



Variations in Medicare Advantage Prior Authorization Policies for High-Cost Oncology Immunotherapies

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BACKGROUND

- Medicare is a federal health insurance program that covers over 63 million beneficiaries in the United States who are elderly, disabled, or have end stage renal disease.¹
- Medicare accounts for nearly 12% of federal spending and 3% of the GDP.²
- Medicare Advantage (MA), a public-private partnership, was initially created to reduce Medicare spending and improve beneficiaries' outcomes.²
- MA plans offer an attractive alternative set of choices compared to Traditional Medicare (TM) including offering extra benefits and limiting annual out-of-pocket expenses.³
- Currently, MA covers more than 27 million beneficiaries (approximately 45% of Medicare enrollees).¹
- The estimated proportion of Medicare annual spending attributed to prescription drugs was 27.2% in 2019, net of estimated rebates and discounts.⁴
- MA plans are increasingly employing various managed care principles, including prior authorization (PA), to control utilization and spending and reduce low-value care.⁵
- PA is a form of utilization management whereby a clinician must receive insurer approval prior to rendering medical service.⁶
- Part B drugs, including high-cost infusion immunotherapies, are one of the services where MA insurers most often require PA.⁵
- Currently, the impact of PA on spending, utilization and patients' outcomes remain unknown.

OBJECTIVE

- To examine trends and variations in Medicare Advantage (MA) prior authorization (PA) policies across insurers, years, and selected high-cost infusion immunotherapies and biosimilars, including Rituximab, Pembrolizumab, Nivolumab, Trastuzumab, and Bortezomib.

METHODS

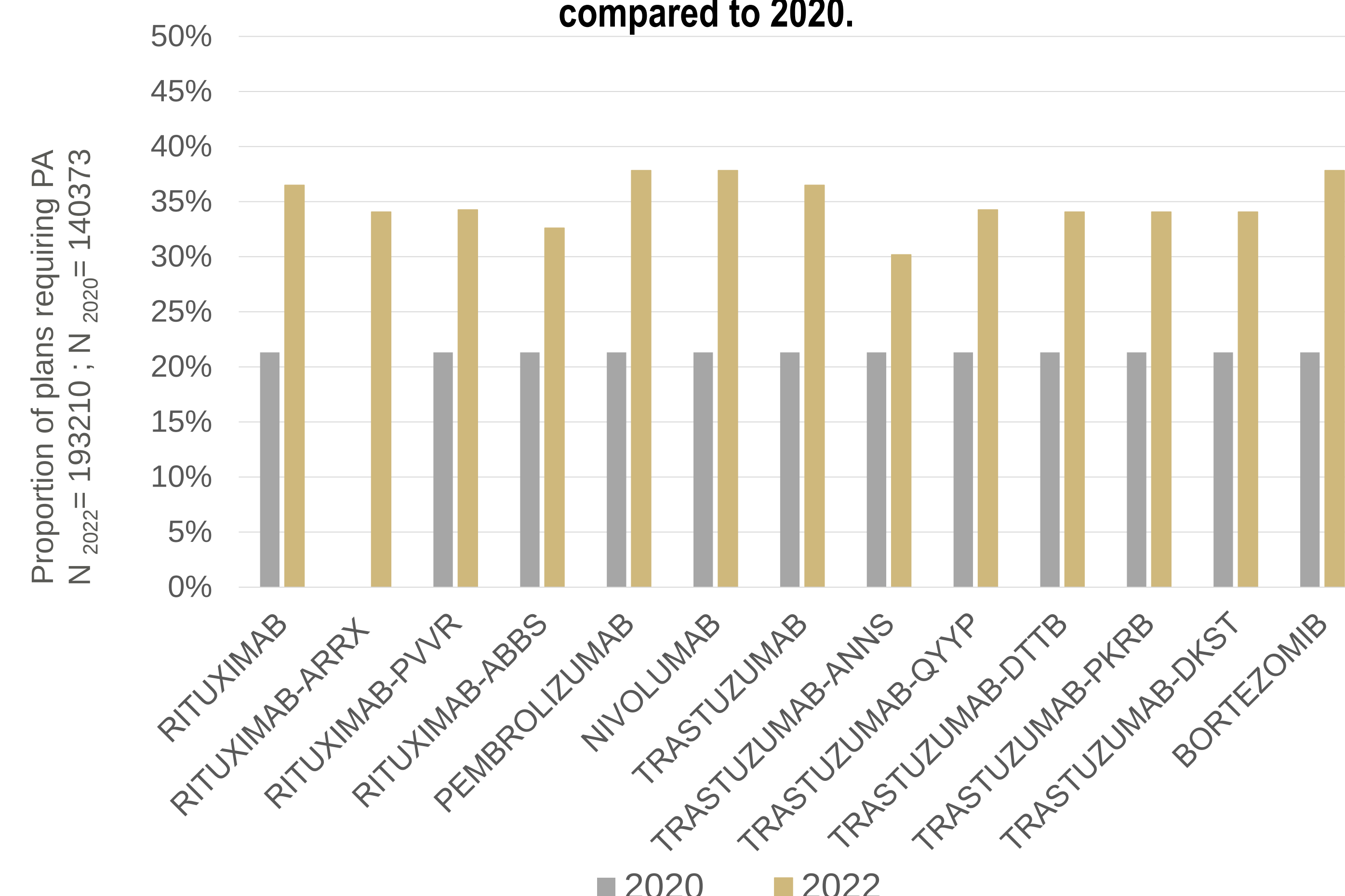
- We selected 5 high-cost infusion oncology biologics and their available biosimilars among Medicare Part B drugs with the highest total expenditures per year:
 - Rituximab (+ 3 biosimilars), Pembrolizumab, Nivolumab, Trastuzumab (+ 4 biosimilars), and Bortezomib.
- We collected publicly available PA policies for MA insurers operating in Colorado from 2020 to 2022.
- For each of the selected immunotherapies, we determined by insurer, the plan name and type (HMO or PPO), the year of coverage, whether the product is subject to PA, and whether there are any other restrictions that determine the product's coverage.
- We matched Colorado monthly MA enrollment rates to the identified plans. Then, we estimated the share of enrollees in plans requiring PA per year and per product.

