

# Realizing the Benefits of Biosimilars: BIOSIMILARS AND REBATE WALLS

## Realizing the Benefits of Biosimilars: Overcoming Rebate Walls

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### Executive Summary

**Issue:** Rebate walls, also called rebate “traps,” occur when a drug manufacturer pays list price discounts to health plans or pharmacy benefit managers (PBMs) based on meeting market share targets. While such practices might seem to have the short-term effect of lowering net costs for a particular drug or biologic, they also have the effect of blocking patient use of competing, lower-priced products. Rebate walls are the result of an incumbent drug manufacturer leveraging its high market share. The use of rebate walls benefits the incumbent and can cause plans or PBMs to financially benefit from purchasing exclusively from the originator, deterring investment by potential biosimilar entrants and consequently diminishing market entry and competition over time that could help lower net costs. Rebate walls are particularly challenging in the context of biosimilar competition: while biosimilars are as safe and effective as the originator biologic and offered at a reduced list price, demand for products has been slow to shift from incumbents, especially if clinicians and patients do not regard the products as clinically equivalent. The result can be harm for patients and the health care system, through reduced access to drugs that are just as safe and effective but cost less. Furthermore, growth in rebates has been linked to a growth in list prices, and highly rebated products are often accompanied by higher out-of-pocket costs for patients. This issue brief examines the potential anticompetitive implications of rebate walls, categorizes their use and impact, and offers solutions to increase biosimilar uptake and reduce net prices and patient out-of-pocket costs in the U.S.

**Key Findings:** Promoting policies that make it easier for health plans to switch a sufficient share of patients from originator biologics to biosimilars would make biosimilar markets more in line with successful generic markets and would break down rebate walls. Perception-related barriers complicate the large-scale shift to biosimilars that would be necessary to overcome basic rebate walls. This includes education and awareness gaps related to perceptions that biosimilars are not clinically equivalent and switching is associated with higher rates of adverse events—perceptions that are not supported by regulatory requirements or the growing evidence on biosimilar adoption. In addition, although pharmacists generally can automatically substitute a generic for its brand-name drug, biosimilars must clear an additional regulatory hurdle to gain the “interchangeability” designation that (subject to state law) permits pharmacy substitution without the explicit authorization of the prescriber, limiting the rapid and

automatic market growth that happens in generic markets. With more positive physician and patient perceptions and permissive state substitution laws, offering a lower net price per-unit for a generic allows for a very large share of the market to shift from the brand, reducing the threat of rebate walls. In addition to switching-related barriers, the high costs of biosimilar market entry—primarily regulatory hurdles related to large preapproval clinical testing requirements and patent-related barriers—reinforce the originator’s existing market power and further reduce competition between originators and biosimilars.

**Policy Recommendations:** To reduce the impact of rebate walls and promote greater biosimilar uptake, we propose the following strategies:

- 1) The Federal Trade Commission (FTC), the Department of Justice, state Attorneys General, and any private party that suffers harm from anticompetitive rebate wall conduct should pursue actions under the antitrust laws that target anticompetitive bundles and product ties; The FTC should be encouraged to investigate and challenge rebate walls under Section 5 of the Federal Trade Commission Act;
- 2) The Food and Drug Administration (FDA) and physician organizations should support continued educational activities and real-world evidence development to combat provider (and patient) misperceptions about biosimilars to support a large-scale switch to biosimilars; The FTC, where appropriate, should deter and address false or deceptive communications concerning biologics and biosimilars;
- 3) The FDA should assist biosimilar sponsors to obtain an interchangeability designation, which could encourage substitution by pharmacy dispensers (noting, however, that most biosimilars are physician-administered and therefore pharmacy benefit solutions do not address the entire segment of the biologic/biosimilar market); and
- 4) The FDA should take steps to streamline biosimilar approval pathways with product-specific flexibility to make biosimilar entry more efficient and foster a more robust, competitive market; The US Patent and Trademark Office (USPTO) and Congress should address patent thickets that deter biosimilar entry.

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## Background

Spending on biologic drugs, a category that includes a wide range of products such as vaccines, cell and gene therapies, and allergenics,<sup>1</sup> makes up a large and growing proportion of spending on medicines in the United States (U.S.). In fact, in 2019, biologics spending reached \$211 billion, accounting for 43% of invoice-level medicine spending in the U.S., and this spending grew at a compound annual growth rate of 14.6% from 2015 to 2019—in contrast to the 1.6% compound annual growth rate of spending on small-molecule products in the same period, according to data from IQVIA.<sup>2</sup> Biosimilars have offered hope for controlling national spending on biologic drugs.<sup>3</sup> However, the potential savings from biosimilars have been hindered by several factors in the U.S., including broadly: regulatory uncertainties, intellectual property barriers, provider and patient perceptions,<sup>4</sup> misaligned payment incentives,<sup>5</sup> and potentially anticompetitive practices by originator manufacturers.

