

The Impact of Step-Therapy Policies on Patients

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Key Findings

- While payers think that step therapy has little to no downside in treatment, patients and physicians feel differently.
- Payer requirements for patients to first try a medication that is not preferred for them by their provider resulted in more missed work, more out-of-pocket expenses, and more of a decrease in quality of life—both physically and emotionally—compared to patients who did not experience step therapy.
- Step therapy results in chronically ill patients, like those with rheumatoid arthritis and psoriasis, having to pay more out of their own pockets, leading to increased rates of nonadherence compared to those not experiencing step therapy.
- The significant variation among payer formulary protocols, among and within plans, calls into question the clinical rationale for step therapy and drives concerns that step therapy is motivated by rebates.
- Policies that result in forced drug switching, treatment gaps, and cessation of effective therapy are dangerous to patients because of the potential for disease flares, negative immune responses, adverse effects, and complete loss of response.

Introduction

The doctor-patient relationship sits at the center of the healthcare system. Knowing that physicians have the clinical knowledge and insight into their specific circumstances builds trust and confidence for patients, especially those dealing with chronic illness. However, over the last few years, payers, like employers and health plans, have increasingly inserted themselves into the clinical decision-making process through their use of pharmacy benefit managers (PBMs). This paper, at times, may use the terms “payer” and “PBM” interchangeably due to the integral role that PBMs play in payers’ management of prescription drug costs.

PBMs help payers manage their prescription drug programs through formulary construction and tools that are intended to reduce plan spending on medications. These utilization management (UM) tools restrict patients’ access to medications by requiring additional permissions, forms, and/or medicines before the prescriber’s preferred treatment can be filled. From the vantage point of prescribers and patients, UM tools can interfere with the practice of medicine and limit patient access to preferred treatments. Additionally, UM tools create an administrative burden for provider offices that require significant resources to fulfill payer requirements on behalf of patients.

One of these restrictive UM tools is step therapy. Step therapy requires patients to first try alternate treatments—selected by the PBM—before covering the prescriber’s preferred treatment for that patient. For patients with chronic conditions, especially those with heterogeneous diseases, the lack of patient-specific treatment is harmful; it also allows the disease to worsen, and many times the progression of their disease is irreversible.¹ This begs the question: What **is** driving these requirements, and at what cost to patients?

The objective of this paper is to explore the practice of step therapy. Specifically, using our analysis of interview, survey, and claims data, we will assess the impact step therapy has on key stakeholders within the United States (US) healthcare delivery system.

Payer Management of Prescription Drugs Through PBMs

Many payers (and/or their health plans) use PBMs because of their buying power and ability to manage formularies and prescription drug utilization, while driving rebates from manufacturers in an effort to keep costs down. Today, the largest health plans own or are under the same organizational umbrella as the PBMs who negotiate on their behalf.

One way that PBMs control prescription drug utilization is through formularies. Whereas 20 years ago, formularies might have had 1 or 2 tiers (preferred and nonpreferred), today's formularies have as many as 5 or more tiers. These tiers consist of preferred and nonpreferred generics; preferred and nonpreferred brands; and specialty drugs. Each of these tiers has different cost-sharing requirements for patients. Alongside formularies, PBMs also use a variety of UM tools intended to control costs and implement safety controls, such as quantity limits, prior authorization, non-medical switching, and step therapy.

Quantity Limits

This is when a payer limits the amount of a particular medicine that a patient can receive in a given time by not covering the cost beyond a certain quantity.

Non-medical Switching

This is when a patient is forced to change to a different medication for a non-medical reason. Usually, this is because their original medicine will no longer be covered by the payer.

Prior Authorization

When a prior authorization is required, the payer reviews the pharmacy health plan benefit to determine whether to approve coverage of a certain drug or therapy prescribed by a provider. As a UM tool, payers use prior authorization to ensure that medical necessity for a drug or treatment exists.

Step Therapy

Step therapy is another UM tool used by payers that requires patients to fail first on an alternate (payer-preferred) drug before covering the healthcare provider's originally preferred prescription for that particular patient.

While quantity limits are typically done for safety concerns (eg, limiting the quantity of addictive medication a patient can fill at one time), prior authorization is often used as a check with prescribers—sometimes creating an unsafe delay for patients trying to get a needed medication. The use of non-medical switching (which is out of the purview of this paper) and step therapy are considerably more complicated and contentious. Critics of step therapy highlight that step therapy results in patients facing potentially higher out-of-pocket (OOP) costs and delays in treatment, as they are required to fail first on at least 1—but sometimes several—PBM-preferred treatments that may not work before having access to drugs that their physician may find more effective.

When PBMs develop a health plan's formulary and UM requirements, the primary consideration is managing their costs and the benefits for the plan's overall population—not for individual patients. Unfortunately, this broad, one-size-fits-all approach is a major issue for patients with diseases that are heterogeneous in terms of symptom manifestation and response to drug treatments, such as immunological diseases. Since one patient may respond differently to a treatment than another patient, it means that an individual may be forced to take ineffective medicines that are less costly to the PBM while their disease progresses.

The use of step therapy has increased steadily over the last few years, even expanding into Medicare Part C, also referred to as Medicare Advantage. In Medicare Advantage, beneficiaries assign private insurance companies to manage their Medicare benefits, providing beneficiaries with all-in-one coverage for Medicare Part A (predominantly inpatient services), Part B (physician services and physician-administered drugs), and, usually, Part D (prescription drug program).

In August 2018, the Centers for Medicare & Medicaid Services (CMS) changed its step-therapy policy for Medicare Advantage plans so that as of January 2019, Medicare Advantage plans can choose to use step therapy for Medicare Part B drugs.² This differentiated coverage under Medicare Advantage from original fee-for-service Medicare, which does not permit step therapy for Part B drugs. The increased use of step therapy in Medicare Advantage plans prompted letters to CMS from dozens of medical societies and patient advocacy organizations, including the American Medical Association and the American College of Physicians,³ expressing “serious concerns” regarding the consequences of step therapy both for patients and prescribers.

The Realities of Step Therapy in Practice

In order to better understand the realities of step therapy in practice, Xcenda conducted research in a variety of ways:

- Qualitative, double-blind, 15-minute online survey to better understand the attitudes of payers, specialty physicians (eg, rheumatologists, dermatologists, and gastroenterologists), pharmacists, and patients
- Analysis of commercial, Medicare Part D, and Medicaid plan formularies to understand how payers are managing access and utilization for claims data for rheumatoid arthritis
- Claims data analysis to evaluate access barriers that prevent patients with rheumatoid arthritis and psoriasis from receiving timely or needed therapy
- Robust secondary research to examine the impact of the use of step therapy

Survey Findings

The survey findings for each of the 4 key stakeholder groups interviewed (patients, physicians, pharmacists, and payers) are detailed below, followed by results from the formulary review and claims data analyses.

Patients

Chronically ill patients already face high OOP costs from numerous prescriptions and doctor visits. Requiring these patients to jump through **additional** hoops before receiving the medication that their provider originally prescribed only increases the likelihood of higher OOP costs.

Xcenda’s survey also found that **patients who experienced step therapy were more likely to be nonadherent or pay out of their own pocket for a medication compared to patients who did not experience step-therapy restrictions**. Specifically, results showed that **40% of step-therapy patients stopped taking medicines that did not help, 29% stopped taking medicines due to cost, and 27% stopped taking medicines because the insurance company did not pay for the medicines taken**.⁴



40%

of patients stopped taking medicines that they were forced to step through that did not help



29%

stopped taking medicines due to cost



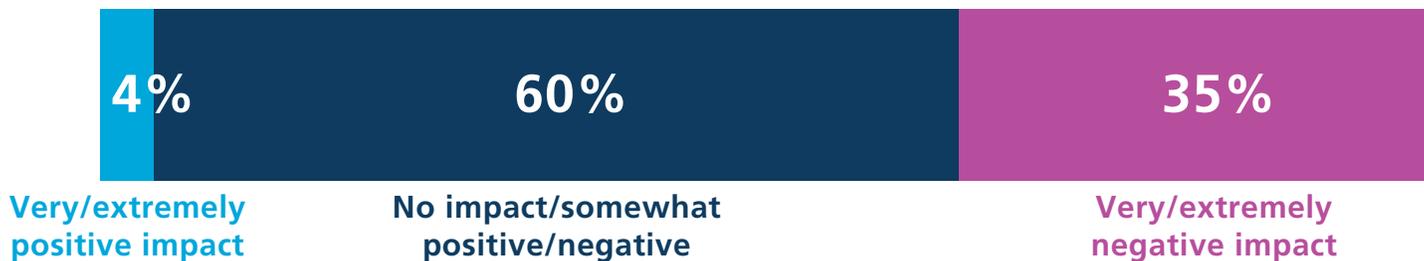
27%

stopped taking medicines because the insurance company did not pay for the medicines taken

If a PBM requires step therapy, particularly for specialty drugs, there may be a number of preferred medications that the patient may need to fail first that still have high cost-sharing. This results in more OOP costs and patients spending even longer periods of time taking medications that may not be effective. Consequently, the patient's wallet is negatively affected and time is lost in achieving the goal of improved health. The Xcenda patient survey found that when comparing consumers who have experienced step therapy with those who have not, there is a statistically significant, although moderate, decline in overall health (13% vs 20%) and quality of life (26% vs 36%).⁴

