Employer Strategies for Use of Biosimilar Pharmaceuticals

Segal

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This paper was prepared in March 2020 for The ERISA Industry Committee (ERIC) by Segal, an objective and industry-leading strategic global human resources and employee benefits consulting firm. For media inquiries, please contact Amira Rubin at 212.251.5322.

Introduction

Employers want to provide their employees with access to safe, effective and affordable prescription drugs as a part of their employee benefit health coverage. However, the continuing rise in prescription drug costs, especially specialty drugs, has made this goal ever more challenging to meet, despite the various strategies employers use to control costs while maintaining high-quality prescription drug benefits.

Employers have a relatively new instrument in their drug-management toolkit: biosimilars. Mirroring the use of generic drugs for brand-name non-biologic drugs, biosimilars have the promise of being less expensive alternatives to their biologic brand-name counterparts. This is good news for employers, since biologics make up the majority of specialty drug costs and are a leading driver of overall rising prescription drug cost trends for most employers.

This paper introduces biosimilars, the market challenges facing them and the strategies employers can follow to increase their use and/or help manage ongoing utilization.

Background

Brand-name drugs come in two forms: non-biologic and biologic. Most non-biologic drugs are chemically synthesized.[1] Biologics are more complex than non-biologics. Biological products, which are regulated by the U.S. Food and Drug Administration (FDA), are a diverse category of products and are generally large, complex molecules.[2] They are isolated from a variety of sources (human, animal or microorganism) and may be produced by biotechnology methods and other cutting-edge technologies.[3] They also include a wide range of products, such as vaccines, gene therapy and recombinant therapeutic proteins.[4] Biologics are usually administered through injection rather than other methods, such as pills or oral liquid form.

Once brand-name non-biologic drugs are free from their original patents, other pharmaceutical manufacturers may produce generic versions. Non-biologic generic drugs have the identical chemical composition and perform in the same manner as their brand-name counterparts. Moreover, generics do not require as many levels of clinical trials as the original brand-name drug before receiving FDA approval, resulting in lower generic drug development costs.

Brand-name biologics are more complex to develop and manufacture. A biosimilar is a biologic that is "similar" to another brand-name biologic medicine (commonly known as the reference product). While not identical to their biologic counterparts, biosimilars have the same clinical effect, and regulators have created guidelines to support their development, making them less expensive than their reference product. Since biosimilars cannot be perfectly substituted with their originator biologics (as seen with most non-biologic generic and originator brand-name drugs), they have more modest price discounts when compared to that of generics.[5]

In 2010, Congress passed the Biologics Price Competition and Innovation Act (BPCIA), which established an abbreviated regulatory process for biosimilars and paved the way for their approval.[6]

[1] U.S. Food and Drug Administration. "What Are 'Biologics' Questions and Answers." [website], www.fda.gov/about-fda/center-biologics-evaluation-and-research-cber/what-are-biologics-questions-and-answers. February 6, 2018.

[2] U.S. Food and Drug Administration, "Biosimilar and Interchangeable Products." [website], https://www.fda.gov/drugs/biosimilars/biosimilar-and-interchangeable-products#biological. October 23, 2017.

[3] U.S. Food and Drug Administration. Resources for You (Biologics)." [website], https://www.fda.gov/vaccines-blood-biologics/resources-you-biologics. March 28, 2019.

[4] Refer to the FDA webpage cited in footnote 3.

[5] ER Kabir, SS Moreino and Siam Sharif. "The Breakthrough of Biosimilars: A Twist in the Narrative of Biological Therapy." *Biomolecules*. (August 24, 2019.)

[6] The BPCIA was signed into law as part of the Patient Protection and Affordable Care Act. (See Section 7001.)