Perhaps the most troubling contributor to the high cost of biologics is the growth and pervasiveness of anticompetitive practices in the pharmaceutical market. The Federal Trade Commission (FTC) and the Food and Drug Administration (FDA) recently issued a joint statement declaring the agencies' intention to "address and deter anticompetitive behavior in the U.S. market for biological products."<sup>6</sup> The statement signals the agencies' determination to combat anticompetitive "pay for delay" patent settlements, tackle the abuse of the citizen petition process to delay competition,<sup>7</sup> and combat misinformation and disparagement related to biosimilars. To this list of anticompetitive practices requiring attention, we add the use of rebate walls. Rebate walls are exclusionary contracting practices designed to limit competitive entry, thereby reducing patient and payer product choices and thus price competition. Continued entry barriers are also likely to reduce innovation and impose long-term harm on the pharmaceutical market.

Following up on an earlier Duke-Margolis Center for Health Policy brief detailing the most significant barriers to U.S. biosimilar adoption,<sup>8</sup> this issue brief explores the use of rebate walls and begins with an overview of the current landscape of drug rebates and rebate walls in the U.S. It then outlines the different types of rebate walls and how they are created and perpetuated. In the following section, it evaluates the anticompetitive impact of biologic rebate walls and related switching barriers on biosimilar entry. While there is no easy solution to eliminate or overcome rebate walls entirely, in the final section of this brief, we identify several potential solutions that may help mitigate the problem and facilitate greater biosimilar uptake and long-term savings in the U.S.

## Introduction of Rebate Walls

### Drug Rebates

Drug rebates are after-the-fact payments, usually calculated as a percentage of a drug's list price, from manufacturers to pharmacy benefit managers (PBMs) and/or health plans. Because rebates determine a drug's ultimate price, they play an important role in what products are utilized by payers in the U.S. Drug companies use rebates as a way to encourage payers to include their products on formularies, or in preferred tiers of the formulary. Drug rebates can offer conditional volume- or performance-based discounts off the list price for a single product or a bundle of multiple products.<sup>9, 10</sup> They are most commonly used for high-cost, branded drugs in therapeutic classes that face competition from other branded drugs or from follow-on products, such as generics or biosimilars,<sup>11</sup> and they can be substantial for branded drugs that face competition, amounting to hundreds or thousands of dollars per prescription.

While rebates are typically procompetitive when there are multiple entrants, aiming to lower a product's net price, they also affect the U.S. pharmaceutical market in a number of negative ways. First, rebates have unfortunate distributive consequences. Because rebates are not usually passed directly to enrollees (although some commercial plans have been doing so),<sup>12</sup> their cost-sharing is often based on the list and not on the net price.<sup>13</sup> Consequently, highly rebated products with higher list prices are often accompanied by higher out-of-pocket (OOP) costs for patients, particularly when they are set as a fixed percentage of a drug's list price (also called coinsurance).<sup>14</sup> Since cost-sharing is typically higher in Medicare Part D plans than in commercial plans, Part D enrollees are particularly adversely impacted by increasing list prices, without benefitting directly from rebates.<sup>15, 16</sup> While plans apply rebates to lower premiums for all their beneficiaries equally, basing cost-sharing on the list price of drugs increases OOP costs for beneficiaries that use heavily rebated drugs.

The growth in rebates has also been linked to increases in list prices that have significantly exceeded the growth in net prices.<sup>17, 18</sup> Research has found that on average, drug rebates have increased along with list prices in recent years. A 2020 study of 1,335 U.S. branded prescription drugs found that in the three years between 2015 and 2018, the average rebate nearly doubled.<sup>19</sup> Each additional dollar of rebate was associated with a \$1.17 increase in list price.<sup>20</sup> The term "gross-to-net bubble" was coined to describe the speed and size of growth in the total dollar value of manufacturers' gross-to-net reductions—mostly driven by rebates.<sup>21</sup>

If drug rebates were banned, manufacturers would compete based on the net prices of their products without the benefit of existing incumbent status, potentially enhancing price competition and driving plans towards lower-cost biosimilars. In turn, this could encourage more investment in biosimilars, more product launches, and bolstered drug utilization. The Trump administration attempted to address the market distortions that rebates create in Medicare Part D by eliminating rebates from manufacturers to PBMs and replacing them with point-of-sale (POS) discounts that are passed on directly to buyers. However, the rule was projected to substantially increase Medicare spending,<sup>22</sup> in part through actually raising net

drug prices,<sup>23</sup> and its effective date was delayed until 2023 by a federal judge order and delayed until 2026 by Congress as part of the Infrastructure Investment and Jobs Act to help pay for the legislative package.<sup>24</sup>