Xcenda surveyed patients on what was the "one main thing" that gives them the most satisfaction in life. Additionally they were asked what impact, if any, step therapy had on that "one main thing." Slightly over one-third responded that step therapy had a negative effect on that "one main thing" (Figure 1)⁴

Figure 1. Patient Responses to the Impact of Step Therapy on the "One Main Thing" That Gives Them the Most Satisfaction in Life



Patients view physicians and insurance plans as important in helping them get the best medications, but those required to go through step therapy (32%) are more likely than those not required to go through step therapy (12%) to view insurance companies as a barrier to accessing the best possible treatment.⁴ Patients experiencing step therapy are also more likely to believe that they are not taking the best possible medicine because it is not covered (40%).⁴

In addition to reporting less satisfaction with their health insurance, patients experiencing step therapy also reported less satisfaction with costs. Step therapy vs non-step therapy patients were "very/extremely dissatisfied" with their health insurance (23% vs 8%) and the overall cost to them (20% vs 13%).⁴ Additionally, a significant percentage of patients (52%) and friends/family members (44%) who experienced step therapy reported that the restriction "extremely/very negatively" affected their emotional health.⁴

Physicians and Pharmacists

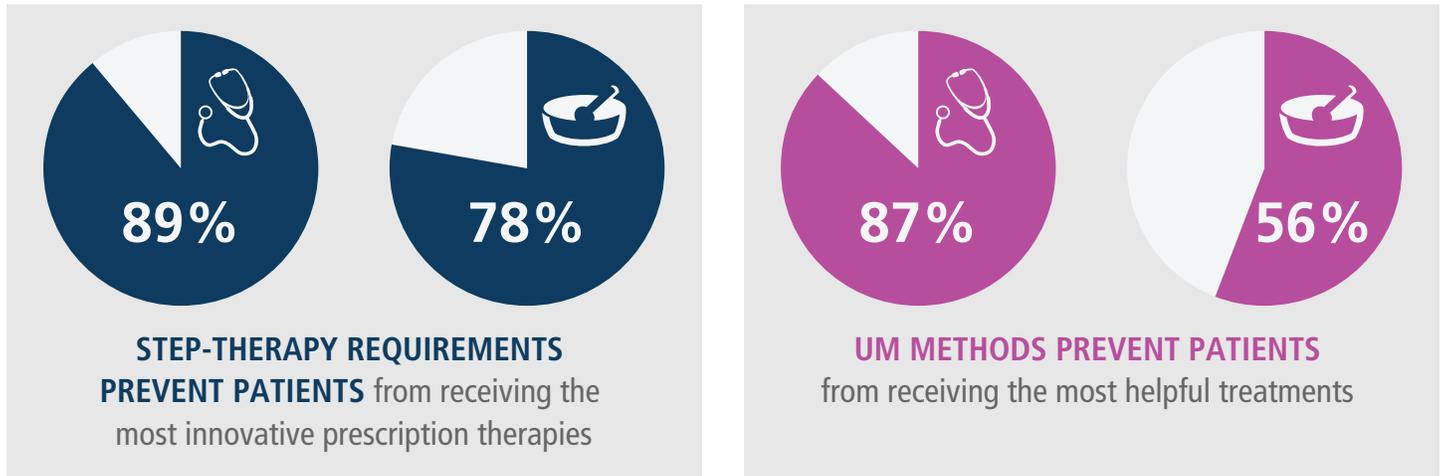
In Xcenda's survey of physicians, respondents said they were concerned that step therapy diminishes the provider-patient relationship and hands their clinical decision-making role over to payers who do not have the complete picture of the individual patient.⁴ Physicians strongly believe that payers should **not** be making treatment decisions. Rather, physicians believe that payers should primarily take into account physician judgment and treatment outcomes when making product-management decisions and cost, whereas Pharmacy & Therapeutics (P&T) committees should be given the **least** consideration.⁴

Physicians reported that while payers benefit financially from step therapy, it does not ultimately result in keeping costs down. The survey found that "prescribers recognize that payers have a financial stake in step therapy, but only 8% 'strongly/ completely agreed' that payers play 'an important role in keeping costs down.'"⁴ Overall, physicians felt that step therapy had a negative impact on patient care and health outcomes, with no measurable benefit in any other areas. While efficacy and safety are key determinants when selecting a medication, **a patient's ability to pay is the top consideration for over half of physicians and patients, according to Xcenda's survey results.**⁴

Pharmacists agree that cost and utilization restrictions are the key challenges for patients and physicians. A big challenge for pharmacists is managing denied medications due to step-therapy policies.⁵ **The pharmacists surveyed indicated that they spend at least 20% of their time simply managing denied medications (due to step therapy), with some reporting that this task consumes 80% of their time.** The negative impact of step-therapy policies on patients would be even greater without the additional time, effort, and resources (additional staff, etc) absorbed by prescribers and pharmacists.⁴

Medical innovation has led to improvements in treatment, quality of life, and health, according to physicians and pharmacists surveyed. Physicians view innovation as a benefit in its own right—one that leads to improved effectiveness and quality of life.⁴ Pharmacists indicate that innovation, while improving patient attitudes, also comes with costs that are concerning to them. In addition, patients don't seem to be focused on innovation, with 60% of those surveyed saying that they were bothered by the high cost of innovative treatments, while 38% of patients wanted to learn about innovation.⁴ Further, 89% of physicians and 78% of pharmacists believe that step-therapy requirements prevent patients with autoimmune diseases from receiving the most innovative prescription therapies, and 87% of physicians and 56% of pharmacists surveyed also said that the UM methods prevent patients from receiving the treatments that could help them most.⁴

Figure 2. Physician and Pharmacist Responses Regarding Impact of Step Therapy and Utilization on Patients



Payers

Overall, the payers that Xcenda surveyed believe that step therapy is not a bad thing, with 83% of payers reporting that they “agreed completely/very much” that step therapy was “a reasonable approach to keeping healthcare costs under control.”⁴

Payers view step therapy as having a strong positive effect on costs with little to no downside to treatment. A majority of surveyed payers (70%) responded that the impact of step therapy was “extremely/very positive” on the “ability to contain plan costs,” **but a full 90% of payers also said that step therapy had “little to no impact” on the physician’s “ability to provide the best guidance and care,” and the remaining 10% reported that step therapy had an “extremely/very positive” impact on this same issue.**⁴

Additionally, nearly 50% of payers responded that step therapy had “little to no impact” on the “ability to optimally treat patients.”⁴ However, this same group of payers also acknowledged that step therapy can create “an administrative burden for physicians” and “be a frustration to patients,” with 27% of payers indicating that they “agreed completely/very much” with each of these statements.⁴

Of the payers Xcenda surveyed, 90% reported that “providing quality care for patients” was “extremely/very important”⁴; however, 73% of payers surveyed also reported that requiring patients to try and fail less expensive therapies prior to covering more expensive therapies (ie, step therapy) was an **equally** important priority.⁴

What might have been most surprising is the reluctance for payers to definitively say that efficacy and safety were more important than cost. When asked if “cost takes priority over efficacy and safety,” 20% of payers “agree completely or very much” and (60%) “neither agree/disagree somewhat” with that statement, while only 20% reported that they “disagree very much/completely” that cost takes priority over efficacy and safety.⁴ Consequently, **only 1 out of 5 payers agree that efficacy and safety are more important than cost,** while 3 out of 5 are ambiguous and the rest view cost as more important.

Payers Response When Asked if Cost Took Priority Over Safety and Efficacy

20% agree | **60%** neither agree/disagree | **20%** disagree

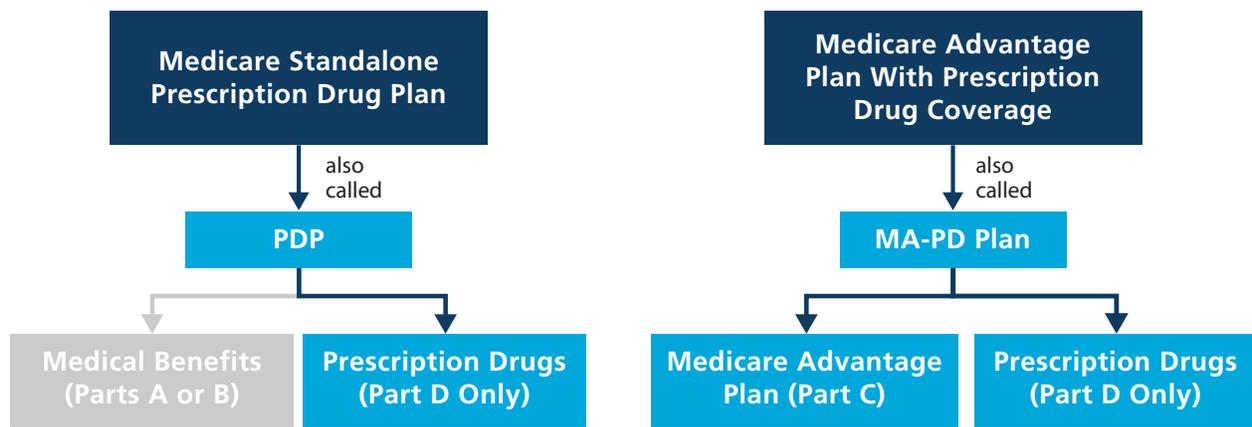
Formulary and Claims Analysis

While the survey findings represent perceptions of the current environment, formulary and claims analyses showcase the quantitative reality of patient access. Xcenda examined UM techniques used by PBMs and utilized claims data to determine delays in treatment for patients with rheumatoid arthritis and psoriasis. These therapeutic areas were chosen because of the concentration of specialty drugs and mix of newer and more established products. The analysis focused on 4 products: Humira®, Enbrel®, Xeljanz®, and Taltz®. These products were chosen because they represent 2 well-established biologics in the marketplace and 2 innovative molecules that have differentiated mechanisms of action. The analysis below is based on plans that covered these 4 therapies. Additional information on the methodology is available in the Appendix.