RESULTS

- All of the products were subject to PA by at least one insurer during at least one year of the study period.
- Overall, there is an increase in the proportion of plans requiring PA for all of the biologics and their biosimilars between 2020 and 2022 (**Figure 1**).

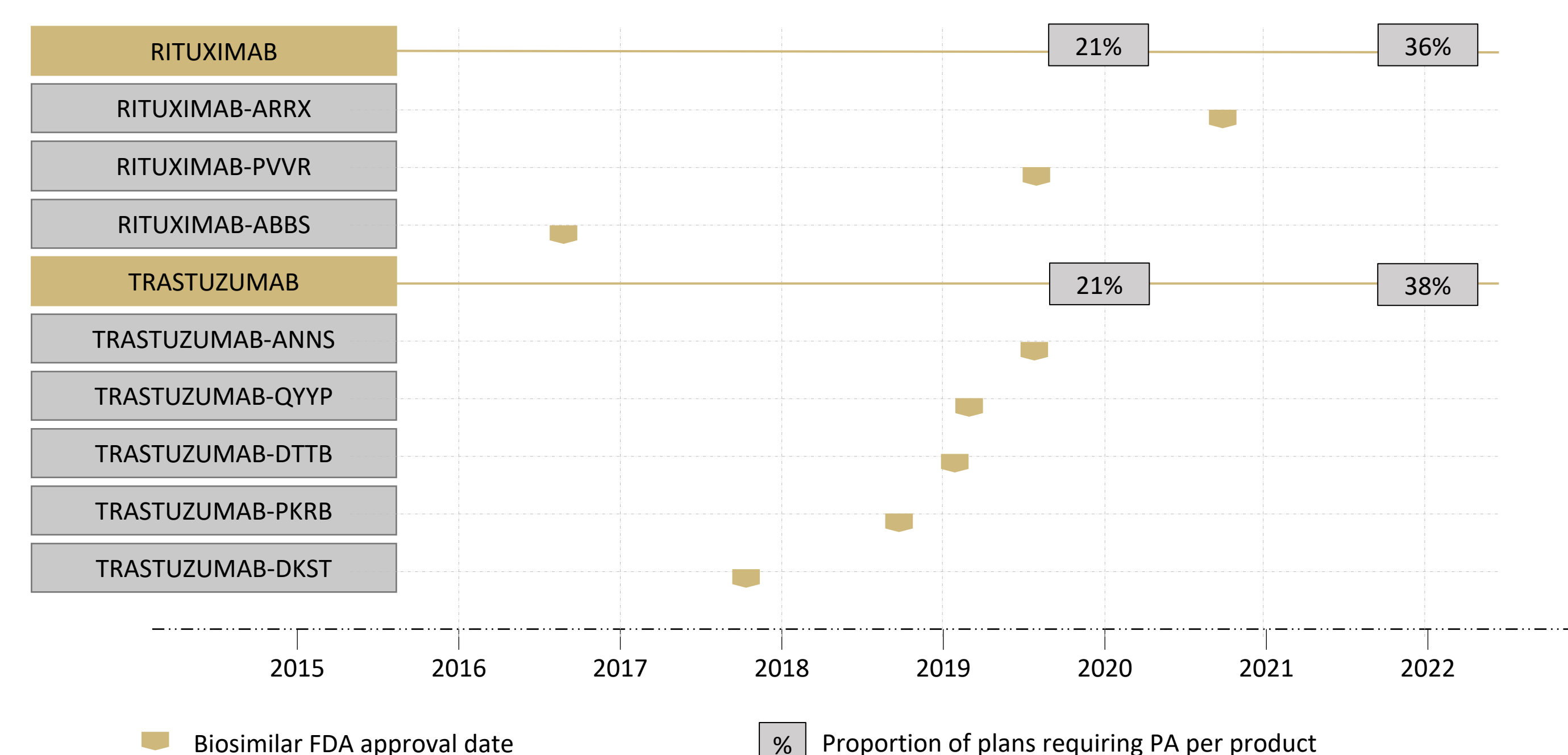
- Among biosimilars, we found variation in PA requirements between the different insurers and plans.

