S. Senators Maggie Hassan and Mike Braun sent a letter to the Centers for Medicare & Medicaid Services (CMS), expressing concerns about "loopholes" inhibiting the intent of the TiC rule to allow consumers to leverage data to assess drivers of healthcare costs, make informed healthcare decisions and develop targeted solutions.

While most health plans are technically complying with the TiC rule, many have provided information in an "indecipherable" structure, omitted important pricing information and compiled information into files too large to be processed by average consumers. The senators also noted significant inconsistencies between files as an additional challenge in performing cross-plan comparisons.

Potential solutions for CMS to consider include limiting file size, creating a standardized reporting template, creating a central repository for all files, a reduction in frequency of reporting and requirement of a clear organizational system and standardized labeling.

Compliance reminder: First "gag clause" attestations are due by the end of 2023

Plan sponsors should work with their legal counsel to ensure any contracts with TPAs or other network service providers do not contain gag clauses, as well as prepare to complete an online attestation by December 31, 2023. Learn more about this in our March 10, 2023 insight.

To discuss the implications for your plan of anything covered here, contact your Segal consultant or get in touch via our website, segalco.com.

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