Formulary Coverage

As a baseline, Xcenda examined formulary coverage in 3 kinds of plans: commercial, Medicare standalone prescription drug plans (PDPs), Medicare Advantage prescription drug (MA-PD) plans, and Medicaid (state Medicaid and managed Medicaid

Figure 3. Medicare Part D Plans: PDP vs MA-PD Plans



Key: MA-PD - Medicare Advantage Prescription Drug; PDP - prescription drug plan.

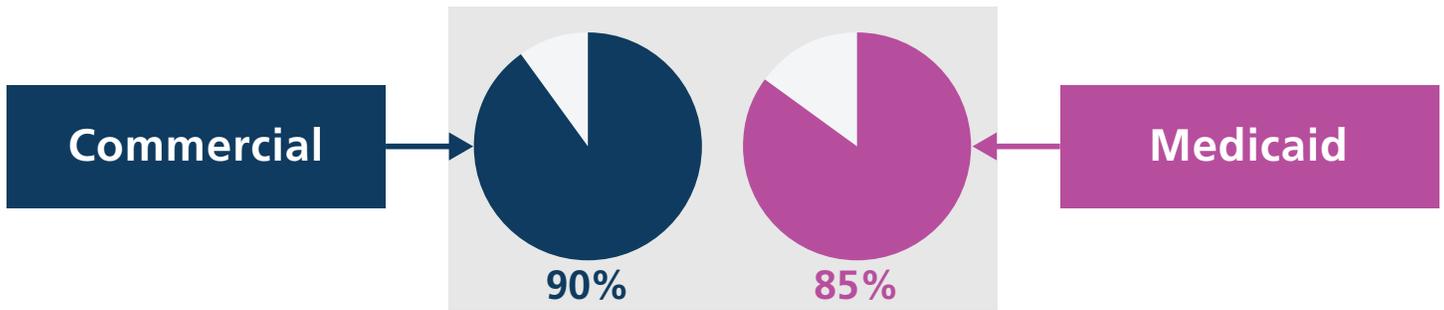
plans) (Figure 3). Note that formulary coverage does not imply how they are covered (cost-sharing or what UM the patient may be subjected to), just whether the drug is on or off the plan's formulary.

Xcenda found that while commercial and Medicaid plans typically had all 4 products (ie, Humira®, Xeljanz®, Enbrel®, and Taltz®) on formulary, both PDP and MA-PD plans were less generous.

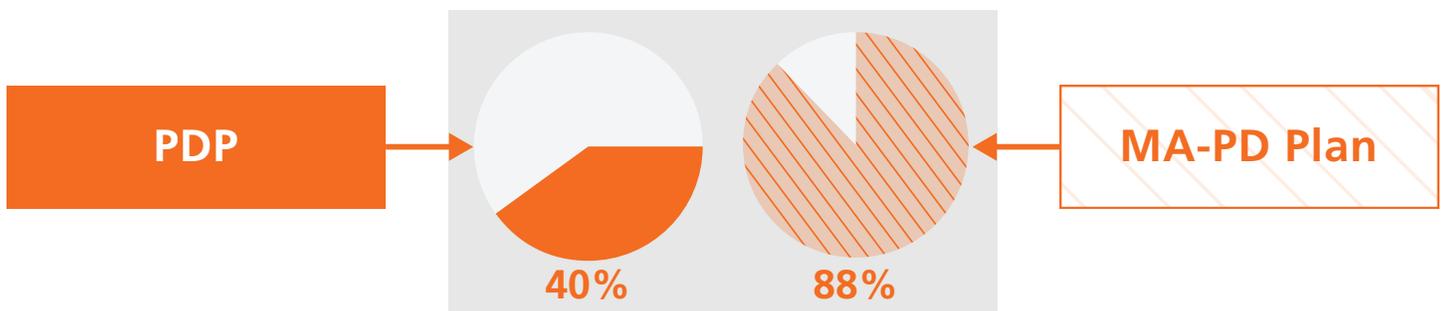
Over 90% of commercial plans and over 85% of Medicaid plans cover all 4 products. In both PDPs and MA-PD plans, there is significantly better coverage for Humira®, Xeljanz®, and Enbrel® compared to Taltz®, with 48% to 95% of MA-PD plans

Figure 4. Plan Formulary Status by Product

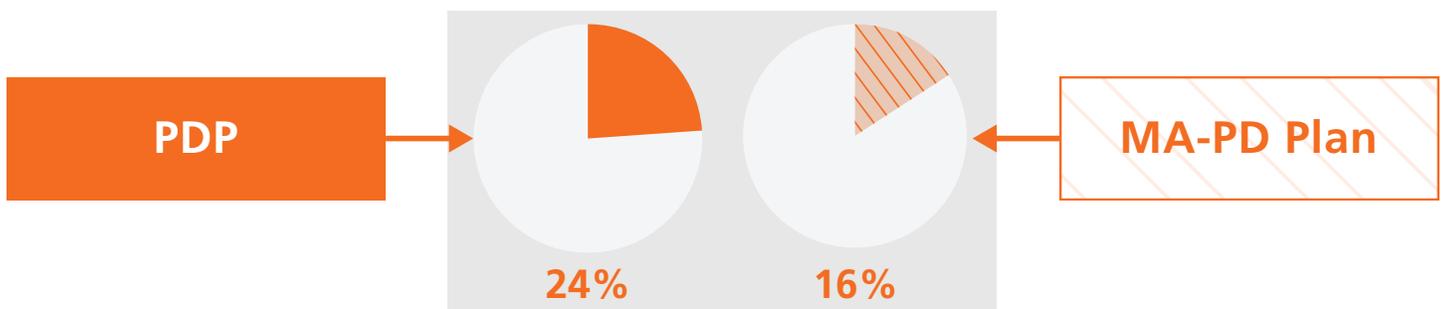
COMMERCIAL AND MEDICAID COVERAGE OF ALL 4 PRODUCTS:
HUMIRA®, ENBREL®, XELJANZ®, TALTZ®



MEDICARE COVERAGE OF ALL 3 PRODUCTS:
HUMIRA®, ENBREL®, XELJANZ®



MEDICARE COVERAGE OF
TALTZ®



Key: MA-PD - Medicare Advantage Prescription Drug; PDP - prescription drug plan.

covering Humira®, Xeljanz®, and Enbrel® and 80% to 92% of PDPs covering Humira®, Xeljanz®, and Enbrel®. Only 20% to 25% of PDPs and MA-PD plans cover Taltz® (Figure 4).

UM Assessment⁶

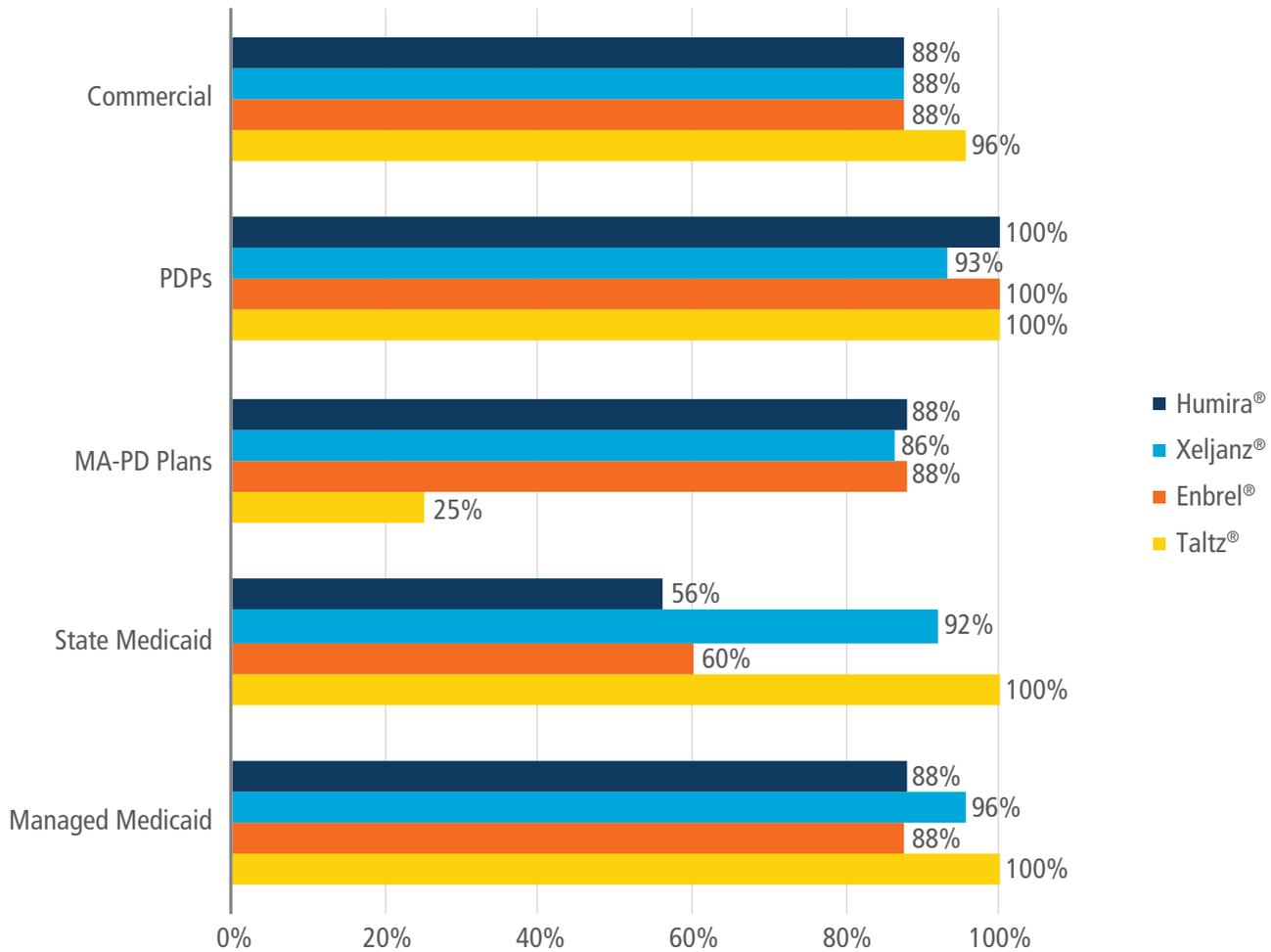
Building on the formulary analysis, Xcenda looked at the plans that covered the products to see what UM methods (eg, prior authorization, step therapy, and quantity limits) were used and how often. Of the plans covering the product in Figure 4, Xcenda found that UM methods were utilized by at least 70% of all plans reviewed in the analysis. Of these, prior