The first biosimilar approved by the FDA came out in the U.S. market nearly five years ago to great excitement: Zarxio®, used to treat neutropenia[7] associated with chemotherapy. It competes with the popular drug Neupogen®. Since the launch of Zarxio®, uptake has been slow but steady. As of December 2019, the FDA has approved 26 biosimilar products used to treat anemia, autoimmune diseases and cancer. The biosimilars approved most recently by the FDA are Avsola™ and Abrilada™. However, of the approved FDA drugs, only 15 have launched in the U.S.[8] Factors contributing to the delay in bringing biosimilars to market include legal and patent disputes, manufacturing issues, and prescriber and patient awareness. The hope is that the biosimilar market will continue to expand with increased awareness and support from the medical community and policymakers.[9]

Biosimilar drugs are generally 15 to 20 percent less expensive than their biologic counterparts, and some may be as much as 30 percent less. For example, a comparison of the list price for the biologic Neupogen® and the biosimilar Zarxio® shows that Zarxio® costs roughly 17 percent less than Neupogen® Plan sponsors may see a discount of greater than 17 percent after accounting for negotiated discounts through their medical or pharmacy provider. The following chart illustrates an average discounted price per prescription for a sampling of large employer clients.[10]

Label Name	Average Price Per Unit
Zarxio® INJ 300/0.5	$498
Neupogen® INJ 300/0.5	$643

Source: Segal (2018)

"Availability of biosimilar and interchangeable products that meet the FDA's robust approval standards will improve access to biological products through lower treatment costs and enable greater economies of scale in biosimilar manufacturing."

— FDA's Biosimilars Action Plan

[7] Neutropenia is a low count of neutrophils, a type of white blood cell.

[8] For details, refer to the table on page 11.

[9] The FDA published its Biosimilars Action Plan in July 2018, outlining how it will promote innovation and competition in biologics and biosimilars.

[10] Price comparisons are based on a sample of discounted network prices before rebates and copays are considered.

The Employer's Role in Promoting Biosimilars

Employers can play a significant role in promoting biosimilars as an alternative to more expensive biologic drugs, where medically appropriate. This paper describes four strategies employers may consider to promote and/or manage their use.

1. Increase understanding of biosimilars by health plan participants and health care providers through education and incentives.
2. Adopt clinical management programs.
3. Design the payment features of prescription drug benefits to account for biosimilars.
4. Address biosimilar drugs when negotiating pharmacy benefit manager (PBM) contracts.

Implementing these strategies effectively could increase biosimilar awareness and use, and help employers maximize their cost savings on specialty drugs.

Increase Understanding of Biosimilars by Health Plan Participants and Health Care Providers

Biosimilar drug production is growing and the availability of these biosimilars is relatively new. So too, is the understanding of the benefits of these drugs. While some providers and patients are new to the issue, others may have misconceptions that need to be overcome. Effective biosimilar education can result in plan participant and health provider awareness and use. The FDA has produced a variety of educational materials in its role as the steward of safe and effective biosimilar products. Provider education coupled with medically appropriate incentives may also increase biosimilar awareness and use, since most patients rely on their health care providers for guidance on the appropriate medications for their health-related needs.

FDA educational resources

The FDA offers a variety of patient and provider educational materials, including graphics, drop-in content and social media messages, to help promote understanding of biosimilars.[11] Additionally, the FDA has produced a stakeholder toolkit, to "help you promote [the] FDA as a resource for information on biosimilars…and encourage prescribers and patients to talk to each other about these medications."[12]

Plan participant education

Employers use various methods to communicate with plan participants about their health care benefit options. Biosimilar information can be included in print, email and online communications to highlight their use and potential cost savings. Additionally, real-time benefit lookup tools and cost calculators offered by many benefit plan vendors should include biosimilars as available options. While the impact of direct-to-participant communications may be limited given the few biosimilar drugs currently available, this should increase as more biosimilar products become available in the market.

Provider incentives

Provider incentives may be used to encourage prescribing biosimilar drugs when medically appropriate. These incentives can be offered through direct contracting arrangements or by working with the employer's insurance carrier or third-party administrator to ensure that the contracted health care providers are aware of and considering biosimilars as a treatment option.

