Assessment of Barriers to Fair Access

Final Report

December 1, 2021

Institute for Clinical and Economic Review

December 8, 2021 Update: The team learned of a few edits related to table 10 and these were updated accordingly. Note the edits do not affect the criteria concordance for the drugs.

AUTHORS:

Steven D. Pearson, MD, MSc
President
Institute for Clinical and Economic Review

Molly Beinfeld, MPH
Senior Research Lead, Evidence Synthesis
Institute for Clinical and Economic Review

Noemi Fluetsch, MSc, MPH
Research Assistant, Health Economics and Outcomes Research
Institute for Clinical and Economic Review

Maggie O'Grady, BS
Program Manager
Institute for Clinical and Economic Review

Kanya Shah, PharmD, MS, MBA
Evidence Synthesis Intern
Institute for Clinical and Economic Review

Sarah K. Emond, MPP
Executive Vice President and Chief Operating Officer
Institute for Clinical and Economic Review

We would also like to thank Meaghan Cummings, Matthew Seidner, and Yvette Venable for their contributions to this report.

DATE OF PUBLICATION: December 1, 2021

How to cite this document: Pearson SD, Beinfeld M, Fluetsch N, O'Grady M, Shah K, Emond SK. Assessment of Barriers to Fair Access. Institute for Clinical and Economic Review, December 01, 2021. https://icer.org/policy-papers/fair-access-2021/

About ICER

The Institute for Clinical and Economic Review (ICER) is an independent non-profit research organization that evaluates medical evidence and convenes public deliberative bodies to help stakeholders interpret and apply evidence to improve patient outcomes and control costs. Through all its work, ICER seeks to help create a future in which collaborative efforts to move evidence into action provide the foundation for a more effective, efficient, and just health care system. More information about ICER is available at https://icer.org/.

The funding for this report comes from non-profit foundations, including Arnold Ventures and the California Health Care Foundation. No funding for this work comes from health insurers, pharmacy benefit managers, or life science companies. For more information on ICER's overall financial support, please visit https://icer.org/who-we-are/independent-funding/.

Table of Contents

List of Acronyms and Abbreviations Used in this Report

AHRQ	Agency for Healthcare Research and Quality
BCBS	Blue Cross Blue Shield
BCBSMA	Blue Cross Blue Shield of Massachusetts
BCBSMN	Blue Cross Blue Shield of Minnesota
BRCA	Breast cancer gene
CAR-T	Chimeric antigen receptor T-cell therapy
C1-INH	C1 esterase inhibitor
CGRP	Calcitonin gene-related peptide
ECOG	Eastern Cooperative Oncology Group
evLYG	Equal value of life years gained
FDA	U.S. Food and Drug Administration
FSS	Federal Supply Schedule
HAE	Hereditary angioedema
HCSC	Health Care Service Corporation
ICER	Institute for Clinical and Economic Review
IRS	Internal Revenue Service
IV	Intravenous injection (infusion)
ODT	Orally disintegrating tablets
PBM	Pharmacy benefit manager
QALY	Quality-adjusted life year
SC	Subcutaneous
SMA	Spinal muscular atrophy
TKIs	Tyrosine kinase inhibitors
WAC	Wholesale acquisition cost

Introduction

The national debate about drug pricing has focused attention on methods to determine whether the price of a drug is "fair" or "reasonable." A question far less examined is how to determine whether insurance coverage is providing fair access to that drug. It appears widely agreed that cost sharing and drug coverage criteria serve everyone's interest when they steer patients toward evidence-based use of treatments that achieve equal or better outcomes at lower costs. But this level of conceptual agreement does little to help advance thinking on how to assess and judge specific cost-sharing provisions and prior authorization protocols. Is it fair to have patients pay at the highest cost-sharing level when there is only a single drug available in a drug class? What are the circumstances in which step therapy is a reasonable approach to targeting coverage? When is it appropriate for the clinical criteria required for coverage to be narrower than the Food and Drug Administration (FDA) labeled indication? And how should the pricing of a drug factor in to whether certain strategies to limit or steer patient access are appropriate?

To help address these questions, ICER has developed a set of appropriateness criteria for pharmaceutical insurance coverage, as described in our 2020 white paper, Cornerstones of "Fair" Drug Coverage: Appropriate Cost-Sharing and Utilization Management Policies for Pharmaceuticals. Readers of this current assessment are encouraged to read the earlier white paper to understand the broader ethical analysis that led to the framing of these appropriateness criteria. The criteria are based on analyses of prior policy and ethical research, with input from multiple stakeholders and active deliberation and revision following a December 2019 ICER Policy Summit attended by representatives from patient groups, clinical specialty societies, private payers, and the life sciences industry. That process led to a deeper understanding of the justification for cost sharing and prior authorization while specifying the way that these policies should be developed and implemented to ensure that patients receive appropriate evidence-based access to pharmaceuticals.

The goal from the outset of this larger initiative was for these criteria to serve as a tool for assessment and as the starting point for dialogue and action to achieve fair access. This first **Barriers to Fair Access Assessment Report** is intended to help move this process forward. A comprehensive assessment of concordance with fair access criteria was not possible given limitations to the available data. This report remains therefore an exploratory analysis intended to chart a roadmap for future research. But it also allows for a deeper understanding of where current insurance coverage does or does not align with some of the most important elements that determine whether patients are gaining fair access to pharmaceuticals.

The report uses a leading proprietary database of formulary coverage information as the source from which to evaluate the rate of concordance with fair access criteria for 28 drugs deemed fairly priced by ICER across 15 of the largest commercial formularies in the United States. Analyses have

been performed to evaluate concordance with fair access criteria related to the design of cost sharing and prior authorization for each drug, across all drugs in each of the major domains of fair access, and by payer formulary.

The limitations of this analysis will be emphasized throughout the report and are summarized in Table 1 below. First, among the full set of fair access criteria contained in the white paper, many were not able to be assessed given that they cannot be determined from viewing insurance coverage and tiering information. Second, the formulary database used for this report does not include all coverage policies, leaving gaps in our ability to review all fair access criteria for the full set of drugs. Third, we were not able to assess how prior authorization policies were implemented, including the relative level of documentary burden and the ease of obtaining reasonable exceptions, both of which are critical to achieving fair access. Fourth, for judgments on cost-sharing, we could only use tiering as a signal of the relative magnitude of out-of-pocket payment required, an approach that does not capture the wide variety of levels of copayments and co-insurance that can be used by plan sponsors within any tiering structure. Fifth, one important element of fair access for patients is the number of step therapies they must take without adequate response before qualifying for coverage for the drug they initially feel is best for them. Our fair access criteria did not establish a threshold for the number of steps that when viewed cumulatively represent an unreasonable barrier. And sixth, our selection of the formularies with the largest number of covered lives for each payer may skew our analysis toward formularies with policies more, or less, in concordance with the fair access criteria.

Table 1. Key Limitations to This Analysis of Barriers to Fair Access

Key Limitations
1. Many important fair access design criteria not able to be evaluated from insurance coverage policies alone, including, for example: a. Patient cost sharing should be based on the net price to the plan sponsor, not the unnegotiated list price; b. As part of step therapy, when patients try a lower cost option with a lower cost-sharing level but do not achieve an adequate clinical response, cost sharing for further therapies should also be at the lower cost-sharing level if those further therapies are priced fairly; c. Clinical eligibility criteria should be developed with explicit mechanisms that require payer staff to document that they have confirmed that clinical eligibility criteria have not gone beyond reasonable use of clinical trial inclusion/exclusion criteria to interpret or narrow the FDA label language in a way that disadvantages patients with underlying disabilities unrelated to the condition being treated
2. Between 2%-24% of relevant insurance coverage policies for each of the seven fair access criteria studied were not available publicly or through the database used for this assessment
3. Performance related to implementation of insurance coverage provisions could not be determined from available documents. Key elements not evaluated include: a. Relative documentary burden to establish eligibility; b. Efficiency of process for requesting and adjudicating medical exceptions for individual patients
4. Assessment of tiering as surrogate for cost sharing unable to examine whether tiering directly associated with co-payment versus co-insurance structure or the specific out of pocket amounts, all of which are selected by the plan sponsor
5. Assessment of step therapy policies evaluates each step on specific clinical criteria but does not include a threshold for the number of steps that equate with unreasonable burden
6. It is possible that the 15 formularies selected for this assessment provide superior coverage than formularies covering fewer individuals offered by the same payer

FDA: U.S. Food and Drug Administration

Further description of these and other limitations is included in the relevant report sections below, and their importance highlights the exploratory nature of the conclusions that should be drawn from the results of the assessment. Despite these limitations, however, we believe this analysis is a valuable first step in assessing fair access to pharmaceuticals using a detailed and publicly available set of criteria. The decision to limit this analysis to drugs that have been previously assessed to be priced fairly was intentional. Patients should receive fair access to all covered services, but insurers have an ethical responsibility to administer health benefits in an evidence-based, prudent manner to serve as effective stewards of the shared resources provided through health insurance premiums. When drugs are deemed to be priced fairly in alignment with patient benefits, the criteria for fair access are stricter, and the implied ethical responsibility for fair access even stronger. Examples in which fair access criteria are not met for fairly-priced drugs should serve as key points of public discussion in order to understand whether there are special circumstances, or whether action is required to change these policies moving forward.