authorization and step therapy were the UM tools used most often.

Prior Authorization

As might be expected with these specialty products, use of a prior authorization requirement was high, with at least 88% of commercial plans requiring prior authorization across all 4 products. In other types of plans, prior authorization was inconsistent between the products. Of the Medicare plans (PDPs and MA-PD plans) that cover Humira®, Enbrel®, and

Figure 5. The Percentage of Plans Imposing Prior Authorizations (of Plans that Cover the Product)



Key: MA-PD - Medicare Advantage Prescription Drug; PDP - prescription drug plan.

Xeljanz®, approximately 90% require a prior authorization. Nearly 70% of Medicaid plans (state and managed) require a prior authorization for Humira® and Enbrel®, while over 90% require a prior authorization for Xeljanz® and Taltz® (Figure 5).

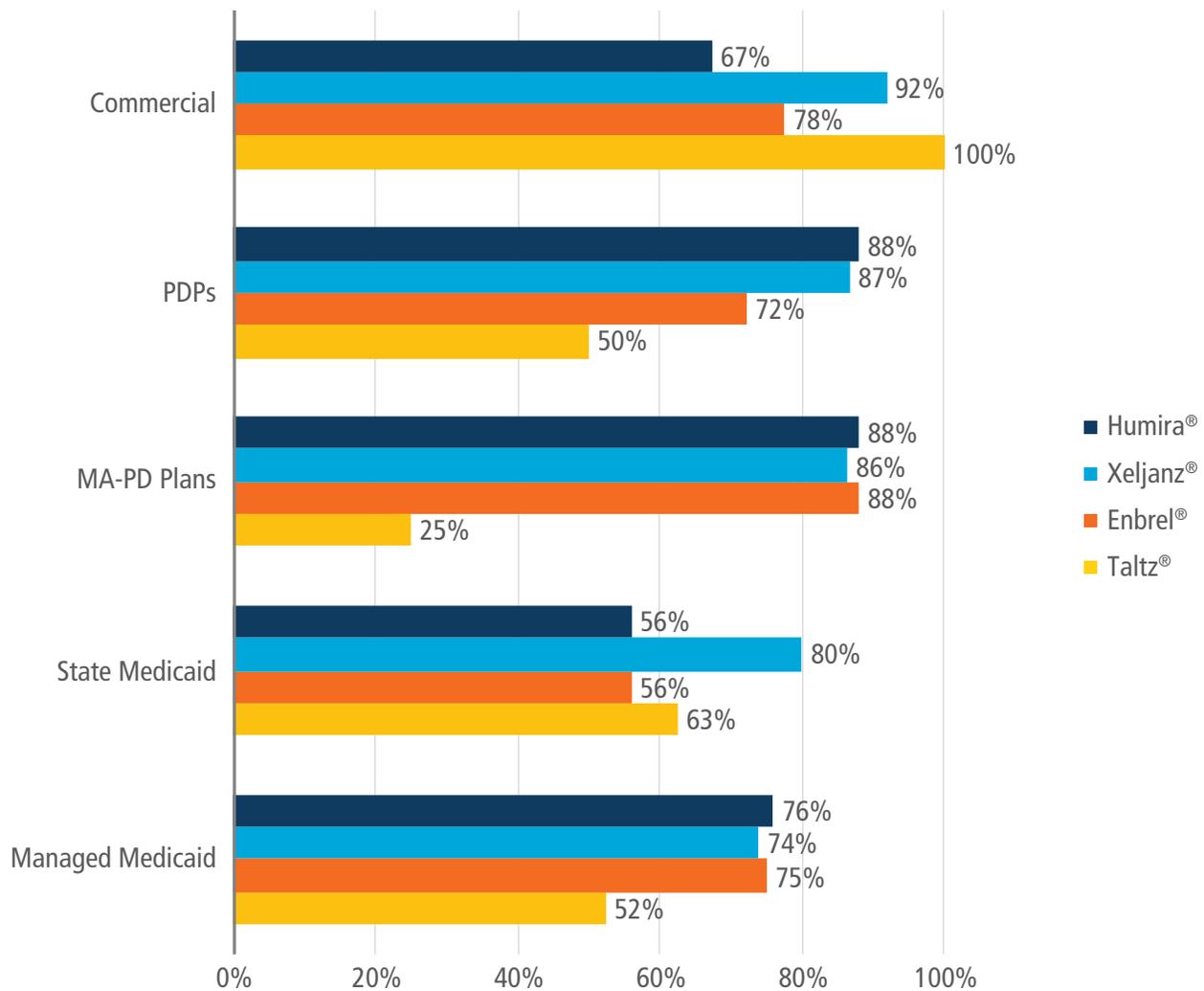
Step Therapy

More interesting was the variation in step therapy use between different types of plans (when they cover the product at all).

- On average, 72% of commercial plans mandate step therapy for Humira® and Enbrel®, while 96% impose step therapy for Xeljanz® and Taltz®.
- Of Medicare plans (standalone PDPs and MA-PD plans) that cover Humira®, Xeljanz®, and Enbrel®, at least 80% impose step therapy on these products, while only 40% require step therapy for Taltz® (although far fewer plans cover Taltz® to begin with).
- Of the plans that cover the products, at least 58% of Medicaid plans (state and managed) mandate step therapy across all 4 products (Figure 6).

These results demonstrate that step therapy is pervasive but not applied in a consistent manner. This is particularly troubling

Figure 6. The Percentage of Plans Imposing Prior Authorizations (of Plans that Cover the Product)



Key: MA-PD - Medicare Advantage Prescription Drug; PDP - prescription drug plan.

when considering the indications and labels for the products. For example, Humira® is indicated for patients who fail methotrexate, and yet almost 30% of plans have no step therapy for Humira®, whereas Xeljanz® and Taltz® are indicated as a monotherapy and have extremely high rates of step therapy.

UM Criteria⁶

Xcenda also reviewed what was needed to overcome the UM requirements for prior authorization and step therapy as a way to gauge access barriers. It becomes clear that there are payer-preferred alternatives, but there is enough inconsistency to bring into question whether it is done for clinical or financial reasons.

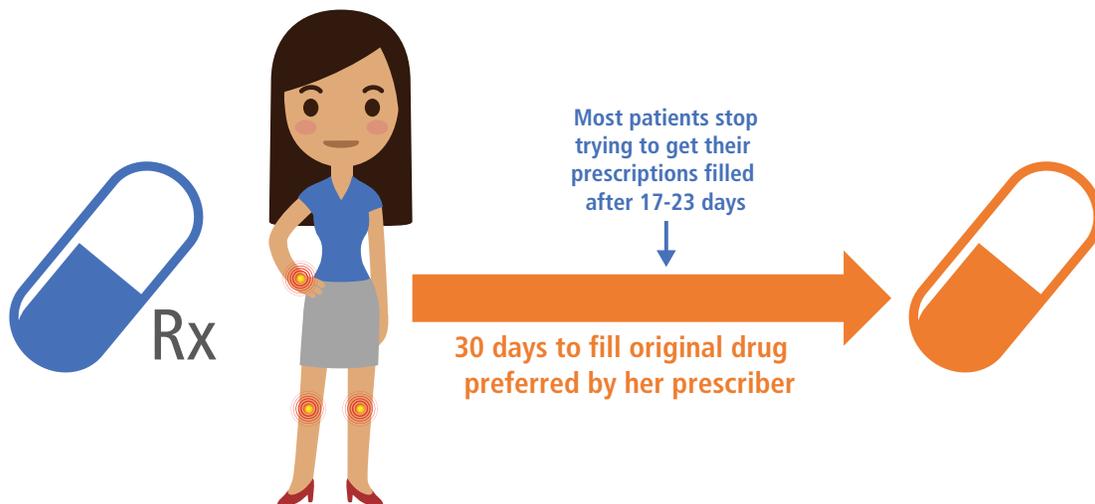
Of commercial plans that require prior authorization for Taltz®, 74% specify restrictive criteria, with 51% approving it for at least 1 year. None of the Medicare plans (standalone PDPs and MA-PD plans) specify prior authorization criteria for Humira® and Enbrel®; 58% of state Medicaid plans and 38% of managed Medicaid plans specify restrictive criteria for Taltz®.