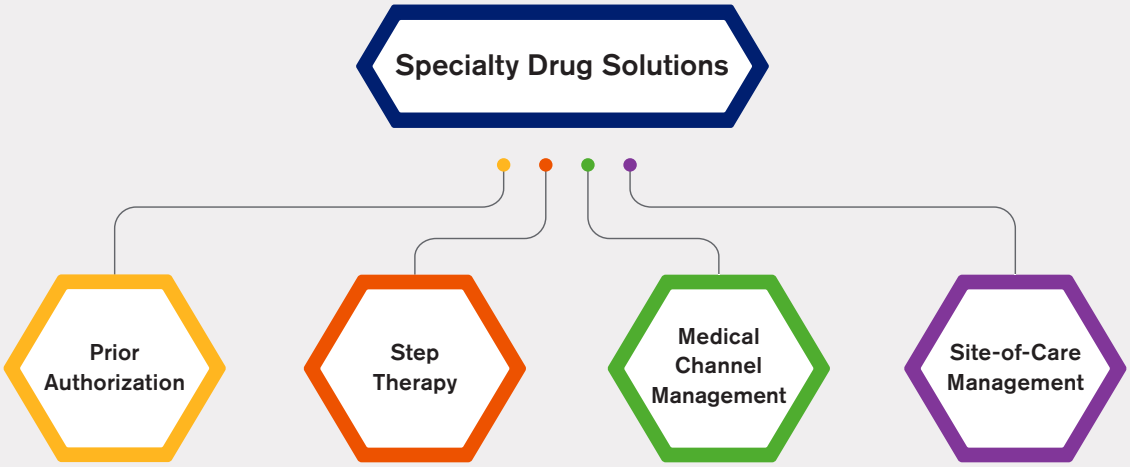
[11] U.S. Food and Drug Administration. "Health Care Provider Materials." [website] https://www.fda.gov/drugs/biosimilars/health-care-provider-materials. September 23, 2019. U.S. Food and Drug Administration. "Prescribing Biosimilar and Interchangeable Products." [website] https://www.fda.gov/drugs/biosimilars/prescribing-biosimilar-and-interchangeable-products. October 23, 2017.

[12] Refer to the Stakeholder Toolkit in the first webpage referenced in footnote 11.

Adopt Clinical Management Programs

Employers commonly use a variety of clinical management techniques to improve health care quality while lowering costs. Employers can take advantage of these same techniques with their prescription drug benefits and apply specific utilization management (UM) strategies, such as prior authorization, step therapy, medical channel management and confirming the most appropriate and cost-effective location for administering biosimilars.

Strategies for specialty drug utilization management



Prior authorization

Prior authorization is one of the most common UM strategies used by employers. When a PBM flags a drug for prior authorization, the prescription is not filled at the point of sale. Instead, the PBM will conduct a coverage review that consists of contacting the prescribing physician to review the reason for and dose of the drug in light of the patient's clinical situation, and then discuss other options available to treat the condition.

This UM technique helps ensure appropriate use of selected drugs and guides the selection of drugs that are most effective for a particular health condition. Biosimilars should be included in this authorization process as an alternative to more expensive biologic drugs. That said, while biosimilars are generally less expensive than their biologic counterpart, managing their proper use to make sure they are the most appropriate treatment for a medical condition will still be important for clinical quality.

Step therapy

Step therapy is another PBM formulary management tool used to drive savings. It promotes taking lower-cost, therapeutically equivalent medication to treat certain conditions before "stepping up" to more expensive drugs. For instance, generic drugs, which are typically less costly than brand-name drugs, are commonly prescribed as the first step.

Similar to prior authorization, the PBM flags more expensive drugs for step-therapy review. This means a pharmacist will be restricted from filling the drug until the PBM staff contacts the prescribing health care provider and reviews the reason for prescribing an advanced step drug rather than starting with a drug in a lower step.[13]

Other traditional cost-management strategies encouraging generic drug usage may also apply in the biosimilar market. However, unlike conventional generic drugs, a pharmacist cannot substitute a biosimilar for a biologic without a health care provider's prescription specifically indicating the biosimilar.