The PBM industry has argued that antitrust law precludes PBMs from using simpler and more transparent discounts, causing their heavy reliance on drug rebates. However, a review of relevant law suggests that that is not the case and that discounts are permitted if they are offered in response to a purchaser's ability to affect market share (as they are typically used, and can be used more commonly, in exchange for favorable formulary placement).<sup>25</sup>

## Rebate Walls

Rebate practices have been reported in an anti-competitive context, called rebate "walls" or "traps," which occur when a drug manufacturer's rebates are tied to specified volume, or more accurately, market share targets. Rebate walls can occur when different brand name pharmaceutical or biologic products that treat the same condition compete against one another (brand on brand competition), or when a generic or a biosimilar competes against an originator product. This paper focuses on originator versus biosimilar competition. In the biologic and biosimilar context, rebate walls can favor more expensive drugs over lower-cost and therapeutically equivalent alternatives.<sup>26</sup>

Rebate walls occur when manufacturers leverage their dominant market position by removing rebates to payers unless the competing product is effectively excluded from that payer's market or receives a non-preferred formulary placement. Payers are effectively incentivized by rebates, and the threat of losing them, to keep the more expensive drugs on their formularies.<sup>27</sup>

Barriers to large-scale switching from the originator to the biosimilar, due to structural or perceived reasons as we discuss below, could mean that even though the biosimilar is sold at a lower per-unit price than its originator counterpart, buyers still purchase the incumbent originator product exclusively or in very high volumes because of the large rebates that its manufacturer provides to that buyer—thus the phrase "rebate wall." Because the terms of these rebate arrangements are held as confidential trade secrets, the extent of market distortions they create is obscured from regulators and the public.<sup>28</sup>

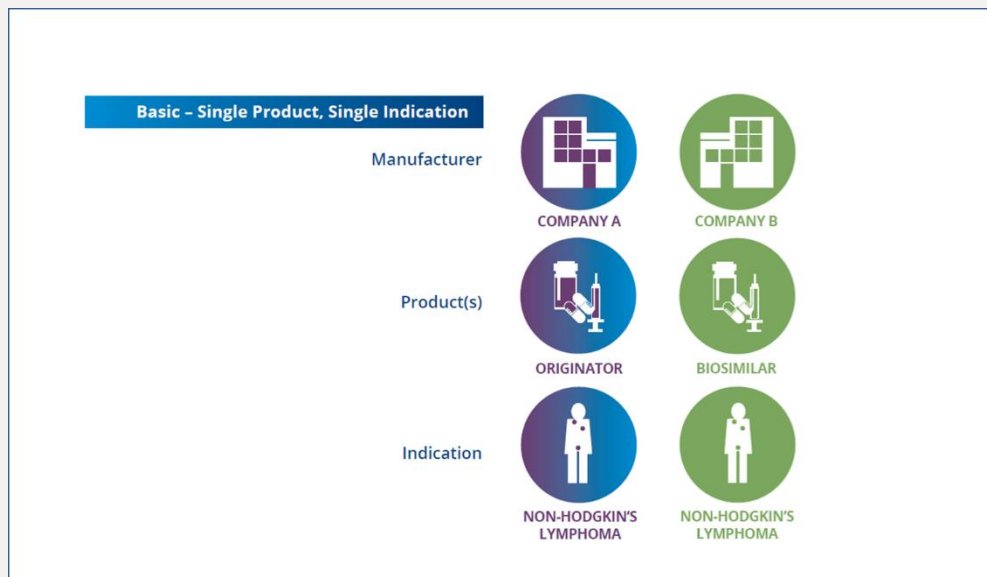
As described with examples below, health plans may face three general categories of rebate walls as they evaluate biosimilar market entrants. All three of these rebate wall categories place anticompetitive entry barriers to biosimilars.

**Types of rebate walls:**

**1) Basic–Single product, single indication**

**Description:** The basic rebate wall or trap occurs when a biosimilar is approved and brought to market for the same indication or indications as the originator biologic that has the entire market share and favorable formulary placement. The potential cost savings to a plan from switching patients to the biosimilar are often insufficient to match the total rebate offered by the manufacturer of the originator biologic. Even if the per-unit discount of the biosimilar matches or exceeds the savings of the per-unit rebate of the originator, the plan may still be stuck in a rebate trap, unable or unwilling to provide open access to the biosimilar. This is because depending on the conditions of the rebate agreement with the originator, putting some patients on the biosimilar may cause the payer to be financially penalized if a certain volume threshold of the originator product is not achieved. The plan must decide to keep the biosimilar off its formulary (or otherwise limit its uptake) or pay the full list price for the originator, greatly increasing its costs. In other words, the plan would pay more for the originator and some biosimilar utilization, than for the rebated originator alone.