Of commercial plans that mandate step therapy, 24% require failure of 1 generic only, 11% require failure of both 1 generic and 1 brand, and 64% require failure of **multiple** brand alternatives for Taltz®; 25% of Medicare plans (standalone PDPs and MA-PD plans) that mandate step therapy and 81% of Medicaid plans (state and managed) that impose step edits require failure of at least 1 brand alternative for Taltz®. By contrast, of the 50 commercial plans assessed, 49 specifically have no branded steps before Humira® or Enbrel®. Prior authorization and step-therapy criteria are specified for Taltz® more often than any of the other 3 products across most payer channels.

Claims Data Analysis⁷

Xcenda also looked at claims data to get a better sense of the patient experience when it comes to UM requirements. Of rheumatoid arthritis and psoriasis patients, 14% to 16% had at least 1 claim that was initially rejected the first time they tried to fill a prescription. In addition, the analysis found that the average time between the first and last attempt to fill a script before deciding to stop trying was 17 to 23 days, suggesting that patients do not continue their attempts to access medications if it is not filled within 2.5 to 3.5 weeks.

While the majority of patients (approximately 81% of rheumatoid arthritis patients and 77% of psoriasis patients) who were



initially denied (due to a coverage issue or required a prior authorization) for a medication eventually received an approval for the original drug their physician prescribed, it took an average of **30 days** to receive that approval, while the data shows that patients give up trying to get their prescription filled at 17-23 days.

Discussion

Patients

While each situation is different, in general, patients subjected to step therapy experienced delays in treatment, increased OOP expenses, and added stress and, often, faced poorer health outcomes.

The most significant impact of step therapy on patients is the barrier to timely treatment, particularly for those with chronic illness. This impact has been well documented in literature on autoimmune disorders. A 2017 systematic literature review was conducted to assess the effect of step therapy, prior authorization, or both on medication adherence, clinical outcomes, treatment satisfaction, drug utilization, healthcare resource utilization, and economic outcomes. Step therapy resulted in unfavorable outcomes in 83 (50.6%) of 164 outcomes across patient, drug use, healthcare resource utilization, and economic outcome categories.⁸

These findings aligned with those of a study by Boystov et al, published in 2019 in *Pharmacoeconomics*, comparing treatment efficacy for rheumatoid arthritis and psoriatic arthritis patients *with and without* access restrictions for biologic disease-modifying antirheumatic drugs (DMARDs) or targeted synthetic DMARDs. Among the subset of patients whose access

Figure 7. Impact of Step Therapy on Treatment Efficiency and Adherence



restrictions included step therapy (with or without prior authorization), **treatment efficiency during 12 months of follow-up was 19% lower for rheumatoid arthritis patients and 27% lower for psoriatic arthritis compared to patients without step therapy, mainly due to lower odds of adherence treatment (Figure 7).**⁹

The claims data analysis conducted by Xcenda further reinforced the finding that step therapy can delay rheumatoid arthritis and psoriasis patients' access to drugs, even when an appeal for the original prescription eventually produces a positive result. The examination found that patients waited over 30 days (4 weeks on average) to receive their prescription while awaiting the appeals process. Also, the average time between first and last attempt for a patient to fill a prescription before abandoning it altogether was 17 to 23 days (or 2.5 to 3.5 weeks).¹⁰ A 2019 letter to CMS from the American College of Rheumatology underscored the serious risk that step therapy presents to patients with autoimmune diseases by delaying effective treatment, including, "dangerous reactions when the biologic is re-initiated" and "irreversible damage."¹¹

In addition, critics of step therapy point out that taking decision making from the hands of patients and their physicians ultimately leads to poorer patient outcomes. A study by Feldman SR, et al in 2016 found that **a step-therapy approach may limit prescribers in their ability to treat psoriasis patients with moderate to severe disease, subsequently leading to undertreating this patient population.**¹² This calls into question the notion that step therapy will lead to reduced costs; poorer outcomes lead to greater costs to the system in terms of additional medical spending to treat worsening conditions and complications, as well as the resources required to handle utilization management requirements in the clinical practice setting. And then there is also the quality of life of the patient to consider.

Patients are going through the step-therapy process for rheumatoid arthritis or psoriasis because they are experiencing symptoms that have driven them to seek or change their regimens (painful flares, extreme fatigue, loss of mobility, etc). While they wait for the paperwork to be resolved for a product their physician preferred for them, their quality of life suffers on a daily basis.

It is important to note that not all drugs that treat autoimmune diseases are the same. Treatments that include similar agents, even those with the same mechanism of action, do not necessarily extend to equivalent efficacy, adherence, safety, and

tolerability profiles. **Policies that result in forced drug switching, treatment gaps, and cessation of effective therapy pose a danger to the patient in terms of lost access to therapy, disease flares, immunogenicity (ie, negative immune response), adverse effects, and secondary nonresponse.**¹³

Evaluation of the claims data showed **that step therapy protocols are inconsistent** and do not always reflect clinical best practice. Having a variety of rigid step therapy requirements varying from payer to payer can be particularly harmful to patients with immunologic conditions which are heterogeneous in terms of symptom manifestation and drug response. Consequently, a one-size-fits all approach (eg, requiring all patients to try an anti-tumor necrosis factor [TNF] for first-line therapy) is ineffective at best and harmful at worst. Innovative therapies (ie, non-anti-TNFs) that may work best for a patient with an autoimmune disease are often inaccessible as a first-line biologic option. In areas like psoriasis, the first-line biologics (ie, TNFs) are unlikely to achieve National Psoriasis Foundation's established goals for treatment.

Physicians and Pharmacists

Prescribers and pharmacists who have face-to-face interactions with patients are frustrated that payers imposing step-therapy requirements are removed from any of the repercussions or liabilities when step therapy negatively affects a patient.

Step therapy as a UM tool can be detrimental to patients, prescribers, and pharmacists. For the provider, additional resources are needed as a result of payers' increased use of step therapy. Additional staff are needed to manage the UM process, help determine OOP costs for patients, and identify foundations or other sources of health-related financial assistance. *Physicians and pharmacists understand that patients are concerned about OOP costs, often at the expense of the ability to be treated with what might be the best and innovative therapies for them.*

Physicians and pharmacists recognize that out-of-pocket costs are a big concern for patients, often preventing them from receiving the best and most innovative therapies.

Stakeholders also have **concerns that patient protections, like the appeals process, may not be getting sufficient oversight by regulators.** While there are processes for exceptions and appeals, they are cumbersome for all parties involved. Further, it is unclear how closely regulators are monitoring the effectiveness. Often, when there are rules requiring that plans respond to an exceptions or appeals request in a timely response (eg, within 48 hours), plans can send an immediate denial to meet the requirement. The entire process often results in a resource-intensive delay for patients in trying to get their prescriber-preferred medicine. This process is frustrating for prescribers, their office staff, and patients.

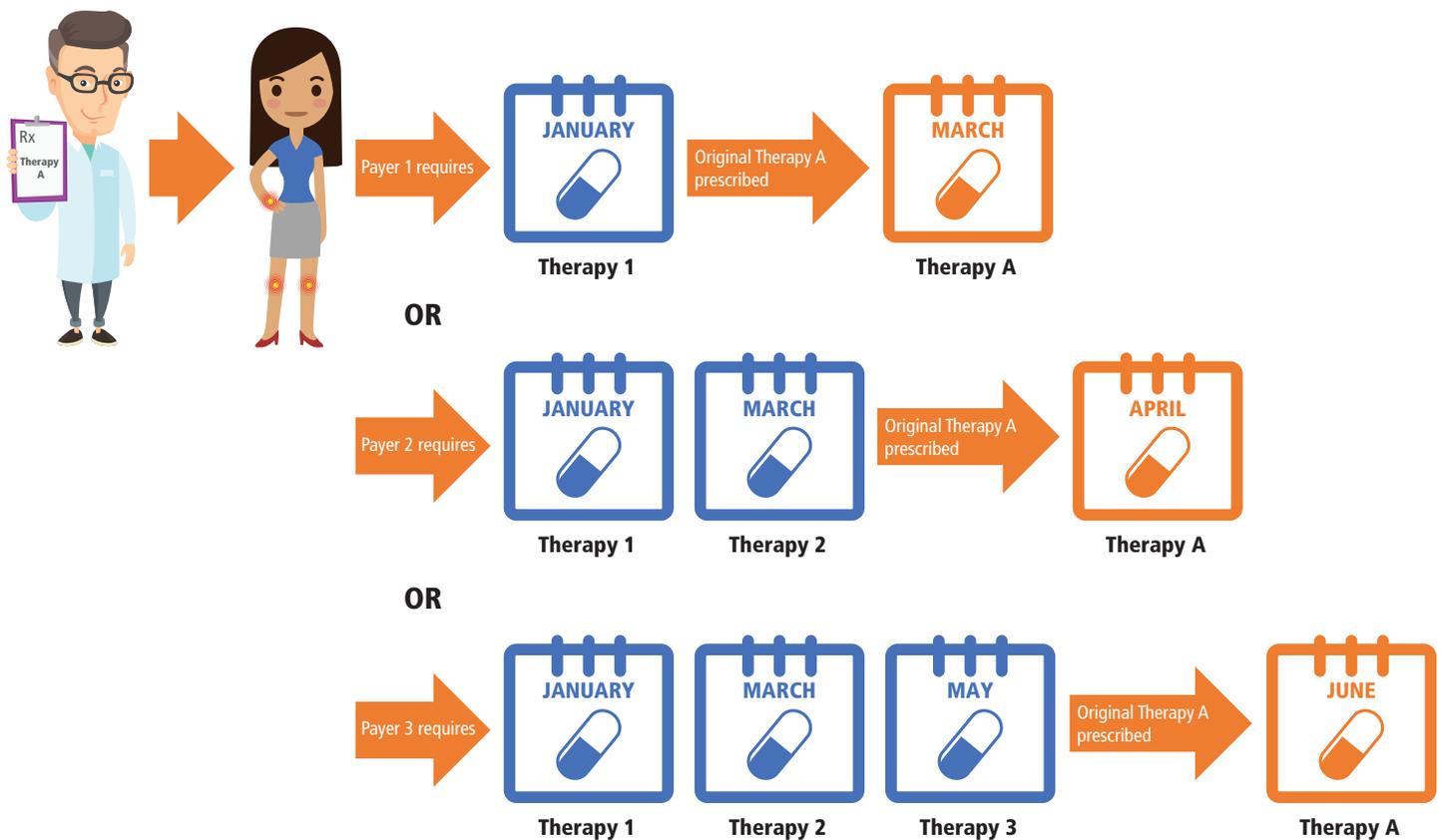
Prescribers treat individual patients, and for those with autoimmune disorders, the therapy selected is based on their particular case. The payer, however, uses a blanket policy for the population of patients in their entire plan. The result of payers prioritizing an entire population over individuals can significantly affect an individual patient's health outcomes.