Medical channel management

Effective health care strategy should include a determination of which employer-sponsored benefit program is best suited to cover specialty drugs. The goal of this approach is to see across both medical and pharmacy benefits to ensure specialty drugs — including biosimilars — are being managed effectively. Medical channel management changes the way certain specialty drugs are paid for by excluding them from coverage under the employer's medical benefit and, instead, covering them under the pharmacy benefit. This strategy can be effective when applied to select self- and clinician-administered biologic drugs.

One reason employers may wish to consider this option is to address the concerns of drugs purchased by health care providers and administered in their offices, which can often be more expensive. Another benefit of this approach is the lack of specificity associated with some medical plan billing practices. For instance, J code billing — which is a common billing practice used by medical plans — allows one code to be used for many drugs (and non-drugs). On the other hand, pharmacy benefit billing uses a National Drug Code, a unique 11-digit code for each drug, assigned upon FDA approval.

However, employers should also be aware that it is not always beneficial to administer specialty drugs through their pharmacy benefit. For example, drugs requiring specialized medical care or expertise — such as intravenous chemotherapy drugs — may be best covered under the medical benefit. Similarly, employers should understand that a PBM's cost-savings estimate for specialty drugs may not always be as high as expected (or quoted). In some cases, medical carriers are better able to leverage provider discounts and allow those providers to dispense medications, resulting in deeper savings for the plan. In other cases, carriers contract with select pharmacies to deliver specialty drugs directly to health care providers who administer the drugs to the patients. These specialty drugs are also typically covered under the patient's medical benefit. Finally, some carriers may offer a fee schedule that applies a fixed unit price per drug based on industry standards, while other carriers contract with network physicians to administer select specialty medications. The costs of these specialty medications may be lower than the combined discounts and rebates offered by PBMs under a pharmacy benefit.

Data analytics can help employers understand whether coverage of a biologic or a biosimilar under a medical or pharmacy benefit will provide the best pricing for specialty drugs. In some cases, it may make sense to carve out specialty drugs from the medical benefit, but in other cases, the potential savings associated with carving out a specialty drug will not outweigh the risk of participant and/or physician disruption. Ultimately, employers must weigh both the savings opportunity and the non-financial considerations to determine appropriate specialty drug carve-outs.

[13] Segal's Fall 2017 *Data*, "Managing the High and Rising Cost of Prescription Drug Coverage; Segal's Research Finds Wide Variance in PBM's Prior Authorization Denial Rates for Specialty Drugs."

Site-of-care management

Injectables can be either self-administered or non-self administered. Specialty infusion and non-self administered injectable drugs often require administration by a trained clinician. Scrutinizing where drugs are administered has increased with the realization that that there is a substantial cost difference among facilities that dispense the same drug. This is especially important for biologics and biosimilars, which are often administered through non-self-administered injections or infusions.[14] A site-of-care analysis can be part of the clinical management process and, depending on plan design, the benefits of an alternative site-of-care can be reviewed with the patient and provider.[15] Plan participants should be armed with resources that provide the most cost-effective and highest-quality facilities available to administer these drugs. For instance, an infusion administered in a hospital outpatient setting may be more costly than if administered at a physician's office or through home-infusion services, where appropriate. Employers interested in encouraging plan participants to obtain care at the most appropriate sites where value and quality are consistent should work with their carriers and benefit advisors.

Case Study: Injectables. In 2019, a large self-funded health plan conducted a drug review of high-cost injectable claims for specialty drugs including Herceptin® and Neulasta®, to help ensure patients start and continue therapy at a clinically appropriate and cost-effective health care provider. The table below summarizes the allowed unit cost range for four relatively high-volume, high-cost drugs in two settings. The amounts were calculated by dividing the total allowed amount by the approved units per claim for each provider. Typically, outpatient facilities, most notably those owned and operated by a hospital system, have substantially higher charges than physicians for treatment delivered in the office or by specialty pharmacies. These disparities could lead to potential savings to employers through site-of-care analysis, plan design and contracting strategies that avoid high-cost settings.