To help provide important guidance on this project, the Barriers to Fair Access Assessment has benefited from ongoing input from a multi-stakeholder Working Group consisting of several representatives from leading patient advocacy groups, two from clinical societies, one each from private payers and pharmacy benefit managers, and one from an umbrella organization for life sciences companies. The Working Group has advised ICER on the application of the fair access criteria to coverage policies; provided insight into the patient experience with prescription drug coverage and access, including real-world examples; and advised on important nuances in the interpretation of payer coverage policies. None of them should be assumed to agree with any of the specific methods, findings, or perspectives presented in this report. Members of the Working Group are listed in the Supplement Material.

Drugs and Formularies to be Assessed

The drugs identified for this assessment are shown in Table 2 on the following page. These 28 drugs (one drug, infliximab, is counted twice since it is fairly priced for two different indications) are those that were reviewed by ICER between 2015 and 2020 and were found to have prices net of discounts and rebates that fall within a reasonable cost-effectiveness range, i.e., with a price lower than that needed to reach a threshold of $150,000 per additional quality-adjusted life year (QALY) or equal value of life years gained (evLYG), whichever is higher. Average net prices between September 2019 and October 2020 for these drugs were evaluated and confirmed to be below the top end of this cost-effectiveness range. ICER's recent update to value-based pricing ranges for C1 esterase inhibitor based on real-world data was not considered for this analysis given that the results of that update were not available during the time when insurer coverage policies would have been developed.

Table 2. Fairly Priced Drugs Identified for Review

Generic Drug Name	Brand Drug Name	Condition	Annual Net Price Estimate*	Maximum Cost-effective Price
Afatinib	Gilotrif	Non-small cell lung cancer	$64,240†	$110,600
Alemtuzumab	Lemtrada	Multiple sclerosis	$165,777†	$328,600
Alirocumab	Praluent	High cholesterol	$2,984	$4,300
Apremilast	Otezla	Plaque psoriasis	$26,762	$38,700
Axicabtagene ciloleucel	Yescarta	B-cell lymphoma	$373,000†	$564,000
Brodalumab	Siliq	Plaque psoriasis	$26,530	$43,900
Dupilumab	Dupixent	Atopic dermatitis	$29,432	$46,100
Elagolix	Orilissa	Endometriosis	$7,731	$13,500
Emicizumab	Hemlibra	Hemophilia A	$558,870	Cost saving
Erenumab	Aimovig	Migraine	$2,167	$5,600
Fremanezumab	Ajovy	Migraine	$1,839	$5,500
Gefitinib	Iressa	Non-small cell lung cancer	$93,440†	$110,600
Guselkumab	Tremfya	Plaque psoriasis	$36,176	$43,200
Icosapent ethyl	Vascepa	Cardiovascular disease prevention	$3,241	$9,500
Infliximab	Remicade	Plaque psoriasis	$12,285	$37,000
Infliximab	Remicade	Rheumatoid arthritis	$7,371	$12,800
Insulin degludec	Tresiba	Diabetes mellitus	$4,723	$8,000
Ixekizumab	Taltz	Plaque psoriasis	$29,257	$54,400
Olaparib	Lynparza	Ovarian cancer	$13,250†	$13,600
Onasemnogene abeparvovec	Zolgensma	Spinal muscular atrophy	$1,613,126†	$2,100,000
C1 esterase inhibitor	Haegarda	Hereditary angioedema	$362,283†	$389,500
Rimegepant	Nurtec	Migraine	$4,542†‡	$4,600
Rivaroxoban	Xarelto	Cardiovascular disease prevention	$1,650	$7,800
Sacubitril/valsartan	Entresto	Congestive heart failure	$3,847	$16,600
Secukinumab	Cosentyx	Plaque psoriasis	$32,278	$41,700
Tisagenlecleucel	Kymriah	Acute lymphoblastic leukemia	$474,387†	$1,782,700
Ubrogepant	Ubrelvy	Migraine	$4,523†§	$4,600
Ustekinumab	Stelara	Plaque psoriasis	$35,952	$40,000

*Average prices net of all discounts and rebates, October 2019-September 2020, obtained from SSR Health. For prices not available or deemed unreliable, prices taken from Federal Supply Schedule (FSS).
† FSS prices
‡ Prices were only available for July – September 2020
§ Prices were only available for March – September 2020

For these 28 drugs we sought to leverage MMIT's Market Access Analytics platform to obtain cost sharing and prior authorization documentation from the largest formularies offered by the 15 largest commercial insurers or PBMs by covered lives in the United States (see Table 3 below). Prior to the initiation of this assessment, we carefully evaluated the relative strengths of different academic and commercial databases detailing insurer coverage policies and found MMIT's platform to be the most comprehensive, up to date, and detailed available. Details on how MMIT assigns who "controls" a formulary and the covered lives under each formulary are provided in the Supplement. The formularies marketed under Express Scripts and CIGNA remain separate in this database even though the companies are now merged because each company continues to make decisions independently. Of note, while Optum Rx represents one of the 15 largest PBMs in the United States, no formulary from this payer is not included in this analysis because their prior authorization policies can only be accessed by licensed providers and therefore are not available under any commercial data provider.

Together, these 15 formularies represent coverage policies that determine pharmaceutical access for approximately 49 million Americans (MMIT Analytics as of 05/21/2021). See Table A4.1 in the Supplement for detailed information on covered lives per formulary.

Table 3. Largest Single Formulary Offered by Each of the 15 Largest Commercial Payers with Coverage Policies Available in the MMIT Analytics Dataset*

Payer	Formulary Name	Tiers Available	Individuals Covered*
CVS Health (Aetna)	CVS Caremark Performance Standard Control w/ Advanced Specialty Control	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand	13,438,437
Express Scripts	Express Scripts National Preferred with Advantage Plus	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand	10,865,105
UnitedHealthcare	UnitedHealthcare Advantage Three Tier	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Generic or Non-Preferred Brand	6,108,784
CIGNA Health Plans, Inc.	Cigna Standard Three Tier	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand	3,691,452
Kaiser Foundation Health Plans, Inc.	Kaiser Permanente Southern California	Tier 1: Generic Tier 2: Brand	3,605,754
Anthem, Inc.	Anthem Essential Four Tier	Tier 1: Preferred Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Generic or Non-Preferred Brand Tier 4: Specialty	2,459,382

Payer	Formulary Name	Tiers Available	Individuals Covered*
MC-RX	MC-RX Formulary	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Generic or Non-Preferred Brand	1,291,711
Blue Cross Blue Shield (BCBS) of Massachusetts	BCBS Massachusetts Three Tier	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand	1,135,006
Elixir PBM	Elixir Standard Formulary	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand Tier 4: Specialty	1,062,407
Blue Shield of California	Blue Shield of California Plus Formulary	Tier 1: Preferred Generic or Low-Cost Preferred Brand Tier 2: Preferred Brand or Non-Preferred Generics Tier 3: Non- Preferred Brand Tier 4: Biologics or Specialty	1,006,214
Health Care Service Corporation (HCSC)	BCBS of Illinois Basic 6 Tier	Tier 1: Preferred Generic Tier 2: Non-Preferred Generic Tier 3: Preferred Brand Tier 4: Non- Preferred Brand Tier 5: Preferred Specialty Tier 6: Non-Preferred Specialty	915,220
Florida Blue	Florida Blue Three Tier	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand	863,657
Highmark, Inc.	Highmark Blue Cross Blue Shield 3 Tier	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand	833,673
MedImpact Healthcare Systems, Inc	MedImpact Portfolio High Formulary	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand	655,756
Blue Cross Blue Shield (BCBS) of Minnesota	BCBS of Minnesota FlexRx Three Tier	Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand	647,652

*Covered lives as of 05/21/2021 according to MMIT

Fair Access Criteria

There are many potential barriers to access spanning health literacy, disability status, provider education and availability, personal resources, and access to affordable insurance coverage. ICER's original white paper focused narrowly on two areas over which plan sponsors and payers (inclusive of both pharmacy benefit managers [PBMs] and insurers) have direct control: cost-sharing provisions and the design and implementation of utilization management. This focus was intended to illuminate the barriers operative in areas over which payers and plan sponsors have significant discretion.

