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ACCESS TO BIOSIMILARS
Impact of Insurance Design

Biologic medicines are used to treat serious and complex health conditions. But access to these treatments is not uniform. Whether a given patient can get a biologic often depends on how his or her insurance plan is designed.

Some insurers are leading the way by supporting wider use of biosimilars, which are lower-cost alternatives to brand-name biologics. Others stick to rebate-driven strategies that block additional options for patients.

HOW ACCESS VARIES BY PLAN

Private insurance and Medicare Advantage plans have adopted biosimilars more quickly than other types of coverage, giving patients faster access to treatment options that may be more affordable.

WHERE PATIENTS BENEFIT THE MOST:

Employer-sponsored insurance covered biosimilars at a rate of 44% shortly after they launched, compared with lower coverage rates in Medicare Part D plans.

Medicare Advantage plans used biosimilars more often than traditional Medicare in six of seven drug classes.

Cancer care practices participating in *Medicare's Oncology Care Model* reached 76% biosimilar use after two years, compared with 64% in other practices.

WHERE PATIENT ACCESS STALLS:

Traditional Medicare and many Part D plans continue to lag behind. These plans often prefer brand-name drugs that offer high rebates, which may be lucrative for insurers but increase costs for patients.

For example, the first adalimumab biosimilars launched in 2023 with prices between 55% to 85% less than the innovator's list price. Even with those savings, they were not added to most drug formularies and only reached 3% of the market by the end of that year.

Part D also poses another challenge. Patients usually pay coinsurance based on the drug's list price, not the lower price after rebates. That means the savings from the lower cost biosimilars often do not reach the pharmacy counter.

POLICY SHIFTS THAT MADE A DIFFERENCE

Several recent policy changes have improved biosimilar access:

- The 2019 Bipartisan Budget Act extended manufacturer discounts in Part D to include biosimilars
- For provider-administered drugs, Medicare now pays an additional 8% based on the brand-name drug's price to encourage biosimilar use under Part B
- In April 2024, the Centers for Medicare and Medicaid Services moved away from longstanding policy to allow for non-interchangeable biosimilar substitution, disregarding current FDA regulatory guidance

BARRIERS THAT PERSIST

Several obstacles still limit biosimilar uptake:

- Pharmacy benefit managers and insurers often choose brand-name drugs with higher rebates
- Hospitals that participate in the 340B program may profit more by using brand-name drugs instead of biosimilars
- Patients rarely see lower out-of-pocket when switching to a biosimilar

WHAT CAN BE DONE

To improve access and realize the full value of biosimilars, health care stakeholders can take the following steps:

- Lower patient cost sharing for biosimilars in Medicare
- Create incentives for providers through quality measures that support biosimilar use
- Increase transparency around how formularies are developed and how rebate decisions are made
- Expand education for providers, pharmacists and patients
- Develop shared savings models for hospitals and outpatient clinics

A MARKET THAT PUTS PATIENTS FIRST

Biosimilars have saved nearly $25 billion over the past nine years. Much of these savings came from price reductions on brand-name drugs due to biosimilar competition. With better-aligned policies, biosimilars could bring even greater value to patients and the health care system.