**Example:**<sup>29</sup> Company A is the manufacturer of an originator biologic, Product A, that is labeled for the treatment of non-Hodgkin's lymphoma (NHL). The list price of Product A is adjusted by a volume-based rebate such that it costs a plan \$50 million a year to treat 1,000 patients with no switching for other products. When Company B launches a biosimilar, Product B, also approved for the treatment of NHL, the plan has the choice to switch patients to the biosimilar with the significantly lower list price. However, even if half of the patient population treated with Product A is switched to the biosimilar, Product B, the plan loses the rebate from Company A and the cost would increase to \$60 million to treat the 1,000 patients, despite the per-unit discount of Product B. Based on this forecast, the plan decides to exclude Product B, the biosimilar, from its formulary.



Only when payers offer the biosimilar exclusively, or almost exclusively, will the savings from the biosimilar be enough to overcome the rebate trap. But for reasons described in this paper, such large-scale switches have not been easy to accomplish in the U.S.

## **2) Single Product, multiple indications**

*Description:* A plan may face a more prohibitive rebate wall than the basic scenario described above if the originator biologic is approved for additional indications beyond the indications for which the biosimilar is approved. This is could be the case because the originator has one or more indications that are protected by patents or regulatory exclusivity (e.g., orphan) and the biosimilar “carves out” these protected indications from its label. When a biosimilar enters the market with fewer indications than the originator, the combined volume of sales driven by the additional indications of the originator will likely greatly exceed the potential volume of sales for the biosimilar. In this case, a lower net price from the biosimilar will not be sufficient to overcome the potential loss of the rebate dollars from the originator and its larger volume of prescriptions, leaving the biosimilar at a disadvantage. To make switching from originators to biosimilars even more complicated when the biosimilar is not approved for all of the reference product’s indications, providers may find it hard to track which biosimilar has which indications and might thus be reluctant to change utilization from existing products. If it is a self-administered product, pharmacies may be at risk of dispensing the incorrect product and might thus only stock the product with the most indications.

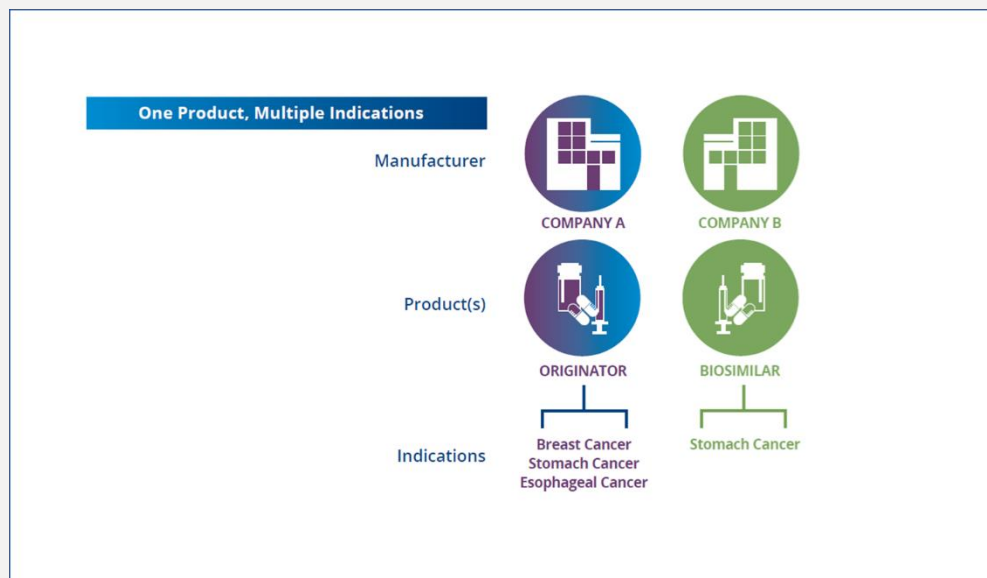
*Example:* Company A is the manufacturer of an originator biologic, called Product A, that is labeled for the treatment of breast, esophageal, and stomach cancers. Breast cancer has a larger patient population than esophageal and stomach cancers.<sup>30</sup> A health plan enters into a rebate agreement with Company A that bundles all indications that can be treated by Product A and offers a 10 percent rebate to the plan if certain large volume targets are met. Altogether, to treat 4,000 patients with Product A across breast cancer (2,000 patients), esophageal cancer (1,000 patients), and stomach cancer (1,000 patients), it would cost the plan \$90 million after rebates. When Company B launches a biosimilar, Product B, approved just for the treatment of stomach cancer, the plan has the choice to include the biosimilar in its formulary. Product B enters the market at a 20 percent discount to the list price of Product A. However, if patients begin treatment or are switched to the biosimilar, Product B, the plan will lose the rebate for the treatment of all three cancer types with Product A, in accordance with the terms of its rebate agreement with Company A. This would increase the cost of treating the patients for breast, esophageal, and stomach cancers, regardless of potential per-unit savings for stomach cancer patients from the biosimilar. Moreover, it would be unlikely for specialists to completely switch to Product B for stomach cancer mid-treatment if patients are stabilized on Product A.<sup>31</sup> Therefore, assuming half of the stomach cancer patients switch to Product B, the plan would need to cover both Product A and Product B for stomach cancer, and Product A for breast and esophageal cancers, at the higher total cost of \$97.5 million for the same group of patients without rebates (see table below). Even if all stomach cancer patients could be switched to the biosimilar, the total cost to cover the same group of patients without rebates for Product A for breast and esophageal cancers would still be higher than it was before Company A withdrew its