Given this focus on cost sharing and utilization management, the white paper did not address many other important areas of coverage policy, including thresholds for the number or type of drugs needed within drug classes; coverage for off-label prescribing; potential changes to the current rebate system; high-deductible benefit designs; and the role of copayment coupons. Instead, the Fair Access Criteria in the white paper directly address the following five domains:

- Cost-sharing provisions and tier placement as part of the drug benefit design
- Timing of development of prior authorization protocols following FDA approval
- Clinical eligibility criteria
- Step therapy and coverage requirements to switch medications
- Restrictions on prescriber qualifications

The purpose of the current assessment was to evaluate concordance of payer coverage policies for fairly-priced drugs with the fair access criteria presented in the white paper. In designing this assessment, however, we had to make several important concessions. First, we felt we would not have the time or resources to be able to do a separate investigation with each payer to seek permission to obtain and evaluate their coverage policies. Instead, we would need to rely on information we could obtain publicly or access through pre-existing coverage policy databases. Second, we had to acknowledge that some of the fair access criteria would not be able to be evaluated without site visits, in-depth interviews, or access to material related to implementation of coverage policy procedures. Given our available resources, and the length of time it would take to perform a full, in-depth assessment of implementation, we decided it would be necessary to narrow the range of fair access criteria we would evaluate.

This meant that we would not seek to evaluate the timing of development of prior authorization following FDA approval. It also meant that we would not be able to evaluate important elements of fair access, such as documentation burden, responsiveness to initial requests for coverage, or timeliness of responses to requests for medical exceptions. We will stress throughout this report that these elements of fair access are critically important to patient and clinician experience and to

patient outcomes. The fact that this current assessment does not seek to evaluate these factors should be viewed as an important limitation on generalizing any judgment of whether a particular coverage policy represents "fair access."

We present on the following pages the entire set of Fair Access Criteria from the original white paper, indicating which criteria we were ultimately able to include within the scope of this current assessment.

Table 4. Cost Sharing Fair Design Criteria

Cost Sharing	
Fair Design Criteria	**In Scope for this Review?**
Patient cost sharing should be based on the net price to the plan sponsor, not the unnegotiated list price.	No
All medications identified by the Internal Revenue Service as high-value therapies should receive pre-deductible coverage within high deductible health plans.	No
At least one drug in every class should be covered at the *lowest relevant* cost-sharing level unless all drugs are priced higher than an established fair value threshold.	Yes
If all drugs in a class are priced so that there is not a single drug that represents a fair value as determined through value assessment, it is reasonable for payers to have all drugs on a higher cost-sharing level.	No
If all drugs in a class are priced so that they represent a fair value, it remains reasonable for payers to use preferential formulary placement with tiered cost sharing to help achieve lower overall costs.	Yes
As part of step therapy, when patients try a lower cost option with a lower cost-sharing level but do not achieve an adequate clinical response, cost sharing for further therapies should also be at the lower cost-sharing level as long as those further therapies are priced fairly according to transparent criteria	No

Table 5. Clinical Eligibility Fair Design Criteria

Clinical Eligibility	
Fair Design Criteria	**In Scope for this Review?**
Payers should offer alternatives to prior authorization protocols such as programs that give feedback on prescribing patterns to clinicians or exempt them from prior authorization requirements ("gold carding") if they demonstrate high fidelity to evidence-based prescribing.	No
Payers should document at least once annually that clinical eligibility criteria are based on high quality, up-to date evidence, with input from clinicians with experience in the same or similar clinical specialty.	No
Clinical eligibility criteria should be developed with explicit mechanisms that require payer staff to document that they have: • Considered limitations of evidence due to systemic under-representation of minority populations; and • Sought input from clinical experts on whether there are distinctive benefits and harms of treatment that may arise for biological, cultural, or social reasons across different communities; and • Confirmed that clinical eligibility criteria have not gone beyond reasonable use of clinical trial inclusion/exclusion criteria to interpret or narrow the FDA label language in a way that disadvantages patients with underlying disabilities unrelated to the condition being treated.	No
For all drugs: Clinical eligibility criteria that complement the FDA label language may be used to: • Set standards for diagnosis; and/or • Define indeterminate clinical terms in the FDA label (e.g., "moderate-to-severe") with explicit reference to clinical guidelines or other standards; and/or • Triage patients by clinical acuity when the payer explicitly documents that triage is both reasonable and necessary because: ○ The size of the population included within the FDA label is extremely large, and there is a reasonable likelihood that many patients would seek treatment in the short term; AND ○ The clinical infrastructure is not adequate to treat all patients seeking care and/or broad coverage would create such substantial increases in short-term insurance premiums or other financial strain that patients would be harmed through loss of affordable insurance; AND ○ Acuity can be determined on objective clinical grounds and waiting for treatment will not cause significant irremediable harm.	Yes
For drugs with prices or price increases that have not been formally deemed unreasonable: Except for the three purposes outlined above, clinical eligibility criteria should not deviate from the FDA label language in a manner than would narrow coverage.	Yes
For drugs with prices or price increases that have not been formally deemed unreasonable: Documentation that patients meet clinical eligibility criteria should represent a light administrative burden, including acceptance of clinician attestation in lieu of more formal medical record documentation unless documentation is critical to ensure patient safety.	No
For drugs with prices or price increases that have been formally deemed unreasonable: Clinical eligibility criteria may narrow coverage by applying specific eligibility criteria from the pivotal trials used to generate evidence for FDA approval if implemented with reasonable flexibility and supported by robust appeals procedures as described in the implementation criteria.	No
For drugs with prices or price increases that have been formally deemed unreasonable: Documentation requirements to demonstrate that patients meet clinical eligibility criteria may represent a modest administrative burden, including requirements for medical record confirmation of key criteria instead of simple clinician attestation. In all cases, however, administrative burden should not result in major barriers to care for patients who meet criteria, and payers should perform and post publicly annual evaluations for each drug of rates of ultimate coverage approval following initial coverage denial due to documentation failures.	No

FDA: U.S. Food and Drug Administration

Table 6. Step Therapy and Required Switching Fair Design Criteria

Step Therapy and Required Switching	
Fair Design Criteria	**In Scope for this Review?**
In order to justify step therapy policies extending beyond FDA labeling as appropriate, payers should explicitly affirm or present evidence to document all of the following: • Use of the first-step therapy reduces overall health care spending, not just drug spending	No
• The first-step therapy is clinically appropriate for all or nearly all patients and does not pose a greater risk of any significant side effect or harm. • Patients will have a reasonable chance to meet their clinical goals with first-step therapy. • Failure of the first-step drug and the resulting delay in beginning the second-step agent will not lead to long-term harm for patients. • Patients are not required to retry a first-line drug with which they have previously had adverse side effects or an inadequate response at a reasonable dose and duration.	Yes
In order to justify required switching policies as appropriate, payers should explicitly affirm or present evidence to document all of the following: • Use of the required drug reduces overall health care spending.	No
• The required switch therapy is based on the same mechanism of action or presents a comparable risk and side effect profile to the index therapy. • The required switch therapy has the same route of administration or the difference in route of administration will create no significant negative impact on patients due to clinical or socio-economic factors. • Patients are not required to switch to a drug that they have used before at a reasonable dose and duration with inadequate response and/or significant side effects, including earlier use under a different payer.	No