Payers

It is not surprising that cost is a main focus of payers, given that categories such as immunology represent very large areas of spend for health plans.¹⁴ Quite simply, when payers look to offset spending in high-cost categories like immunology, they look to lucrative drug rebates. These rebates are paid by drug manufacturers to PBMs in order to secure the placement of a product on formulary—**often at the expense of patient access to certain other innovative medications.** Despite the wave of new biologics and innovative nonbiologics coming to market, many patients with immunologic diseases have first-line access to only 1 mechanism of action (anti-TNF inhibitors). **In many cases, that same patient must fail 2 TNF inhibitors before a payer will authorize coverage for a drug with a different mechanism of action.**

While we were not surprised to find that payers' perspectives of step therapy were largely supportive, we were surprised by the **Xcenda formulary review results^a showing the significant variance in step-therapy protocols**

Figure 8. Variance in Step-Therapy Protocols by Payer

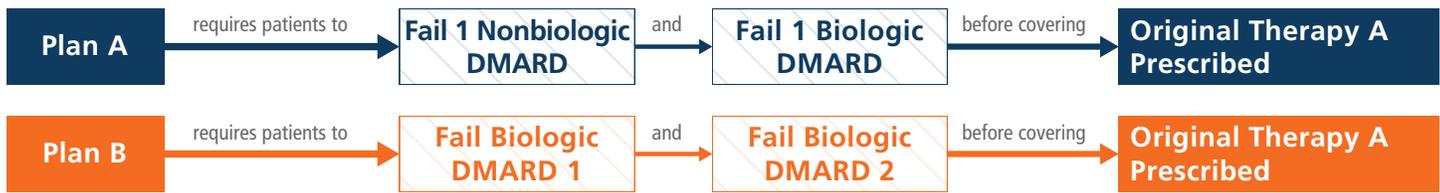


^a Products reviewed were Humira®, Xeljanz®, Enbrel®, Taltz®, and Cosentyx®. The top 50 commercial, 25 MA-PD and 25 PDP, 25 state Medicaid, and 25 managed Medicaid plans by covered lives.⁶

between plans and types of plans. This suggests lack of clinical consensus in creating the protocols.

An analysis of another database (Specialty Drug Evidence and Coverage Database) developed by researchers at Tufts Medical Center confirmed significant variation in the construction of step-therapy protocols across assessed plans, with some payers

Figure 9. Step-Therapy Requirements, According to 2 Different Plans



Key: DMARD - disease-modifying antirheumatic drug.

requiring 1 to 3 therapies for 3 to 6 months before covering the original medicine prescribed.¹⁵

Even when there was consistency in the number of therapies required, the types of treatment patients had to try and fail differed. **As an example, one plan required patients to fail on a nonbiologic DMARD and a biologic DMARD, while a different plan required patients to fail on 2 biologic DMARDs.**¹⁵

If coverage and UM decisions are made strictly based on clinical effectiveness and safety, there should be little divergence between plans, especially since the majority of payers reference many of the same compendia. For instance, Medicare relies on data from American Society of Health-System Pharmacists Drug-Information, Clinical Pharmacology, DrugDex, Lexi-Drugs, and the National Comprehensive Cancer Network® Compendia when making coverage decisions.

In the late 1980s and early 1990s, laws were passed in 32 states that mandated private payers use 3 compendia (American Medical Association Drug Evaluations, United States Pharmacopeia Drug Information, and American Society of Health-System Pharmacists' Formulary) when determining drug coverage. Although additional compendia may be used to supplement what is mandated by their respective states, this practice alone cannot speak to the variance in their coverage decisions. P&T committees assess a drug's efficacy, efficiency, and quality via similar clinical avenues; however, this information is not available to the public. Unfortunately, since there is no transparency about a plan's contracting and rebating practices, patients have little to no recourse—other than accepting potentially adverse determinations and additional treatment delays. When patients change jobs and/or employers change payers, patients are often “whipsawed” back and forth on various medications based on the different formularies. Even worse: plans can change their formulary mid-year, forcing stable patients to switch to a different medication that may not maintain control of their disease and may actually have a higher list price.

Patients often get “whipsawed” back and forth on medications when they change jobs and/or employers change payers due to formulary changes. What's worse is that plans can change formularies mid-year, forcing stable patients on a different medication that may not help with disease maintenance and may actually have a higher list price.

The reason why plans vary significantly may lie in behind-the-scenes rebate negotiations between plans and pharmaceutical manufacturers. **When plans say they construct formularies with the lowest-cost drugs, the question is: lowest cost for whom—the patient or the plan?**

As we explore the rationale behind step therapy, it is important to understand the role that manufacturer rebates play in driving drug formulary access. In January of 2019, the Department of Health and Human Services (HHS) proposed a series of rule changes to the Anti-Kickback Statute¹⁶ which, if enacted, would have made it illegal (within certain CMS programs) for pharmaceutical companies to pay rebates directly to PBMs in exchange for formulary access for their products. Instead, safe harbor would have been created for these rebates to be passed directly to plan beneficiaries at the point of sale. Since releasing its proposed rule change, HHS has consistently reinforced the fact that rebates paid to PBMs are not passed along to beneficiaries *and* frequently result in PBMs favoring high-rebate drugs when making formulary decisions. **In early July 2019, the White House abandoned the proposed rule,¹⁷ citing concerns that premiums would increase for all Medicare patients and that the federal government would end up spending more money, with**

only some beneficiaries getting the benefit of lower drug costs. However, the HHS Secretary was quoted as saying that “...rebates’ days are numbered, but we’re not going to take any action that could run the risk of seniors’ premiums going up.”¹⁸ Many were surprised and, while some supported the withdrawal, numerous stakeholders were disheartened by the removal of this proposed rule.¹⁹

Beyond HHS, there is growing concern from representatives of the federal government, physicians, and patient advocacy groups regarding the contracting practices that drive formulary access in the US, specifically regarding the payer practice of preferring drugs with high rebate streams (and other price concessions) in order to reduce their own cost burden and maximize their profits. In comments to CMS on the proposed rebate rule, Medicare Access for Patients Rx (MAPRx), a coalition of patient, family caregiver, and health professional organizations stated: “One factor contributing to high OOP costs is that patients are paying cost-sharing based on undiscounted prices... and that they [MAPRx]... support the concept of passing negotiated rebates on to the patients at the pharmacy counter.”²⁰

In therapeutic categories that present payers with significant costs, this behavior can be even more pervasive. For example, immunologic diseases make up the largest spend category for payers. Combine this with the fact that 3 pharmaceutical companies control 85% of the market share in this category,²¹ and you have an environment that can create a “rebate trap.” Market-dominant manufacturers have an edge in negotiating with payers to disfavor or exclude newer drugs that lack the market share needed to provide a comparable level of rebates from their formulary—even if these newer drugs offer better outcomes for a lower price.

Rebate traps (also known as rebate walls) are also seen in the biosimilars market, where it is difficult for new products to gain market share from reference products because they simply do not have the sales volume to offer the same rebate potential to PBMs. Another tactic used by manufacturers with a large market share of an existing drug and who also have new products coming to market are performance contracts. PBMs must meet certain percentages of the market share for a new drug or the manufacturer will take away the rebate.

It becomes apparent that step therapy *confers* market dominance to manufacturers who offer the highest price concessions, and once that market dominance is solidified with the year-over-year fail-first advantage, lower-priced, smaller market share medications are essentially walled off.

Rebate arrangements like the one described above (between pharmaceutical manufacturers and payers) result in a healthcare system where competition appears to *raise list prices* as **payers are incentivized to use drugs with higher list prices and rebate offers in order to generate huge rebate (and fee) revenue.** Most importantly, this creates a step-therapy barrier for patients and physicians, preventing them from accessing many innovative therapies that may be the most effective option for a patient’s individual circumstances.