Specialty drug cost variations for active and non-medicare retirees*

	Herceptin®		Neulasta®		Avastin®		Perjeta®	
	Physician	Outpatient Hospital	Physician	Outpatient Hospital	Physician	Outpatient Hospital	Physician	Outpatient Hospital
Minimum	$99	$150	$4,682	$4,314	$75	$71	$12	$17
Median	$107	$207	$4,688	$9,442	$81	$161	$12	$24
Maximum	$116	$396	$7,477	$18,004	$91	$301	$13	$46

* Prices shown are allowed amounts

Source: Segal (2019)

[14] Infusions or infusion therapy means a drug is administered intravenously.
[15] Medical Benefit Management (CVS Health webpage).

Design the Payment Features of Prescription Drug Benefits

Employers interested in expanding the use of biosimilars by their plan participants (where appropriate) should confirm that biosimilars are included in the payment provisions of their prescription drug benefits. This can generally be accomplished through plan design and formulary strategy.

Plan design

Plan design is a powerful tool to help mitigate growing prescription drug costs. A successful plan design should balance quality and cost savings. Tiering, a common pharmacy benefit plan design, places equally effective drugs in different tiers to incentivize the use of the least costly tiers. Typically, it rewards a patient with a lower copay for using a lower-cost generic or preferred brand-name drug.

In a traditional three-tier design, generics typically fall in tier 1. However, employers are now implementing four, six or even eight-tier benefit designs. These tiering strategies are designed to further drive consumerism around the price of the medication. As the number of biosimilars in the market grows, we may see increased use of multi-tier plan designs especially for specialty drugs.

Example of a six-tier strategy

Tier 1 Generics
Tier 2 Preferred Brands
Tier 3 Non-Preferred Brands
Tier 4 Specialty Generic or Biosimilar
Tier 5 Preferred Specialty
Tier 6 Non-Preferred Specialty

Example of an eight-tier strategy

Tier 1 Generics (lower cost)
Tier 2 Generics (higher cost)
Tier 3 Preferred Brands
Tier 4 Non-Preferred Brands
Tier 5 Specialty Generic or Biosimilar (lower cost)
Tier 6 Specialty Generic or Biosimilar (higher cost)
Tier 7 Preferred Specialty
Tier 8 Non-Preferred Specialty

Formulary strategy

Some PBMs are including biosimilars in their formularies. Strategies vary by PBM and may prefer biosimilars based on the specific formulary and the overall cost strategy. Anecdotal experience indicates that there is limited patient disruption associated with preferring biosimilars versus brand-name biologic drugs.

Formulary strategy can include two different techniques: (1) exclusion, where a drug is left off the drug formulary, or (2) changing the drug to preferred/non-preferred status. In the past few years, exclusionary formularies have been a more common practice for many of the PBMs. There are a number of drug classes with viable therapeutic alternatives, which allow employers to leverage the targeted drug exclusion strategy. Formulary-based drug strategies have also expanded to include specialty drugs. There are now enough drug options to treat conditions such as anemia, multiple sclerosis and rheumatoid arthritis to create a specialty preferred drug list. This strategy can play a role in price negotiations with the PBM and pharmaceutical manufacturers because it promotes more competitive pricing within a drug class.

Address Biosimilar Drugs when Negotiating PBM Contracts

As noted earlier in this paper, biosimilars are generally 15 to 20 percent less expensive than their biologic counterparts, although some biosimilars may be as much as 30 percent less. While these savings may not be as high as those of generic drugs, they still provide meaningful cost reductions for the expensive biologics. Employers should review their PBM contract provisions with their benefit advisors and legal counsel and pay particular attention to the provisions related to value-based pricing, inflation-protection caps and manufacturer rebates.

Value-based pricing

There is a movement for some PBMs to offer outcomes-based or value-based pricing. This approach supports setting different drug prices for certain medical conditions. For example, while some oncology medications are approved to treat multiple types of cancer, the cost of each drug may not be justified given the low success rate for specific cancers. Therefore, linking a portion of the drug reimbursement to clinical results or outcomes may help avoid the use of less-effective drugs. A positive value-based result on biosimilar drugs compared to their reference product will likely help physicians feel more comfortable prescribing them.