FDA: U.S. Food and Drug Administration

Table 7. Provider Qualifications Fair Design Criteria

Provider Qualifications	
Fair Design Criteria	**In Scope for this Review?**
Restrictions of coverage to specialty prescribers are reasonable with one or more of the following justifications: • Accurate diagnosis and prescription require specialist training, with the risk that non-specialist clinicians would prescribe the medication for patients who may suffer harm or be unlikely to benefit. • Determination of the risks and benefits of treatment for individual patients requires specialist training due to potential for serious side effects of therapy. • Dosing, monitoring for side effects, and overall care coordination require specialist training to ensure safe and effective use of the medication.	Yes
Requiring that non-specialist clinicians attest they are caring for the patient in consultation with a relevant specialist is a reasonable option when the condition is frequently treated in primary care settings but some elements of dosing, monitoring for side effects, and/or overall coordination of care would benefit from specialist input for many patients.	Yes

Results

Given that we sought to evaluate coverage policies for 28 drug-indication pairs across 15 formularies, there was a maximum of 15 x 28 = 420 possible drug-formulary policy combinations. Relevant policies were available for most drug-formulary combinations, ranging from 302 (72%) of 420 for policies on clinical eligibility to 332 (79%) out of 420 for policies related to cost sharing. MMIT pulls data from a variety of sources known as the MMIT Network, a repository of open-source data including e-prescribing and similar point-of-care solutions, physician educational channels, long-term care and other pharmacies, pharmaceutical manufacturers, and most notably health plans and PBMs. When a policy is not referenced in the MMIT database, it is because MMIT has obtained this information either through a proprietary source, intelligence provided by their network of panelists, and/or other non-publishable digital data assets.

We identified 70 drug-formulary combinations for which there was both a pharmacy and a medical coverage policy available. In 67 (96%) of these dual coverage cases, the concordance rating was consistent for all fair access criteria across the pharmacy and medical policies.

Concordance by Fair Access Criterion

Our analysis of each individual drug-formulary combination is described in the Supplemental Material. As can be seen in Table 8 below, overall concordance with the 7 fair access criteria assessed ranged from a low of 77% for cost-sharing, to a high of 100% for prescriber restrictions.

Table 8. Number of Coverage Policies Available and Overall Rate of Concordance with Fair Access Criteria

Fair Access Criterion	Drug-Formulary Combinations with Relevant Policies Available out of Maximum Possible of 420, n (%)	Concordant Policies, n/N (%)
Cost sharing	332 (79%)	254/332 (77%)
Clinical eligibility	302 (72%)	290/302 (96%)
Step therapy	317 (75%)	313/317 (99%)
Prescriber restrictions	311 (74%)	311/311 (100%)

The percentage of policies judged concordant in Table 8 above uses as a denominator only those policies available. We believe this is the best single quantitative measure of overall concordance because it does not seem reasonable to reduce concordance rates by including policies that were not applicable in the denominator. However, Table 9 below does split out the percentage of policies that were not applicable and not available to emphasize the number of policies that were not available as a separate component of the overall findings. Detailed material in the Supplement demonstrate that some payers had higher rates of policies that were not made available in the MMIT database.

Table 9. Overall Rate of Concordance with Fair Access Criteria, Including Policies Unavailable or Not Applicable

Fair Access Criterion	Concordant, n (%)	Discordant, n (%)	Not Applicable, n (%)	No Policy Available, n (%)
Cost sharing	254 (60%)	78 (19%)	79 (19%)	9 (2%)
Clinical eligibility	290 (69%)	12 (3%)	19 (5%)	99 (24%)
Step therapy	313 (75%)	4 (1%)	20 (5%)	83 (20%)
Prescriber restrictions	311 (74%)	0 (0%)	19 (5%)	90 (21%)

Although concordance rates were generally high, the number of drug-formulary policies not meeting criteria across the 15 formularies ranged from a low of 0 for prescriber restrictions to a high of 78 for cost sharing. Examples of specific coverage policies that did not meet fair access criteria include the following:

1. Cost sharing

As noted in the earlier section describing the Fair Access Criteria, to meet the criterion for cost sharing a fairly priced drug or at least one of its equivalent options must be placed on the "lowest relevant" tier of the formulary. The interpretation of which is the lowest relevant tier for certain drugs is made difficult by the number and labeling of tiers in different formularies. For the purposes of this report, we required a fairly priced drug to be placed in the second tier ("preferred brand") for formularies built with three or four tiers. Thus, even for four-tier formularies with a single "specialty" fourth tier, the formulary was required to place these drugs on the second tier in order to be judged concordant.

This approach was informed by input from payers who noted that they ultimately have discretion on whether to place an expensive "specialty" drug on a lower tier. However, payers also noted that four-tier formularies are designed in conjunction with plan sponsors and that a payer has an implied responsibility to administer a four-tier formulary by putting specialty drugs on the fourth tier. In addition, some plan sponsors may choose to have the same cost-sharing amount for drugs on a specialty fourth tier as on a preferred brand tier, or even if the amount is higher, it may still be a co-payment amount that is less than the amount required out of pocket for the same drug on the third tier of some three-tier formularies. Thus, the correlation of tiering level and actual out-of-pocket cost is not exact across formularies, and the actual question of whether cost sharing is presenting an unfair barrier to access can only be answered at the level of individual plan sponsor.

The difficulty in interpreting tiering level as a surrogate for cost sharing is compounded by the way tiered formularies are related to high-deductible health benefit designs. As shown in a report from Kaiser Family Foundation, in 2020, a higher percentage of all employees in plans without high deductibles had plans with four or more tiers (54%) than three tiers (35%). The report also noted that whereas the percentage of four-tier formularies requiring co-insurance is higher than that for

three-tier formularies (36% to 24%), most four-tier formularies still require only co-payments for all tiers.[1]

Nonetheless, we believe that the general principle can still be applied as a criterion for fair access: fairly priced drugs should be placed on the lowest available relevant tier, which for brand name drugs is usually the second (preferred brand) tier. When results are presented later showing the findings by payer formulary, the distinction between the relative concordance rates for four-tier formularies versus other formulary designs will be evident. One of the main points of further discussion should be whether four-tier formularies are structurally more likely to represent a barrier to fair access or whether they should be held to a different standard than other formulary designs.

Examples of drugs that had a relatively high rate of non-concordance for their tier placement included:

- Dupilumab: Six payers (UnitedHealthcare, Anthem, Elixir, Blue Shield of California, HCSC, and Florida Blue) did not have this drug on the lowest relevant tier, and no alternatives in class are available for atopic dermatitis. Dupilumab serves as an important example of a specialty drug that, at the time of this analysis, did not face competition in this indication. Payers commented that a common approach for such drugs is to start them off at the highest tier, even if they are deemed to be fairly priced, so that placement on a lower tier can be used later as an incentive to lower the price further when there are competing agents available.

- Plasma-derived C1-INH: Seven payers (MedImpact, Cigna, Anthem, MC-RX, Elixir, Blue Shield of California, and Highmark) did not have this drug on the lowest relevant tier and no alternatives in class are available for hereditary angioedema (HAE).

- Emicizumab: Six payers (CVS Health, Cigna, Anthem, MC-RX, Elixir, and MedImpact) did not have this drug on the lowest relevant tier and although factor replacement is an alternative, it is not considered an equivalent option in the same class.

- Rimegepant and ubrogepant: Six payers (Express Scripts, Blue Shield of California, HCSC, Florida Blue, Highmark, and BCBS Minnesota) did not cover any CGRP inhibitors for acute treatment of migraines at the lowest relevant tier.

2. Clinical eligibility

- Emicizumab: Three payers (Cigna, HCSC and Florida Blue) in their pharmacy benefit coverage of this drug have restrictions based on severity of disease qualified by having bled or deemed need by virtue of having low factor levels, neither of which are in the label nor supported by clinical guidelines.

- Tisagenlecleucel: Two payers (Anthem and Highmark) required patients to have a Karnofsky or Lansky performance score greater than or equal to 50% (Anthem) or greater than or equal to 70% (Highmark), and an ECOG performance status <2, eligibility criteria not mentioned in the label or in clinical guidelines.