Conclusion

A major concern expressed by medical professionals and patient advocacy groups is that payers use step therapy to *increase their profits through rebates and fees* passed through to them. This directly affects the cost to the patient (and eventually, the downstream cost to the healthcare system at large), who is forced to fail first on payer-preferred drugs (with coinsurance based on list price, not the rebated price) before receiving coverage for the originally prescribed drug. While more stringent step therapy is associated with controlling pharmacy costs, there is also a corresponding increase in medical costs due to poor patient outcomes.⁸ In addition, step therapy disrupts the relationship that healthcare prescribers have with their patients. And while physicians lose time and money working through the appeals, what patients lose is even more important—control of their disease.

Shared decision making should remain with the provider and the patient, rather than the payer and the manufacturer, particularly for patients with severe or chronic illnesses and older patients in the Medicare population. Further, prescribers

need to have access to all options available when treating patients with severe illnesses, and patients should not be penalized with a new step therapy protocol for changing health insurance or merely to increase profit for the payer. Finally, patients with moderate to severe disease who are stable on their current therapy must be able to remain on their current treatment.

Recommendations

Step therapy explicitly goes against shared decision making between a healthcare provider and their patient; it should be used sparingly and only in situations when it is driven by clinical decision making. A multi-prong effort will be necessary to change the system and reduce restrictive step-therapy policies:

- Patients, patient advocacy groups, physicians, and professional societies need to increase awareness (eg, develop policy positions, etc) with their members to encourage them to raise their voices so that employers and payers recognize the negative effects of step therapy. This is particularly important for immunological diseases. Innovation has brought medications with new mechanisms of action into the market place, and these need to be made available to patients without having to step through other mechanisms of action that may not work as well for them.
- Policymakers and regulators, including the Department of Health and Human Services, the Federal Trade Commission, and Congress, need to address the role rebates and other percentage-based fees play in patient and provider access to innovative drugs and the relationship between rebating/performance-based agreements and restrictive step-therapy policies.

- Employers, as plan sponsors, need to be educated about these restrictive policies and voice their concern about the impact they have on employees' health.

Step therapy, while profitable for the payer, can deny access to the proper medications for patients and do nothing to reduce the cost to the patient. In fact, costs to the patient—physically, emotionally, and monetarily—often increase.

Appendix

Methodology

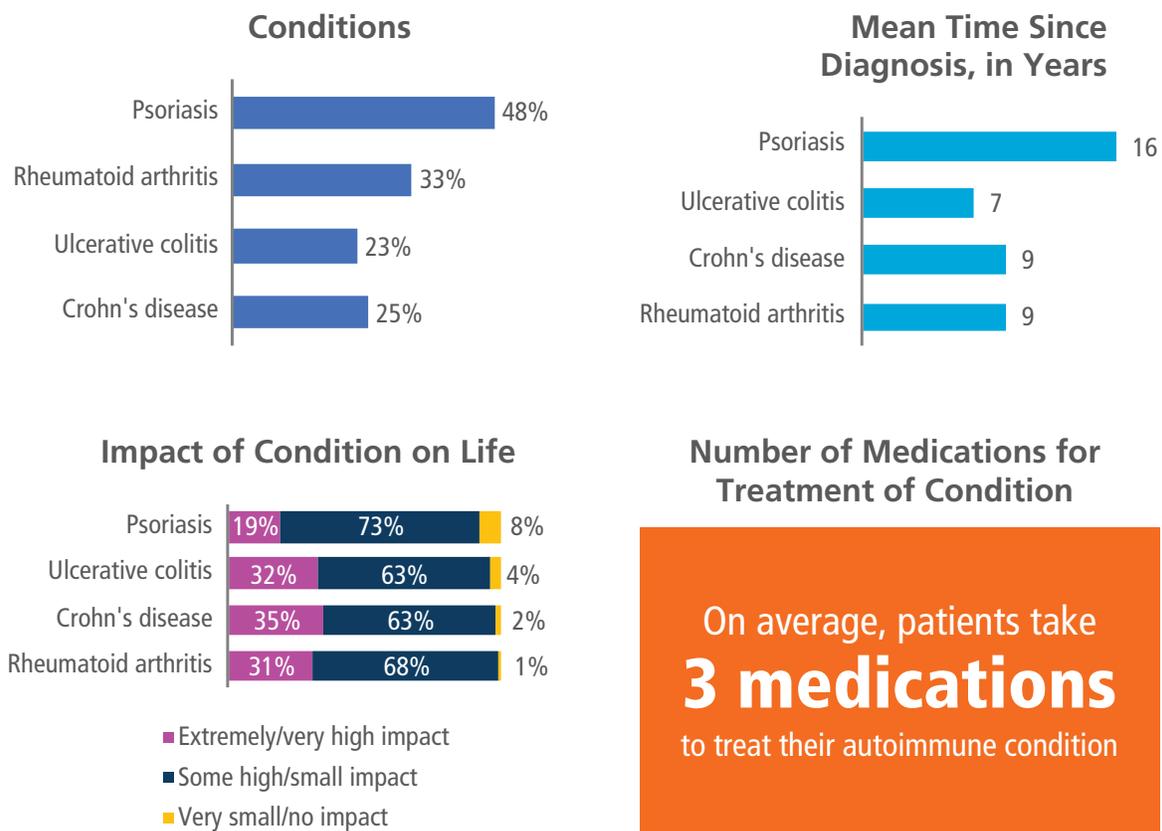
Interviews

In partnership with Adelphi Research, Xcenda designed a qualitative, double-blind, 15-minute online survey to better understand the attitudes of payers, specialty physicians (rheumatologists, dermatologists, and gastroenterologists), pharmacists, and patients. Each group received its own individual survey with questions about attitudes toward innovation, step therapy, and the role of insurance companies in providing treatment access for autoimmune diseases. Research focused on autoimmune diseases because, in recent years, there have been innovative biologics developed for improved treatment that have led to better outcomes, but these are very high-cost therapies. An informal, but targeted, literature review (conducted via PubMed, Kaiser, and other gray literature searches online) highlights UM as a barrier to access. Relevant information from the literature review was incorporated into the survey development.⁴

A total of 634 patients participated in the survey, with a majority being female (65%) across the US. Approximately one-third of the patients resided in the Northeast (31%), one-third from the South (33%), and the remaining one-third from the West (23%) and the Central/Midwest (14%). A significant majority of the patients identified themselves as white/Caucasian (82%).⁴

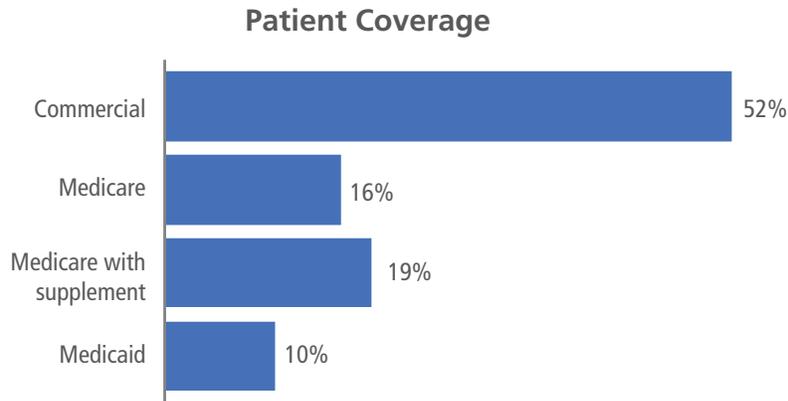
A sampling of patients between the ages of 18 and 74 years were included in the survey. The patients surveyed were

Figure 10. Patient Respondent Profiles



diagnosed with psoriasis (48%), rheumatoid arthritis (33%), or ulcerative colitis (23%)/Crohn’s disease (25%) and were prescribed a medication for this condition. On average, the patients surveyed take 3 medications to treat their autoimmune condition. Patients with psoriasis had the longest mean time since diagnosis at 16 years, followed by Crohn’s and rheumatoid arthritis at 9 years and ulcerative colitis at 7 years. The conditions of Crohn’s and ulcerative colitis had an “extremely/very high impact” on patients’ lives (35% and 32%, respectively), followed by rheumatoid arthritis (31%) and psoriasis (19%) (Figure 10).⁴

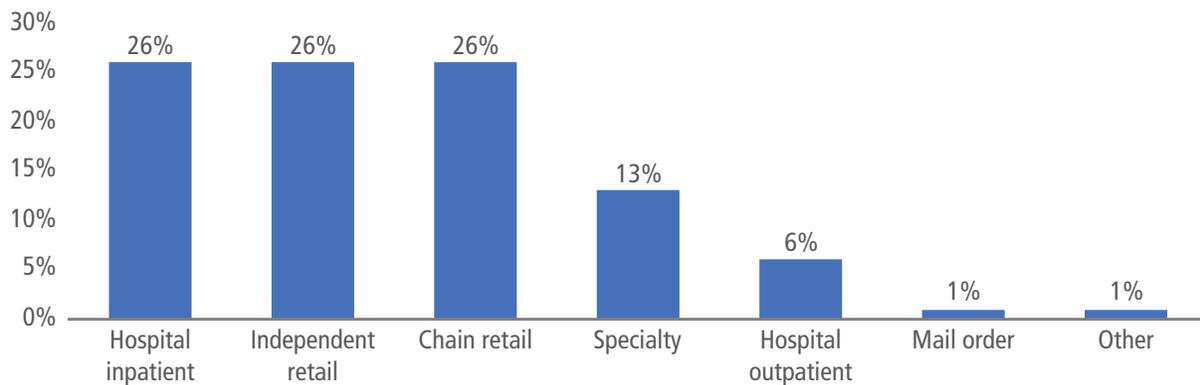
Figure 11. Physician Survey Respondents on their Patients’ Type of Coverage