rebates for the bundle of indications. Not wanting to incur higher costs or lose the ability to provide access to Product A entirely—especially for the additional and higher volume indications for Product A—the plan decides to exclude Product B.

Costs for the plan to cover Product A and/or Product B:

Indication	Annual patient population	Product A - originator		Product B - biosimilar	Combination of Product A and Product B	
		Total cost (gross)	Net cost (gross, after rebates)	Total cost (gross)	Net cost (gross, rebates removed) - 50% stomach cancer patients switch to Product B	Net cost (gross, rebates removed) - 100% stomach cancer patients switch to Product B
Breast cancer	2,000	\$ 50,000,000	\$ 45,000,000	-	\$ 50,000,000	\$ 50,000,000
Esophageal cancer	1,000	\$ 25,000,000	\$ 22,500,000	-	\$ 25,000,000	\$ 25,000,000
Stomach cancer	1,000	\$ 25,000,000	\$ 22,500,000	\$ 20,000,000	\$ 22,500,000	\$ 20,000,000
TOTAL	4,000	\$ 100,000,000	\$ 90,000,000	-	\$ 97,500,000	\$ 95,000,000

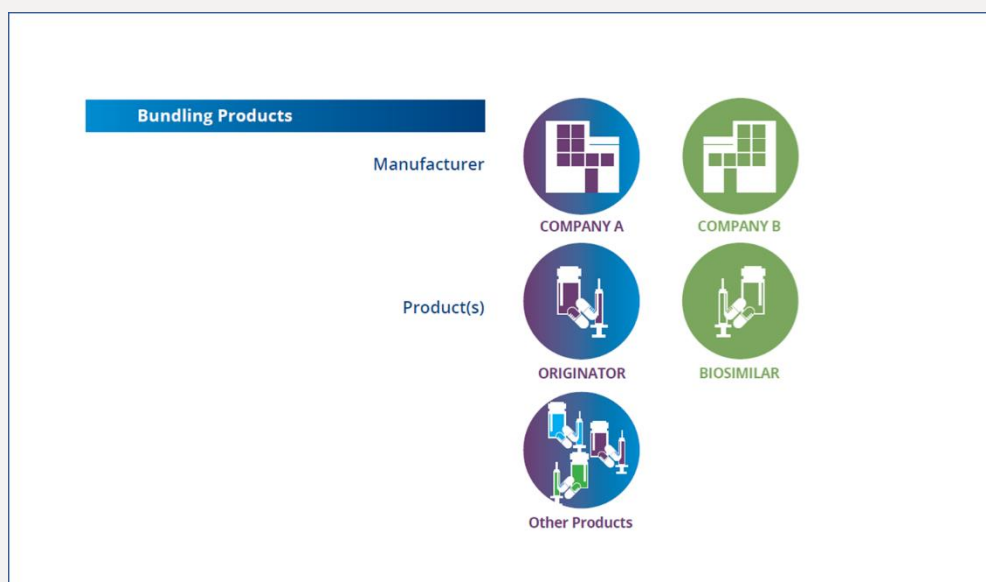


Extrapolation of indications, allowing a biosimilar to potentially be approved for one or more conditions for which the reference product is approved without being directly studied in a comparative clinical trial for these additional indications,<sup>32</sup> is key to help overcome rebate walls for originator products with a greater number of indications. However, extrapolation is not going to be a solution when the difference in the number of indications is the result of the originator’s patent or exclusivity protections. Moreover, biosimilars could potentially be at risk for induced infringement when pursuing a “skinny label” strategy given recent legal developments in the small-molecule generics space.<sup>33</sup> The ability of biosimilar manufacturers to carve out protected indications from their labels is especially vital to biosimilars’ market access given the size of originators’ patent estates, and limiting this practice might further exacerbate and perpetuate biosimilars’ exclusion from markets.