- Axicabtagene ciloleucel: Two payers (Anthem and Highmark) required that patients have ECOG status <2, a requirement neither in the label nor in clinical guidelines.

- Onasemnogene abeparvovec: Two payers (Anthem and BCBSMN) required patients have two copies or less of the SMN2 gene, which is more restrictive than the FDA label and clinical guidelines. One payer (UnitedHealthcare) had a policy in place as of June 30, 2021 that restricted access for presymptomatic patients aged six months to two years by requiring that patients had been treated with either risdiplam or nusinersen.

3. Step therapy

- Dupilumab: Two payers (Kaiser and MC-RX) require that patients step through both systemic therapies and UVB phototherapy, whereas access to UVB phototherapy is problematic for many patients.

- Emicizumab: Two payers (Unitedhealthcare and Florida Blue) require patients with mild to moderate hemophilia to step through a factor replacement product, a step not concordant with fair access criteria given the reduction in trough factor levels with emicizumab and the notably different delivery mechanism of this drug that is preferable to most patients. In addition, emicizumab is cost saving versus factor replacement and therefore does not meet economic criteria justifying step therapy.

Concordance by Drug

Because the drugs included in our analysis could be covered under pharmacy benefits, medical benefits, or both (see Table 10 below), we had to decide how to report the findings in a way that conveys fair "apples to apples" comparisons across formularies. For drugs for which both a pharmacy benefit policy and a medical benefit policy were available for an individual payer, we selected the benefit plan type that was used by the greatest number of payers overall (i.e., the "predominant benefit plan type") to represent the prior authorization information for that payer. As shown in Table 10 below, two drugs (insulin degludec for diabetes and rivaroxaban for cardiovascular disease) had coverage policies that met all fair access criteria across all 15 formularies. All other drugs (26) were covered by at least one formulary that did not meet one or more criteria.

Table 10. Concordance with Fair Access Criteria by Drug: Number (%) of Payers with Concordant Policies out of Payers with Relevant Policies Available

	Predominant Benefit Plan Type	Cost Sharing	Clinical Eligibility	Step Therapy	Prescriber Restrictions
Drug (Indication)	*(n/N)*	*Concordant Policies, n/N (%)*	*Concordant Policies, n/N (%)*	*Concordant Policies, n/N (%)*	*Concordant Policies, n/N (%)*
Afatinib (Non-small cell lung cancer)	Pharmacy (15/15)	12/15 (80%)	11/11 (100%)	11/11 (100%)	11/11 (100%)
Alemtuzumab (Multiple sclerosis)	Medical (11/15)	3/4 (75%)	11/11 (100%)	12/12 (100%)	12/12 (100%)
Alirocumab (Prevention of cardiovascular events)	Pharmacy (15/15)	12/14 (86%)	11/11 (100%)	13/13 (100%)	11/11 (100%)
Apremilast (Plaque psoriasis)	Pharmacy (15/15)	12/15 (80%)	13/13 (100%)	14/14 (100%)	13/13 (100%)
Axicabtagene ciloleucel (Adult aggressive B-cell lymphoma)	Medical (9/10)	1/1 (100%)	7/9 (78%)	9/9 (100%)	9/9 (100%)
Brodalumab (Plaque psoriasis)	Pharmacy (13/15)	10/13 (77%)	10/11 (91%)	11/11 (100%)	11/11 (100%)
Dupilumab (Atopic dermatitis)	Pharmacy (15/15)	9/15 (60%)	14/14 (100%)	13/15 (87%)	15/15 (100%)
Elagolix (Endometriosis)	Pharmacy (15/15)	11/15 (73%)	9/9 (100%)	9/9 (100%)	9/9 (100%)
Emicizumab (Hemophilia A)	Pharmacy (13/15)	7/13 (54%)	8/11 (73%)	9/11 (82%)	11/11 (100%)
Erenumab (Chronic migraine)	Pharmacy (14/15)	14/15 (93%)	12/12 (100%)	13/13 (100%)	13/13 (100%)
Fremanezumab (Chronic migraine)	Pharmacy (13/14)	12/13 (92%)	11/11 (100%)	12/12 (100%)	12/12 (100%)
Gefitinib (Non-small cell lung cancer)	Pharmacy (14/15)	11/14 (79%)	4/4 (100%)	4/4 (100%)	4/4 (100%)
Guselkumab (Plaque psoriasis)	Pharmacy (14/14)	11/14 (79%)	14/14 (100%)	14/14 (100%)	14/14 (100%)
Icosapent ethyl (Cardiovascular disease)	Pharmacy (15/15)	11/15 (73%)	6/6 (100%)	6/6 (100%)	6/6 (100%)
Infliximab (Plaque psoriasis)	Medical (10/13)	2/3 (67%)	12/12 (100%)	13/13 (100%)	13/13 (100%)
Infliximab (Rheumatoid arthritis)	Medical (10/14)	3/4 (75%)	12/12 (100%)	12/12 (100%)	13/13 (100%)
Insulin degludec (Diabetes mellitus)	Pharmacy (15/15)	15/15 (100%)	13/13 (100%)	13/13 (100%)	13/13 (100%)
Ixekizumab (Plaque psoriasis)	Pharmacy (15/15)	12/15 (80%)	12/12 (100%)	13/13 (100%)	12/12 (100%)

	Predominant Benefit Plan Type	Cost Sharing	Clinical Eligibility	Step Therapy	Prescriber Restrictions
Drug (Indication)	*(n/N)*	*Concordant Policies, n/N (%)*	*Concordant Policies, n/N (%)*	*Concordant Policies, n/N (%)*	*Concordant Policies, n/N (%)*
Olaparib (Deleterious germline BRCA-mutated advanced ovarian cancer)	Pharmacy (14/14)	9/14 (64%)	11/11 (100%)	11/11 (100%)	11/11 (100%)
Onasemnogene abeparvovec (Spinal muscular atrophy)	Medical (10/11)	1/1 (100%)	7/10 (70%)	10/10 (100%)	10/10 (100%)
Plasma-derived C1-INH (Hereditary angioedema)	Pharmacy (15/15)	8/15 (53%)	10/10 (100%)	10/10 (100%)	10/10 (100%)
Rimegepant (Acute treatments for migraine)	Pharmacy (15/15)	9/15 (60%)	8/8 (100%)	10/10 (100%)	10/10 (100%)
Rivaroxaban (Cardiovascular disease)	Pharmacy (15/15)	14/14 (100%)	15/15 (100%)	15/15 (100%)	15/15 (100%)
Sacubitril/valsartan (Congestive heart failure)	Pharmacy (15/15)	12/15 (80%)	6/7 (86%)	8/8 (100%)	7/7 (100%)
Secukinumab (Plaque psoriasis)	Pharmacy (14/15)	11/14 (79%)	11/11 (100%)	11/11 (100%)	11/11 (100%)
Tisagenlecleucel (Pediatric B-cell acute lymphoblastic leukemia)	Medical (11/12)	1/1 (100%)	9/11 (82%)	11/11 (100%)	11/11 (100%)
Ubrogepant (Acute treatments for migraine)	Pharmacy (15/15)	9/15 (60%)	10/10 (100%)	12/12 (100%)	11/11 (100%)
Ustekinumab (Plaque psoriasis)	Pharmacy (15/15)	12/15 (80%)	13/13 (100%)	14/14 (100%)	13/13 (100%)

BRCA: breast cancer gene**,** C1-INH: C1 esterase inhibitor, n: number, N: total number
Note: denominators vary due to differing numbers of available policies across formularies

Because overall concordance with the fair access criteria was so high, there is little variation across drugs by which to explore correlation with features of the drug, drug class, or condition. However, the findings for one drug stands out. The single drug with notably lower rates of concordance across cost sharing, clinical eligibility criteria, and step therapy, is emicizumab for hemophilia A. This is one of the most expensive drugs among those in this assessment, and it is used chronically, unlike the one-time CAR-T and gene therapy treatments that round out the most expensive drugs in this list. Emicizumab is also a drug for which there are alternative treatments, albeit treatments

that are more expensive on an annual basis. Therefore, it may not be surprising that the utilization management of emicizumab is more restrictive than for other drugs in this assessment.