Rheumatologists, dermatologists, and gastroenterologists in practice between 3 and 30 years, with at least 70% of time spent in direct patient care, were interviewed; 301 physicians responded to the survey, with one-third making up each of the 3 specialties. The mean years of experience were 14 years. The region where most physicians were licensed was the South (34%), followed by the Northeast (28%) and an about even percentage in the Midwest (22%) and West (21%). According to the physicians, a total of 52% of their patients had commercial insurance, 19% had Medicare with supplemental (Medigap), 16% had Medicare, and 10% were covered by Medicaid (Figure 11).⁴

Criteria for inclusion of clinical pharmacists or pharmacy managers/directors were participants with 3 to 30 years of experience

Figure 12. Pharmacist Survey Respondents by Type of Pharmacy

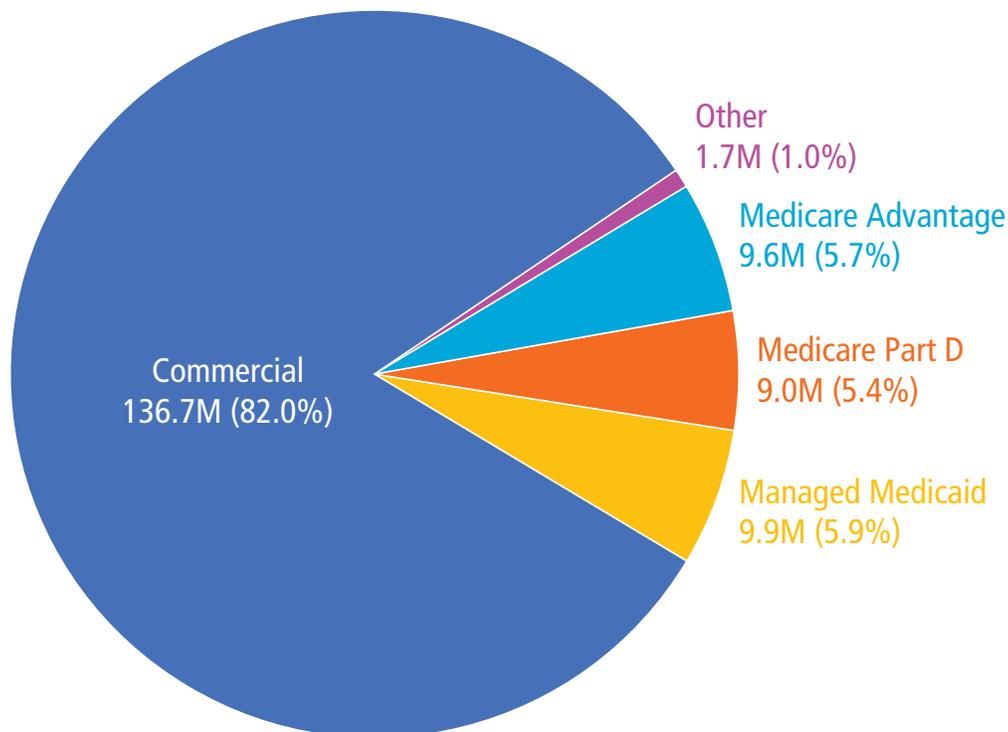


who had dispensed at least 10 prescriptions for autoimmune diseases in the past month. Of the 72 pharmacist respondents, two-thirds had the job title “pharmacy manager/director” (67%) and one-third had the title of “clinical pharmacist.” Most pharmacists were licensed in the Northeast (42%), with the other respondents licensed about evenly over the remaining regions: 25% in the West, 24% in the Central/Midwest region, and 22% in the South. A little over one-quarter of pharmacists reported working in the hospital inpatient, independent retail, and chain retail setting (26% in each). This was followed by pharmacists who worked in a specialty pharmacy (13%), hospital outpatient (6%), mail order (1%), or other settings (1%) (Figure 12).⁴

For payers, criteria for inclusion were pharmacy or medical directors for managed care organizations (MCOs) or PBMs who were responsible for commercial business. Payer representatives who were interviewed must have been in their current role for at least 3 years and have rated 5 to 7 on 7-point scale (1 being not at all involved to 7 being extremely involved) in formulary decision making on 2 of the following autoimmune diseases: rheumatoid arthritis, inflammatory bowel disease, or psoriasis. Additionally, in order for payer representatives to be included in the survey, they had to be directly involved in contracting for one of the aforementioned conditions. A mix of payers utilizing and not utilizing step therapy was included.⁴

A total of 30 payers (25 MCOs and 5 PBMs) responded to the survey. Of the approximately 166 million lives represented, over 82% were commercial (136.7M), 5.7% were Medicare Advantage (9.6M), 5.4% Medicare Part D (9.0M), and 5.9%

Figure 12. Payer Survey Respondents Representing Total Covered Lives



managed Medicaid (9.9M) (Figure 12). Managed Medicaid beneficiaries receive health benefits and additional services from private commercial health plans that provided health benefits and additional services. Services are provided through a contracted arrangement between state Medicaid agencies and MCOs that accept a capitated payment (ie, a set per-member per-month payment for the services.) The remaining 1% were covered by health insurance exchanges (1.7M) or other (50,000). A majority were regional representatives (60%), 10% were a regional affiliate of a national organization, and 30% were national representatives.⁴

Formulary Data Analyses

Xcenda conducted an analysis of commercial, Medicare Part D, and Medicaid plan formularies to understand how payers are managing access and utilization for claims data for rheumatoid arthritis (Humira Pen® [Humira®] and Xeljanz®), psoriasis (Enbrel®), and Taltz Autoinjector® (Taltz®). The plans included 300 million covered lives, including the top 50 commercial plans, 25 MA-PD plans, and 25 standalone PDPs. Claims data were also pulled from 25 state Medicaid and 25 managed Medicaid

Table 1. Basis for Claims Data Analysis¹⁰

Primary Research Questions
What therapies are rheumatoid arthritis and psoriasis patients using?
What are patients' OOP cost-sharing by product and class?
What is the utilization of copay cards by product and class?
What types of access issues do patients encounter while trying to fill a prescription?
Which payers pose the biggest challenges?

plans. The Managed Markets Insights & Technology (MMIT) analytics database, as of July 2017, was used to review formulary management across these payers. (This time period was selected to align with the same time frame as the access prescription drug claims analysis.)

A separate claims data analysis¹⁰ was also performed to evaluate access barriers preventing rheumatoid arthritis and psoriasis patients from receiving timely or needed therapy. To understand the access landscape, 5 primary research questions were analyzed (Table 1).

Table 2. Patient and Product Selection Criteria for Claims Data Analysis¹⁰

Patients by indication	Rheumatoid arthritis	Psoriasis
Drugs of interest	Humira [®] , Enbrel [®] , Xeljanz [®] , Orencia [®] , Cimzia [®]	Humira [®] , Enbrel [®] , Cosentyx [®] , Stelara [®] , Taltz [®]
Other drugs	Actemra [®] , Inflectra [®] , Kevzara [®] , Kineret [®] , Olumiant [®] , Orencia [®] , Rituxan [®] , Remicade [®] , Simponi [®]	Inflectra [®] , Otezla [®] , Remicade [®] , Siliq [®] , Simponi [®] , Tremfya [®]

The Symphony Health Solutions Lifecycle claims dataset from 2017 was used in the analysis. Lifecycle data contain transactional-level information (eg, approvals, denials, reversals) and provide visibility into information exchanged between pharmacies and payers when working to fill patients' prescriptions. In 2017, the Lifecycle database captured at least roughly 60% of all prescriptions adjudicated through retail, mail-order, and specialty mail-order pharmacies. The data are linked at the patient level, which provides the ability to analyze patient longitudinal claim activity.

Commercial, Medicare Part D, state Medicaid, and managed Medicaid claims were evaluated for pharmacy products used to treat psoriasis and rheumatoid arthritis. See Table 2 for the specific patients and products included.

Limitations

There could be several limitations to the surveys, including issues related to the patient's race, geographic location of pharmacists, type of pharmacy where the pharmacist worked, and payer type.

- Given that an overwhelming majority of patients responding identified themselves as white/Caucasian (82%), data from other races were very limited.⁴ More responses from other races could have provided a clearer picture of the impact of step therapy on patients of all races.
- Pharmacists were licensed more in the Northeast (42%) than any other region (25% in the West, 24% in the Central/Midwest region, and 22% in the South). The overall impact of step therapy may have differed with a more even geographical representation, especially since there are fewer rural areas in the Northeast. This could have resulted in a greater impact of step therapy on patients in regions other than the Northeast due to the distance that patients may be required to travel in order to pick up prescriptions.
- Additionally, there may have been a significant difference if more pharmacists working in a specialty pharmacy responded, given the high cost of these drugs and because many drugs for autoimmune diseases are specialty drugs. (Only 13% of pharmacists reported working in a specialty pharmacy.)⁴
- More input from PBMs could have resulted in an even stronger view of how step therapy reduces costs for the PBM. (Of the 30 payer representatives, 25 MCOs and 5 PBMs participated).

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