### 3) Bundling products

**Description:** Rebate walls in which the manufacturer of the originator bundles additional products in its rebate agreement with a payer may be the most challenging to overcome. In these cases, if the payer picks a biosimilar instead of the originator, the originator manufacturer could withdraw the rebates on a bundle of its products. This dynamic can completely prevent a biosimilar competitor that does not have a comparable portfolio of drugs or other products from accessing a payer's formulary.

**Example:** Company A is the manufacturer of an originator biologic, Product A, that is labeled for the treatment of breast, stomach, and esophageal cancers. Company A has a robust product portfolio that spans a range of therapy areas in addition to oncology. A plan receives rebates for Product A that are bundled with other products from Company A. The plan pays \$100 million per year for patients treated with Product A. A competing biosimilar to Product A is introduced, called Product B, which offers a discount compared to Product A. Even though it would cost \$80 million per year to treat the same number of patients with Product B, the plan does not want to risk higher costs if Company A withdraws the rebate for the other products in the bundle. If the plan were to adopt Product B and Company A responded by withdrawing its rebate, the cost to treat the patients on other products in Company A's product bundle would rise by over \$50 million in the same year, causing the plan to lose more money than it would save by switching patients from Product A to Product B. In this way, the potential savings from including Product B is overshadowed by the threat of losing access to rebated prices for the entire bundle of Company A products, so the plan excludes the biosimilar from the formulary.



Rebate walls created by bundling multiple products can cause anticompetitive harm without countervailing efficiencies. Such rebate arrangements should trigger antitrust scrutiny from the FTC and other enforcers.

Each of these scenarios illustrates how the incumbent originator products can use rebate walls to keep out competition from equally effective biosimilars, even when sold at lower prices.<sup>34</sup>

### Shifting the Market to Biosimilars is Difficult

At least for the basic scenario illustrated above, increasing biosimilar uptake when facing a rebate wall requires a switch of large volumes of patients from the reference biologic to the biosimilar. But the payer often cannot switch entirely to the entrant, thereby avoiding the higher costs for the originator, because the entrant does not supply the entire market or not all patients can be quickly moved to the biosimilar. With some exceptions,<sup>35</sup> U.S. stakeholders generally have limited ability and appetite to undertake sufficiently rapid and large-scale shifts from originator biologics to biosimilars. Payers, intermediary PBMs, and providers encounter disincentives and other barriers to biosimilar adoption that, taken together, prevent biosimilar uptake from overcoming even a simple rebate wall.

Biosimilars face challenges in attaining significant volumes even when they offer more cost-effective alternatives to their originator counterparts. One reason is the hesitancy or difficulty for providers to switch to biosimilars from originator biologics. This hesitancy is attributed in part to education and awareness issues.<sup>36</sup> Although all FDA-approved biosimilars are required to be highly similar and without clinically meaningful differences to their reference biologics,<sup>37</sup> some gaps in biosimilar knowledge among clinicians remain.<sup>38</sup>

The FDA interchangeability designation, which only applies in the pharmacy context and is thus irrelevant to most biosimilar therapies that are physician-administered, has also been said to play a role in exacerbating this confusion, leading to a few instances of misinformation.<sup>39, 40</sup> Interchangeability might create a perception that any biosimilars that do not receive the designation are different in clinically meaningful ways from, and potentially inferior in comparison to, reference biologics. The lack of an interchangeable designation for a particular biosimilar thus may imply a lack of safe switching in a lay person's understanding. While interchangeability allows a biosimilar sponsor to show more data on switching between the biosimilar and the reference product, it does *not* present a higher regulatory standard in terms of superiority of performance.<sup>41</sup> It has only been in the last few years that the FDA began disseminating educational materials to providers<sup>42</sup> and patients<sup>43</sup> that seek to provide objective information on the benefits of biosimilars and their development and approval process.<sup>44</sup> More education would be helpful to clarify that all FDA-approved biosimilars are already "interchangeable" for physician switching purposes. Additionally, naming differences between originator biologics and biosimilars can also impede biosimilar uptake,<sup>45</sup> potentially suggesting that biosimilars differ in clinically meaningful ways from their reference biologics.<sup>46</sup>

While some health plans report notable success with providers switching patients to biosimilars, providers are often hesitant to switch patients to equally-effective biosimilars, regardless of potential cost savings, when such patients are already on a stable regimen with the existing originator biologic.<sup>47</sup> This means that payers must continue offering some

originator product utilization, limiting their ability to facilitate a significant switch to the biosimilar for its covered population. Many are likely to favor the originator product over its biosimilar to avoid non-rebated fees for patients that remain on the originator, blocking the biosimilar from that payer's market. The provider may still use the biosimilar for patients covered by other plans that do not require the use of the originator but might prefer to simply standardize on the originator for operational and financial reasons (e.g., receive "loyalty" discounts from the manufacturer).