In Tables 11 and 12 below we show the results of an analysis of the rate of concordance for drugs stratified into two groups: those with an annual price below and those above the median price for all drugs in this assessment ($28,010). Although there is limited variation in concordance overall, we did find that drugs priced above the median had lower rates of concordance, particularly for cost sharing (72% vs. 81%). This finding could, in part, be due to the routine placement of more expensive drugs on the highest specialty tier in four-tier formularies, but it is also likely that the higher cost influenced in some way not only tiering but also considerations related to clinical eligibility criteria and step therapy.

Table 11. Rate of Concordance Among Drugs Below Median Price

Drugs Below Median	Annual Net Price*	% Concordance with Selected Fair Access Criteria			
		Cost Sharing	Clinical Eligibility	Step Therapy	Provider Qualifications
Rivaroxoban	$1,650	100%	100%	100%	100%
Fremanezumab	$1,839	92%	100%	100%	100%
Erenumab	$2,167	93%	100%	100%	100%
Alirocumab	$2,984	86%	100%	100%	100%
Icosapent ethyl	$3,241	80%	100%	100%	100%
Sacubitril/valsartan	$3,847	80%	86%	100%	100%
Ubrogepant	$4,523†§	60%	100%	100%	100%
Rimegepant	$4,542†‡	60%	100%	100%	100%
Insulin degludec	$4,723	100%	100%	100%	100%
Infliximab (rheumatoid arthritis)	$7,371	75%	100%	100%	100%
Elagolix	$7,731	73%	100%	100%	100%
Infliximab (psoriasis)	$12,285	67%	100%	100%	100%
Brodalumab	$26,530	77%	91%	100%	100%
Apremilast	$26,762	80%	100%	100%	100%
Average for Drugs Below Median Price	-	**81%**	**99%**	**100%**	**100%**

* Average prices net of all discounts and rebates, October 2019 – September 2020, obtained from SSR Health, LLC. For prices not available or deemed unreliable, prices were taken from the Federal Supply Schedule (FSS).

† FSS prices, October 2019 – September 2020.

‡ Prices were only available for July – September 2020.

§ Prices were only available for March – September 2020.

Table 12. Rate of Concordance Among Drugs Above Median Price

Drugs Above Median	Annual Net Price*	% Concordance with Selected Fair Access Criteria			
		Cost Sharing	Clinical Eligibility	Step Therapy	Provider Qualifications
Ixekizumab	$29,257	80%	100%	100%	100%
Dupilumab	$29,432	60%	100%	87%	100%
Secukinumab	$32,278	79%	100%	100%	100%
Ustekinumab	$35,952	80%	100%	100%	100%
Guselkumab	$36,176	79%	100%	100%	100%
Afatinib	$64,240†	93%	100%	100%	100%
Gefitinib	$93,440†	79%	100%	100%	100%
Olaparib	$159,001†	64%	100%	100%	100%
Alemtuzumab	$165,777†	75%	100%	100%	100%
Plasma-derived C1-INH	$362,283†	53%	100%	100%	100%
Axicabtagene ciloleucel	$373,000†	100%	78%	100%	100%
Tisagenlecleucel	$474,387†	100%	92%	100%	100%
Emicizumab	$558,870	54%	73%	82%	100%
Onasemnogene abeparvovec	$1,613,126†	100%	70%	100%	100%
Average for Drugs Above Median Price	-	**72%**	**93%**	**97%**	**100%**

C1-INH: C1 esterase inhibitor

*Average prices net of all discounts and rebates, October 2019 – September 2020, obtained from SSR Health, LLC. For prices not available or deemed unreliable, prices were taken from the Federal Supply Schedule (FSS).

† FSS prices, October 2019 – September 2020.

Although overall rates of concordance were very high for step therapy, we found wide variation in some cases in the number of steps required before receiving coverage for the fairly priced drug. As noted earlier, the fair access criteria for step therapy do not currently factor in the number of steps as long as each earlier step treatment meets all the fair access criteria for fair access. However, we acknowledge that for patients the difference can be immense between a requirement to try one treatment first and a requirement to try three, or five, or 10. This consideration will lead to further dialogue with stakeholders and the potential for a future addition to the fair access criteria. For this current assessment, we did not assign a failure rating to step therapy policies based on the number of steps, but we present in Table 13 below the range of steps for each drug to characterize more fully all the step therapy policies in this assessment.

Table 13. Number of Steps Required for Prior Authorization by Drug

Drug (Generic)	Most Common # of Steps	Range	Formularies with Highest Number of Steps
Afatinib	0	0	All identical
Alemtuzumab	3	0-3	CVS
Alirocumab	1	0-3	BCBSMA
Apremilast	1	0-2	Blue Shield of CA
Axicabtagene ciloleucel	2	0-2	CVS, UnitedHealthcare, Anthem, Blue Shield of CA, HCSC, Florida Blue, BCBSMN
Brodalumab	3	1-10	Elixir
Dupilumab	2	1-4	Kaiser
Elagolix	1	1-3	UnitedHealthcare
Emicizumab	1	1	UnitedHealthcare, Florida Blue
Erenumab	2	0-3	Express Scripts and BCBSMA
Fremanezumab	3	0-4	Blue Shield of California
Gefitinib	0	0	All identical
Guselkumab	1	0-6	Elixir
Icosapent ethyl	0	0-1	BCBSMN, Florida Blue
Infliximab	-	-	-
Plaque psoriasis	1	0-3	BCBSMA, Elixir
Rheumatoid arthritis	1	0-3	BCBSMA
Insulin degludec	0	0	All identical
Ixekizumab	1	0-10	Elixir
Olaparib	2	0-3	Anthem, BCBSMA, Blue Shield of CA, Florida Blue, Highmark
Onasemnogene abeparvovec	0	0	All identical
Plasma-derived C1-INH	0	0-1	HCSC
Rimegepant	2	0-3	Florida Blue
Rivaroxaban	0	0	All identical
Sacubitril/valsartan	0	0-1	Express Scripts, UnitedHealthcare
Secukinumab	1	1-3	Elixir
Tisagenlecleucel	2	0-4	HCSC, Florida Blue, Highmark
Ubrogepant	2	0-3	Anthem, MedImpact
Ustekinumab	1	0-2	UnitedHealthcare and Blue Shield of CA

BCBSMA: Blue Cross Blue Shield of Massachusetts, BCBSMN: Blue Cross Blue Shield of Minnesota, C1-INH: C1 esterase inhibitor, HCSC: Health Care Service Corporation

Concordance by Formulary

There was very high concordance across all 15 formularies on fair access criteria for clinical eligibility criteria, step therapy, and prescriber restrictions (see Table 14). The one area in which concordance was lowest was in cost sharing, and in this domain there was considerable variation among formularies, most notably those with a four-tier structure versus formularies with lower or higher numbers of tiers. For example, the cost sharing concordance rates for the three four-tier formularies among the 15 analyzed ranged from 23%-36%, compared to 82%-95% for three-tier formularies. As noted earlier, this notable difference in results may reflect business case reasons for higher tier placement in four-tier formularies but may also suggest an important opportunity to improve access for fairly priced drugs.