Figure 1: Increase in the proportions of plans requiring PA per product in 2022 compared to 2020.



- The proportion of plans requiring PA for biologics with no biosimilars increased from 21% to 38% for Nivolumab and Bortezomib and from 21% to 33% for Pembrolizumab between 2020 and 2022.
- As of 2021, insurers started to shift the PA requirement from biosimilars to the original, and more costly, biologics (i.e., Rituximab and Trastuzumab) (**Figure 2**).

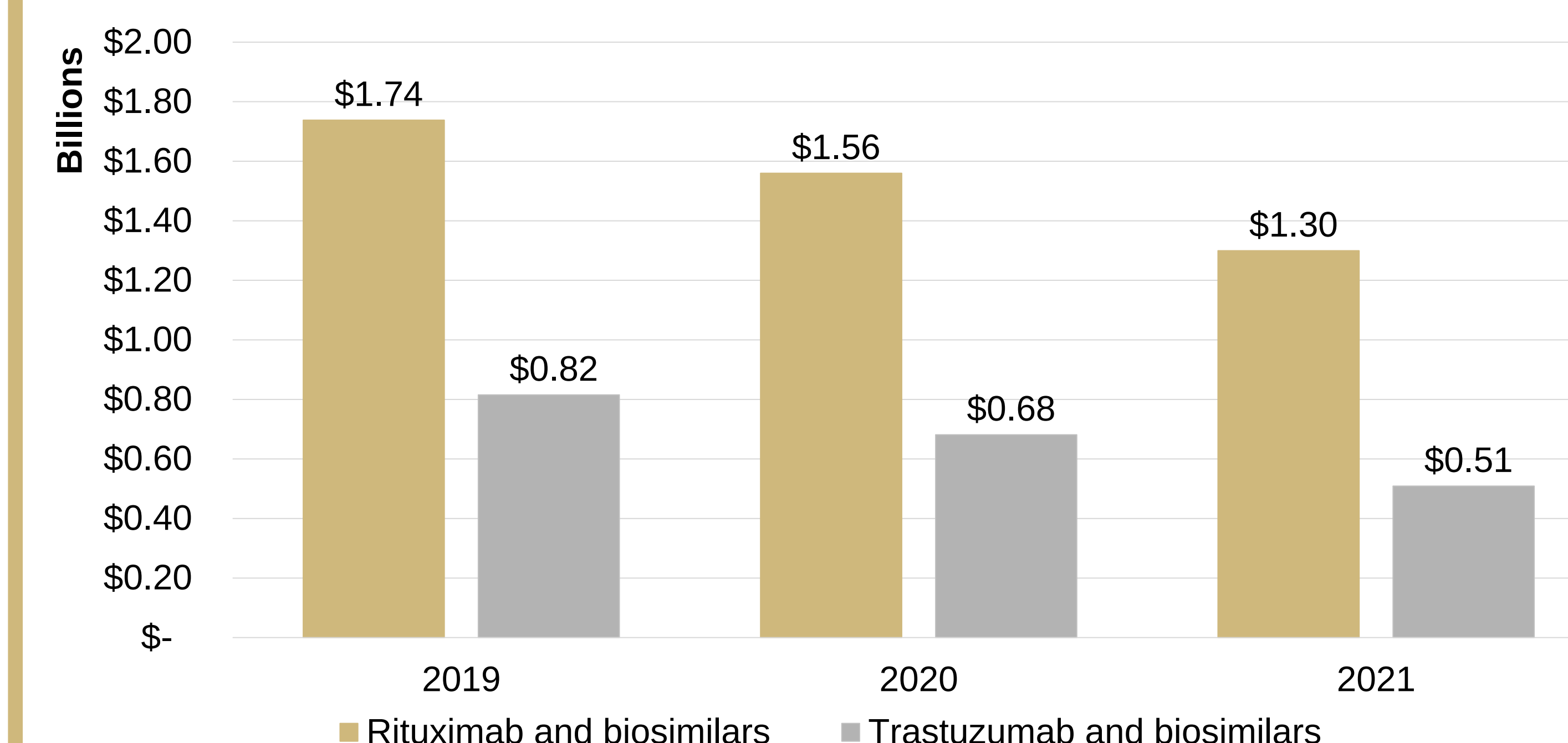
Figure 2: Increase in the proportion of plans that requiring PA for the original biologic after the arrival of biosimilar options to the market.



- The trend of shifting the PA requirement from biosimilars to original biologics started after the launch of multiple biosimilars of both molecules (Rituximab and Trastuzumab) in 2019 and coincided with the increase in biosimilars uptake by providers, especially those participating in the Oncology Care Model (OCM) (**Figure 2**).

- The increase in biosimilars uptake coincided with a decrease in CMS spending between 2019 and 2021 on both molecules:
 - Rituximab and biosimilars: \$672,082,562
 - Trastuzumab and biosimilars: \$306,427,790 (**Figure 3**).

Figure 3: Decrease in CMS spending on Rituximab and its biosimilars and Trastuzumab and its biosimilars between 2019 and 2021.



CONCLUSIONS

- There is wide variation between MA insurers in terms of which drugs require PA.