The therapy's turnover rate, or the number of patients that start treatment compared to those already on the treatment in a given year, also plays a large role in biosimilar uptake. It is especially hard for a biosimilar to capture the majority of the market for that molecule if it is a low turnover drug that treats a chronic condition because providers may resist switching mid-treatment and instead wait for patients to switch out. For many chronic diseases, the rate of patients new to a given biologic therapy is less than 20% of the total patients taking that drug in a given year, with the rest being stable and well-maintained on the therapy and therefore unlikely to switch.<sup>48</sup> These switches would be more feasible for oncology biosimilars where the market turns over rapidly and it would be easier for biosimilars to pick up market share and overcome a potential trap. For example, according to an analysis by IQVIA, bevacizumab (a treatment for several types of cancer)<sup>49</sup> has experienced the fastest biosimilar uptake to date, reaching 42% of the market in June 2020, a year after its launch.<sup>50</sup> This is compared to Tumor Necrosis Factor (TNF) inhibitors for inflammatory conditions that have a relatively low turnover rate, meaning that the payer would need to ask specialists to switch out patients one by one when the biosimilar becomes available.

In other countries where biosimilar uptake has been more substantial, there have been more, and earlier, efforts by regulatory bodies to raise prescriber awareness of the benefits of biosimilars, as well as other policies to encourage their use.<sup>51</sup> In some European countries, authorities have mandated large-scale switches from originators to biosimilars,<sup>52</sup> showing no evidence of changes in clinical outcomes.<sup>53</sup> Canada has also been adopting large-scale switching, beginning with a major private plan followed by several of the country's largest provinces.<sup>54</sup>

Payment practices in the commercial "buy-and-bill" market may also sometimes discourage providers to switch to biosimilars. Physician-administered drugs are often reimbursed as a "percent-of-charge," a discounted rate off of a price that is multiple times the drug's Wholesale Acquisition Cost (WAC),<sup>55</sup> a formula that creates incentives for providers to pick and administer a higher-cost originator that provides them with a higher reimbursement amount than the biosimilar version. While the provider may choose their preferred product based on their financial incentives, the plan sometimes has a "veto" power based on its own economics, therefore these provider incentives do not always contribute significantly to the creation of rebate walls, but may still have an impact when the provider has a strong negotiating position with the payer. In the Medicare market, providers generally have equal financial incentives to utilize either originator biologics or biosimilars under Part B's existing policies, limiting incentives to switch to a biosimilar from the incumbent. Payment reforms are therefore needed

to spur head-to-head price competition between biologics and their clinically similar, lower-priced biosimilars and increase the use of biosimilars.<sup>56</sup>

Furthermore, pharmacy-dispensed biosimilars face substitution-related barriers. Unlike small-molecule generics that can be automatically substituted for their reference drugs at the pharmacy counter, biosimilars without an “interchangeability” designation from the FDA cannot be substituted for their reference products without a prescriber’s direct authorization. When an interchangeable biosimilar is available, a pharmacist may be permitted (subject to state law) to substitute it for the reference product without the intervention of the prescribing physician. While most U.S. states have passed laws that authorize pharmacists to substitute an interchangeable biosimilar for its reference biological product, these state laws also generally permit physicians to prohibit substitution and impose additional restrictions that do not apply in the case of small-molecule drug substitution, such as physician notification.<sup>57</sup> In fact, ninety percent of U.S. states impose more heightened requirements on the substitution of interchangeable biosimilars compared to small-molecule generics.<sup>58</sup> Taken together, these substitution-related barriers mean that there is no “automatic” market growth for biosimilars as is the case with generic drugs after their launch, further complicating the ability to effectively shift market shares from originators to biosimilars. With more restrictive state substitution laws and challenges related to physician and patient perceptions of biosimilars’ safety and effectiveness, offering a lower net price per unit for a biosimilar does not allow the market to switch in the same way that occurs for small-molecule generics. Promoting policies that allow the market to shift more easily from originators to biosimilars, as we describe below, would help replicate the success of generic markets and break down biologic rebate walls.

Lastly, biosimilar uptake is heavily influenced by the formularies shaped by PBMs. PBMs are already significant in determining market share for some biologic therapy areas, such as insulins,<sup>59</sup> and their role is expected to grow as additional pharmacy biosimilars, such as adalimumab and etanercept, for the treatment of several inflammatory and autoimmune conditions, enter the market. Six biosimilars for AbbVie’s Humira (adalimumab) have been approved by the FDA and may come on the market in 2023,<sup>60</sup> but there is already some skepticism around the extent to which biosimilar competition will be able to gain market share and reduce costs.<sup>61</sup> Humira’s broad label centered on disease indications with chronic treatment presents the threat of indication-related rebate walls and may pose a challenge to get prescribers and patients to switch medication.