Table 14. Rate of Concordance by Individual Payer: Number (%) of Policies Meeting Each Fair Access Criterion out of all Available Policies

	Cost Sharing	Clinical Eligibility	Step Therapy	Prescriber Restrictions
Payer/PBM (Largest Formulary)	*Concordant Policies, n/N (%)*	*Concordant Policies, n/N (%)*	*Concordant Policies, n/N (%)*	*Concordant Policies, n/N (%)*
Three-Tier Formularies				
CVS Health/Aetna (CVS Caremark Performance Standard Control w/ Advanced Specialty Control)	20/21 (95%)	22/22 (100%)	22/22 (100%)	22/22 (100%)
Express Scripts PBM (Express Scripts National Preferred with Advantage Plus)	26/28 (93%)	15/15 (100%)	16/16 (100%)	16/16 (100%)
UnitedHealthcare (UnitedHealthcare Advantage Three Tier)	18/22 (82%)	21/22 (95%)	21/22 (95%)	22/22 (100%)
CIGNA Health Plans, Inc. (Cigna Standard Three Tier)	19/22 (86%)	19/20 (95%)	20/20 (100%)	20/20 (100%)
Blue Cross Blue Shield of Massachusetts (BCBS Massachusetts Three Tier)	19/21 (90%)	18/19 (95%)	20/20 (100%)	20/20 (100%)
Florida Blue (Florida Blue Three Tier)	19/22 (86%)	25/26 (96%)	26/27 (96%)	26/26 (100%)
Highmark, Inc. (Highmark Blue Cross Blue Shield 3 Tier)	17/21 (81%)	24/26 (92%)	26/26 (100%)	26/26 (100%)
MC-RX PBM (MC-RX Formulary)	18/20 (90%)	4/4 (100%)	8/9 (89%)	5/5 (100%)
MedImpact Healthcare Systems, Inc (MedImpact Portfolio High Formulary)	21/23 (91%)	6/6 (100%)	11/11 (100%)	10/10 (100%)
Blue Cross Blue Shield of Minnesota (BCBS of Minnesota FlexRx ThreeTier)	19/22 (86%)	21/22 (95%)	23/23 (100%)	22/22 (100%)
Four-Tier Formularies				
Anthem, Inc. (Anthem Essential Four Tier)	5/22 (23%)	23/27 (85%)	27/27 (100%)	27/27 (100%)
Elixir PBM (Elixir Standard Formulary)	9/25 (36%)	12/12 (100%)	15/15 (100%)	15/15 (100%)
Blue Shield of California (Blue Shield of California Plus Formulary)	6/21 (29%)	28/28 (100%)	28/28 (100%)	28/28 (100%)
Other				
Health Care Service Corporation (BCBS of Illinois Basic 6 Tier)	18/22 (82%)	25/26 (96%)	26/26 (100%)	26/26 (100%)
Kaiser Foundation Health Plans, Inc. (Kaiser Permanente Southern California 2 Tier)	20/20 (100%)	27/27 (100%)	24/25 (96%)	26/26 (100%)

BCBS: Blue Cross Blue Shield, PBM: Pharmacy Benefit Manager

Changes to Payer Policies After June 30, 2021

Draft results of this analysis were shared with all payers on August 12, 2021. Payers were given three weeks to submit comments and were invited to provide corrections, updates, and perspectives that might justify any policy not meeting fair access criteria. As part of the feedback

received from payers, we were advised of several coverage policies that had been or were in the process of being changed in ways that would meet fair access criteria. Most of these changes affected tier placement, however some reflected changes to clinical eligibility criteria. In order to preserve the integrity of the analysis, we have not included these changes in the primary results presented above. But to capture the status of these policies as of the time of the publication of this report, and to suggest how coverage policies may evolve to meet fair access criteria, we summarize these changes in Table 15 below and calculate the hypothetical updated concordance rate based on those changes.

Table 15. Changes to Payer Policies After June 30, 2021

Payer	Policy Change	Now Meets Criteria?	Concordance with Policy Change Included
Anthem, Inc.	Removed its prior authorization criteria for sacubitril/valsartan, effective August 1, 2021 (see updated policy)	Yes	Clinical Eligibility: 24/27 (89%)
Blue Cross Blue Shield of Minnesota	Added rimegepant to its formulary in a preferred brand position, effective October 1, 2021 (see updated policy)	Yes	Cost Sharing: 21/22 (95%)
	Added ubrogepant to its formulary in a preferred brand position, effective October 1, 2021 (see updated policy)	Yes	Cost Sharing: 21/22 (95%)
Blue Cross Blue Shield of Massachusetts	Updated step therapy criteria for alirocumab to no longer require additional trials of statins for patients who are stable on a high-potency statin in combination with ezetimibe. This change is effective July 1, 2021 (see updated policy)	Yes	Step therapy: 20/20 (100%)
	Updated clinical eligibility criteria for brodalumab and other non-preferred drugs to require a diagnosis of moderate-to-severe plaque psoriasis (previously severe plaque psoriasis). ICER was alerted to this change on August 30, 2021 (see updated policy).	Yes	Clinical Eligibility: 19/19 (100%)
Elixir PBM	Will be moving elagolix from its specialty tier to Tier 2 (Preferred Brand),* effective January 1, 2022.	Yes	Cost Sharing: 10/25 (40%)
Florida Blue	Moved dupilumab from Tier 3 (Non-Preferred Brand) to Tier 2 (Preferred Brand), effective October 1, 2021 (see updated formulary).	Yes	Cost Sharing: 22/22 (100%)
	Moved ubrogepant from Tier 3 (Non-Preferred Brand) to Tier 2 (Preferred Brand), effective October 1, 2021 (see updated formulary).	Yes	Cost Sharing: 22/22 (100%)
	Moved rimegepant from Tier 3 (Non-Preferred Brand) to Tier 2 (Preferred Brand), effective October 1, 2021 (see updated formulary).	Yes	Cost Sharing: 22/22 (100%)
UnitedHealthcare	Removed criteria that differentiates between symptomatic infantile onset and later onset SMA, effective July 1, 2021 (see updated policy)	Yes	Clinical Eligibility: 22/22 (100%)

*Updated tiering information was received through personal communication with Elixir.

Discussion

This assessment set out to use a pre-existing database on payer coverage policies to evaluate whether policies for drugs considered to be fairly priced in ICER reviews were covered in concordance with fair access criteria for cost sharing, clinical eligibility criteria, step therapy, and prescriber restrictions that could be evaluated from the content of available policies. As noted in the introduction, this assessment was not able to evaluate critical elements of how these coverage policies are administered in the real world, including their level of documentation burden, how transparent and efficient the prior authorization process is to clinicians and patients, and how responsive payers are to requests for medically appropriate exceptions. This, and other limitations noted in the Introduction and throughout this report, are important in framing the results of the assessment, which found a high level of concordance of coverage policies with fair access criteria across the formularies with the highest number of covered lives of large private payers in the United States.

For further context, it is important to emphasize that the assessment was limited to drugs that were judged to be priced fairly in ICER reviews. It is not known whether these results would be consistent with those for drugs that have not been found to be priced in alignment with reasonable cost-effectiveness standards. This question should be the focus of future research. In addition, it is possible that the 15 formularies selected for this assessment provide coverage more consistent with fair access criteria than formularies covering fewer individuals offered by the same payers, or than formularies from smaller payers. Therefore, the results of this current assessment should not be taken as a general reflection of whether payers are providing fair access to drugs in the United States.

As noted, we are aware of 10 coverage policies that were changed by payers after they received draft results of this assessment. In some cases, these changes were minor clarifications of clinical eligibility criteria, but other policy changes included more substantial broadening of coverage or important shifts in tiering placement that would lead to lower out-of-pocket cost sharing for patients. Insurers and PBMs may continue to reflect further on their own procedures and approaches to coverage determination, and we encourage patient advocates and clinicians to continue to engage on these issues. We believe that the changes made during this assessment suggest an openness and an opportunity to use fair access criteria to achieve a more consistent approach to providing fair access for drugs.

The results of this assessment suggest that for the subset of fair access criteria we could evaluate, the large majority of coverage policies across these formularies are structured to provide fair access for the drugs ICER has deemed to be fairly priced. This does not mean that payers provide access without prior authorization or step therapy. These tools can be based on solid, reasonable

interpretation of the available clinical evidence and are used to target coverage to patients for whom the benefits of treatment have been demonstrated. Payers have a responsibility to use evidence to establish prudent limits to coverage, and when structured appropriately and administered well, these policy tools can in many cases be important in protecting patients from the risks of care outside of established evidentiary boundaries. Prior authorization thus can advance the best interests of patients while also serving a role in prudent stewardship of the premium dollars of all health plan enrollees.