Inflation-protection caps

Specialty drugs have about 10 to 20 percent yearly inflation rates. Due to this high rate of increase, some PBMs offer inflation-protection caps, which are intended to shield plans from the full impact of these year-over-year price increases. High inflation rates will likely be an issue with biosimilars, as well. Employers should understand how their plan's inflation cap is calculated by the PBM and confirm the PBM delivers these protections to all specialty drugs, including biosimilars.

Manufacturer rebates

PBMs negotiate rebates from drug manufacturers for formulary placement. Higher rebates are paid by the manufacturer to have their drug receive a more preferred formulary position. Based on the selected PBM formulary, a biosimilar drug may be preferred over a reference brand-name product. Plan sponsors should ensure that biosimilars are included in rebate payment calculations.

The Biosimilar Pipeline

Due to increased spending on specialty drugs year over year, employers should be familiar with the biosimilar drug pipeline. This pipeline continues to evolve with many manufacturers seeking FDA approval for biosimilar versions of many biologic drugs. The table below shows FDA-approved biosimilar drugs and whether they have been launched into the U.S. market.

Biosimilar Drug Name (chemical name*)	FDA Approval Date	Innovator Drug Name	Biosimilar Launch
Avsola™ (infliximab-axxq)	December 2019	Remicade®	No
Abrilada™ (adalimumab-afzb)	November 2019	Humira®	No
Ziextenzo® (pegfilgrastim-bmez)	November 2019	Neulasta®	Yes
Hadlima™ (adalimumab-bwwd)	July 2019	Humira®	No
Ruxience™ (rituximab-pvvr)	July 2019	Rituxan®	Yes
Zirabev™ (bevacizumab-bvzr)	June 2019	Avastin®	Yes
Kanjinti™ (trastuzumab-anns)	June 2019	Herceptin®	Yes
Eticovo™ (etanercept-ykro)	April 2019	Enbrel®	No
Trazimera™ (trastuzumab-qyyp)	March 2019	Herceptin®	Yes
Ontruzant® (trastuzumab-dttb)	January 2019	Herceptin®	No
Herzuma® (trastuzumab-pkrb)	December 2018	Herceptin®	No
Truxima® (rituximab-abbs)	November 2018	Rituxan®	Yes
Udenyca® (pegfilgrastim-cbqv)	November 2018	Neulasta®	Yes
Hyrimoz™ (adalimumab-adaz)	October 2018	Humira®	No
Nivestym™ (filgrastim-aafi)	July 2018	Neupogen®	Yes
Fulphila™ (pegfilgrastim-jmdb)	June 2018	Neulasta®	Yes
Retacrit™ (epoetin alfa-epbx)	May 2018	Epogen®/Procrit	Yes
Ixifi™ (infliximab-qbtx)	December 2017	Remicade®	No
Ogivri™ (trastuzumab-dkst)	December 2017	Herceptin®	Yes
Mvasi™ (bevacizumab-awwb)	September 2017	Avastin®	Yes
Cyltezo® (adalimumab-adbm)	August 2017	Humira®	No
Renflexis® (infliximab-abda)	May 2017	Remicade®	Yes
Amjevita™ (adalimumab-atto)	September 2016	Humira®	No
Erelzi® (etanercept-szzs)	August 2016	Enbrel®	No
Inflectra® (infliximab-dyyb)	April 2016	Remicade®	Yes
Zarxio® (filgrastim-sndz)	March 2015	Neupogen®	Yes

* The chemical names for drugs are determined by the International Union of Pure and Applied Chemistry (IUPAC).

Source: Biosimilar Product Information (FDA website, January 9, 2020)

Overall, almost half of biosimilars approved by the FDA have been released to market with many of them not publicly announcing a release date due to ongoing patent litigation or previously announced settlements delaying release. Biosimilar release dates between January 2023 and September 2023 have been announced for the top-selling prescription drug in the world: Humira®. While it is exciting that the FDA is approving an increasing number of biosimilar drugs, we continue to question the various legal tactics and negotiations between brand-name and biosimilar manufacturers to delay the release of less expensive alternatives to higher-cost medications.