- Requiring PA for more costly biologics could direct beneficiaries to similarly or equally effective lower cost options or biosimilars.
- However, since most immunotherapy regimens require monthly injections, PA policies and restrictions might hinder patients' access to treatment which can exacerbate cancer.
- Currently, it remains unclear if the effects of PA policies on patients' outcomes, exceed their benefits in lowering costs.
- We plan to further investigate the impact of the increasing use of PA by insurers on patients' access to care and cancer related outcomes.

REFERENCES

1- Data.CMS.gov/ CMS Program Statistics - Medicare Total Enrollment. 2- Peter G. Peterson Foundation. Budget Basics: Medicare. September 2, 2021. 3- Better Medicare Alliance. Medicare Advantage Outperforms Fee-For-Service Medicare on Cost Protections for Low-Income and Diverse Populations. Data Brief. April 2022. 4- Dusetzina SB. Prescription Drug Spending in Fee-for-Service Medicare, 2008-2019. JAMA. 5- Cubanski et al, Medicare Part B Drugs: Cost Implications for Beneficiaries in Traditional Medicare and Medicare Advantage, (KFF, Mar 15, 2022).

RELEVANT FINANCIAL RELATIONSHIP DISCLOSURES

- Dr. Kelly E. Anderson is the Principal Investigator of the "Measuring the Effects of Medicare Advantage Prior Authorization Policies for Chemotherapy" study, funded by The Commonwealth Fund.
- Dr. Kelly Anderson was previously employed by the Lewin group.

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