Nonetheless, the results of this report do not negate findings from other work documenting the barriers that coverage policies can present to appropriate, timely care. For example, a 2018 Physician Survey conducted by the American Medical Association on prior authorization found that 65% of providers had to wait, on average, at least one business day within the previous week before receiving a prior authorization decision from a health plan, and 26% of providers waited three business days or more.[2] A recent compilation and analysis of the existing peer-reviewed and professional literature estimated that payers, manufacturers, physicians, and patients together incur approximately $93.3 billion in costs annually on implementing, contesting, and navigating utilization management.[3] It should also be remembered that even the best prior authorization protocols impose an administrative burden on patients and clinicians that can create a barrier to fair access unless implementation is done well. Patients can suffer important delays in receiving care they and their clinicians have determined is needed. Patients' health outcomes can be affected, and clinicians have cited the burden of prior authorization as one of the leading causes of burnout.[4]

The concerns are equal if not more for policies requiring step therapy beyond that included as part of the FDA label. Although step therapy is also justified when used to encourage use of safer, better established treatment options, the ethical tension inherent in maintaining fair access becomes extremely visible to patients and clinicians, and access is constrained not just by differential cost sharing but by a coverage on-off switch. Not surprisingly, some studies have demonstrated negative effects on patient outcomes related to step therapy, and there has been a consistent push from many patient groups, clinical societies, and commentators to add meaningful consumer protections and transparency to step therapy policies not rooted in the FDA label.[5]

Because our assessment could not include evaluation of whether implementation processes of these formulary policies met the implementation criteria provided in the original white paper, we provide below anecdotes suggested by members of our Working Group as indicative of serious problems that patients can experience even if the design and content of coverage policies meet fair access criteria. These anecdotes come from a variety of sources and have not been validated but we believe they are useful to provide context to the results of this current assessment:

Cost sharing

1. An 18-year-old person with a seizure disorder was prescribed Vimpat, a brand name drug with a list price over $1,000 per month. This person had been paying $50 copayment per month as the only cost sharing throughout all of 2020. The drug coverage plan changed in January of 2021, pushing the medication to a higher tier that required co-insurance at $700 per month. No alternative medications were available due to previous side effects. The provider's office therefore requested a tier exception but the plan denied the request stating it was not allowed. The person with epilepsy used a copay assistance card provided by the manufacturer and exhausted the maximum $1300 annual allowance. Alternative insurance may be the only option left (National Patient Advocate Foundation, email communication, June 2021).

Clinical Eligibility Criteria and Step Therapy

1. An insurance company provided a patient coverage for a drug for migraine in 2018 and covered it until September 2019, when the company informed the patient that they would no longer cover it unless the patient tried two other drugs (Ajovy, Emgality) first without adequate response. But the patient had been doing well on the current medication and did not want to go through the trial and error of trying other drugs (National Patient Advocate Foundation, email communication, June 2021).

2. Patient communication: I have been living with psoriasis and psoriatic arthritis for most of my life…. After years of trying various medications and treatments, including injectable biologics and light therapy treatments, last January, my doctor told me about a new medication on the market that was showing great promise for psoriasis and psoriatic arthritis. My doctor thought the treatment might work but warned me that insurance companies were repeatedly denying prescriptions.

   As predicted, the first prescription my doctor wrote was denied. I was told I would have to try and fail on other medications before the insurer would consider covering the prescribed medication. Following intensive follow-up by my doctor, my insurer relented -- somewhat. They offered to help cover the cost of the drug, but my monthly out of pocket costs for the medication would be $1,000 -- who could possibly afford that?[6]

3. Patient communication: In order to "prove" I needed the medication, the insurance company told me I needed to fail on two biologic injectable medications -- despite the fact my doctor, the staff in his office, and I repeatedly told the insurer that I have tried -- and failed -- on those same medications in the past. We also told them that not only had I tried and failed these medications that they were trying to force me to take had actually made my condition worse in the past. It didn't matter to them.[6]

4. Patient communication: I first learned about step therapy when I began the treatment process for my arthritis a few years ago. My insurance company would only approve treatments in a certain order, like steps up a ladder. First, I had to use a chemotherapy drug that gave me a severe reaction. Then, my doctor had to fight to get me started on an injected treatment, but this medicine only worked for a short period of time before it stopped helping me. Next, I had to get a type of biologic infusion that requires another medication to prevent the body from making antibodies. Except I couldn't take that medication, which meant my body made the antibodies and that treatment stopped working. I have no idea how those antibodies could affect me in the future. Now my newest infusion treatment is also failing after only five months, and most days I have to use my wheelchair.

   My mom spends hours on the phone fighting to get my treatments approved by the insurance company. Now that my current treatment is failing, my doctor is already talking about how we may have to fight the insurance company for it. I have an amazing doctor who has always been a strong advocate for my family and me, but just recently he moved out of state. To be able to see him, my mom and I drive 15 hours to Arkansas every few months because we don't want to start all over with a new doctor.

   I know my parents are extremely frustrated by all the steps I've had to take and the treatments that I was forced to take even when we knew they would fail. Just thinking about step therapy makes me sick. Insurance is making me wait for the medication that I need to get healthy.

   In a way, step therapy is hurting me, making me sicker at times due to the steps I have to take to get better medicine. I could have been on a drug that might have worked from the beginning, but I needed to take these "steps," and this is why I am advocating to change this. I want to be a voice for all the children that can't speak up or won't be taken seriously. Step therapy has failed me, but I want to keep pressing on. I live my life remembering that the most important thing is to never let anything dull your sparkle, not even Juvenile Arthritis.[6]

Conclusion

This assessment has been presented as much as a sign of the limitations in the evidence available to us – and to the public – as it has a report that can give important insights into the current status of insurance coverage for drugs in the US. As such, it is likely to fully satisfy no one. It will leave some patient advocates and clinician representatives feeling a disconnect between the overall high marks given to payer formularies and their lived experience with cost sharing and prior authorization. Conversely, payers may feel that too much emphasis has been given to the minority of examples in which coverage policies were judged not to meet fair access criteria, and, in particular, that there are contextual factors behind tiering decisions and the actual amounts that patients pay out of pocket that render our judgments superficial and potentially misleading.

All are right to some extent. Perhaps the most salient conclusion from this assessment is that there should be greater transparency regarding how insurers frame and implement their coverage policies. Transparency certainly for affected patients and their clinicians, but also for the broader research community and the public. Coverage policies and tiering have been treated by some companies as competitive assets, held in confidence, and used to seek advantages against rivals. Other payers post all their policies publicly. Only with greater transparency across the entire industry will payers be able to demonstrate fully their commitment to the appropriate application of evidence to insurance coverage. And only with greater transparency will payers' call for fair pricing be heard by the public with the power it deserves.

However, despite the gaps in transparency and the other limitations we have highlighted, we hope this report is a first step that stimulates further action. Payers should be accorded credit where credit is due: the evidence available and the limitations of our research effort leave many questions, but the great majority of payer policies in the formularies evaluated are structured in a way to support many key elements of fair access. In addition, the changes in coverage policies noted following initial assessment are an early sign that payers are listening, and that transparency may lead to positive change. This assessment was never meant to produce a definitive evaluation of fair access for pharmaceuticals. We hope that it helps move all participants in the health system toward greater understanding and dialogue. In closing, we wish to note again that underlying this effort is the white paper on Cornerstones for Fair Access that was produced with substantial guidance and input from members of the ICER Policy Leadership Forum. We wish to acknowledge and thank the participants in that effort, and also those individuals who gave us continued input as part of our Working Group for this assessment. None of these individuals, or organizations, should be viewed as agreeing with this assessment, and any errors in this paper are solely the responsibility of the authors. To all, however, we give our thanks and our praise for their honesty and willingness to pursue a common goal from different starting points.

References

1. Kaiser Family Foundation, Claxton G, Rae M, Young G, McDermott D, Whitmore H, Kerns J, Cifuentes J, Damico A, Strange L. *Employer Health Benefits 2020 Annual Survey* United States of America October 08, 2020.
2. American Medical Association. 2018 AMA prior authorization (PA) physician survey. https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf. Published 2018. Accessed August 16, 2021.
3. Howell S, Yin PT, Robinson JC. Quantifying The Economic Burden Of Drug Utilization Management On Payers, Manufacturers, Physicians, And Patients. *Health Affairs.* 2021;40(8):1206-1214.
4. Robeznieks A. 1 in 4 doctors say prior authorization has led to a serious adverse event. 2019. https://www.ama-assn.org/practice-management/sustainability/1-4-doctors-say-prior-authorization-has-led-serious-adverse. Published February 05, 2019.
5. Zon RT, Frame JN, Neuss MN, et al. American Society of Clinical Oncology Policy Statement on Clinical Pathways in Oncology. *Journal of Oncology Practice.* 2016;12(3):261-266.
6. Prescription Process. Patient Stories. http://prescriptionprocess.com/patient-stories/. Published 2021. Accessed July 9,2021.