Outside of the U.S., biosimilars are widely available for many biologic drugs and the number of biosimilars in development is extensive. However, with so many biosimilars in the market and more on the way, there is concern that market saturation will lead many manufacturers to reevaluate their efforts in categories with too small a market to allow for effective competition or sufficient profitability.[16] What this means in the U.S. is unknown at this time due to the limited number of available biosimilars. Many of these drugs have small populations of patients and newer drugs are being developed on a continuous basis, which may lead a manufacturer to reassess the market and its investment in creating biosimilars with potentially limited payoff.

The following table is a representative sample of biologic drugs, their respective manufacturers and the biosimilars in development worldwide. The great majority of these biosimilars are in preclinical development and not yet available for use.

Active Agent	Reference Product (Drug Manufacturer)	Number of Biosimilars in Development
Tumor necrosis factor mAb	Humira® (AbbVie)	25
Tumor necrosis factor mAb	Remicade® (Janssen/J&J)	14
Erythropoietin; epoetin alpha	Epogen® (Amgen)/Procrit® (J&J)	86
Granulocyte colony stimulating factor; filgrastim	Neupogen® (Amgen)	57
Granulocyte colony stimulating factor; pegylated; pegfilgrastim	Neulasta® (Amgen)	20
Tumor necrosis factor, mAb-like fusion protein	Enbrel® (Amgen)	28
CD20 mAb	Rituxan® (Genentech/Roche)	48
Her2 receptor mAb; trastuzumab	Herceptin® (Genentech/Roche)	37
Insulin glargine	Lantus® (Sanofi)	7
Vascular endothelial growth factor mAb; bevacizumab	Avastin® (Genentech/Roche)	22
Insulins	Multiple insulin products	50
Interferon alpha	Multiple interferon alpha products	69
Interferon beta	Multiple interferon beta products	26
Human growth hormone; somatropin	Nutropin® (Genentech)	34

Source: Cheng Liu and K. John Morrow, Jr., *Biosimilars of Monoclonal Antibodies: A Practical Guide to Manufacturing, Preclinical and Clinical Development* (John Wiley & Sons, Inc., December 2016) page 387. (Reprinted with permission.)

[16] Cheng Liu and K. John Morrow, Jr., *Biosimilars of Monoclonal Antibodies: A Practical Guide to Manufacturing, Preclinical and Clinical Development* (John Wiley & Sons, Inc., December 2016) page 387.

Putting the Biosimilar Pieces Together

While utilization of the handful of available biosimilars is currently low, there is positive movement towards the growth of these drugs. Although biosimilars are still an emerging drug option, they offer another way for employers to offer high-quality, affordable drug options to their health plan participants. Employers interested in fully exploring the benefits of offering these drugs to medical and pharmacy plan participants should work with their partners and benefit advisors, develop a go-forward prescription drug strategy including biosimilars and make efforts towards creating awareness of these drug options.

Work with partners. Employers should work with their PBMs, health plan carriers, pharmacy benefit consultants and legal counsel to understand the ongoing evolution of the biosimilar market and monitor the pipeline of new biosimilar drugs. It is also important for employers to identify which PBMs are promoting greater use of biosimilar drugs and include biosimilar provisions and competitive payment features in their PBM contracts. For example, as modifications are made to how biosimilars are administered or where they are administered, there may be savings opportunities for employers.

Develop a strategy. Employers interested in exploring the cost-savings potential of biosimilars should include them in their pharmacy benefit strategy. There are numerous clinical management strategies employers can take to improve the quality of care offered to plan participants while also lowering costs.

Create awareness. It is not too early to increase awareness of biosimilars through communication campaigns aimed at plan participants and health care providers. Additionally, it may be helpful to consider how PBMs and health plan carriers will handle newly launched biosimilars. Some PBMs are already making strides by promoting select biosimilars on their formularies.

This paper was prepared in March 2020 for The ERISA Industry Committee (ERIC) by Segal, an objective and industry-leading strategic global human resources and employee benefits consulting firm. For media inquiries, please contact Amira Rubin at 212.251.5322.

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