A PBM collects negotiated rebates from manufacturers after market shares are realized, such that the higher the volume sold relative to the market size (or eligible patient population), the higher the rebate. PBMs then pass most of the rebate through to the respective health plan, however, they may retain a portion of the rebate and thus could be encouraged to pay for large volumes of expensive drugs rather than utilizing less expensive alternatives.<sup>62</sup> PBMs also receive fees from manufacturers that can contribute to more favorable formulary inclusion for companies based on the attractiveness of the terms offered to the PBM, regardless of whether the arrangement benefits patients.<sup>63</sup> A manufacturer competing for formulary placement may also raise its list price, and then “discount a rebate to PBM.”<sup>64</sup> The higher-priced drug offering

the same percentage to the PBM is advantageous from the PBM's perspective because they get back more money in the rebate. Mergers in the PBM market—and the resulting increase in market concentration—might raise PBMs' ability to extract large rebates from manufacturers, thereby directing patients to more costly treatment options and potentially exacerbating rebate wall practices.

## Impact of Rebate Walls

As the FTC recently highlighted,<sup>65</sup> the cost implications of rebate walls are particularly significant in the case of biologics given their generally higher costs in comparison to small-molecule drugs and the role of rebate walls in reducing incentives for the biopharmaceutical industry to invest in lower-cost biosimilars. Rebate walls, therefore, harm patients and the health care system in the long-term by denying access to drugs that are just as effective but cost less.

Rebate walls can either exclude biosimilars from formularies or place them in less favorable tiers. In fact, research published in JAMA found that biosimilars are only preferred 14% of the time by major health plans,<sup>66</sup> despite the discounts that they offer compared to their reference products. Rebate walls consequently create an incentive for payers to prefer more expensive branded biologics over biosimilars. Research has estimated the lost savings created by rebate walls for patients with employer-sponsored health insurance and Medicare who require infusion biologics.<sup>67</sup> For individuals with employer-sponsored health insurance, biosimilar competition could generate between \$893 and \$1,561 in OOP savings and \$6,254 and \$10,928 for biologics with a \$10,000 and \$70,000 list price, respectively.<sup>68</sup> The analysis found the lost savings for patient OOP costs due to successful rebate walls under Medicare Part D are less than under the employer-sponsored benefit design yet still substantial.<sup>69</sup> The suppressive effect of rebate walls on potential cost savings from biosimilars is especially important because biologics currently make up a large and increasing share of overall spending on pharmaceutical drugs in the U.S. Although they constitute only about 2% of all prescriptions in the U.S., biologics account for 43% of total drug expenditures<sup>70</sup> and have accounted for over 90% of the growth in net drug spending in the country since 2014.<sup>71</sup>

Rebate walls incentivize payers to prefer short-term rebates over long-term savings from biosimilars.<sup>72</sup> In turn, this diminishes incentives for manufacturers to bring new biosimilar products to market with a harmful effect on innovation and competition.<sup>73</sup> Additionally, provider and patient-related barriers to switching contribute to the exclusion of biosimilars from the market that perpetuates rebate walls, thereby limiting competition that could help lower net costs in the U.S. By limiting the scale and speed at which biosimilars can gain access to a sizeable share of the market, rebate walls discourage potential competitors from making the necessary investments. This can complicate the creation of a robust biosimilar market, further contributing to potential lost savings from competition,<sup>74</sup> and potentially adversely impacting supply security for biologic treatments.<sup>75</sup> These impacts are experienced more acutely in the biologics market than in the small-molecule pharmaceutical market because biologics are more resource-intensive to develop and manufacture than small-molecule drugs.

While biosimilars take between seven and eight years to develop, cost between \$100 million and \$250 million, and require human trials,<sup>76, 77</sup> generic drugs take on average one to three years, between \$1 million and \$5 million, and do not require human clinical trials, only relatively simple bioequivalence studies.<sup>78</sup> Rebate walls effectively limit competition and maintain high costs paid by payers and patients, ultimately harming patients by restricting access to equally effective and less costly biosimilars.

## Potential Solutions to Address Rebate Walls

There are several approaches that could provide some solutions to address the issue of rebate walls and, as applicable, it may be effective to use a combination of the approaches described below. In addition, some of these proposed approaches apply to biologics and biosimilars that are covered in both the medical and pharmacy benefits, while others offer solutions that can help mitigate rebate walls only in the retail setting.

Over the past couple of years, there has been bipartisan momentum to address rebate walls as a means to promote competition and lower drug costs. In June 2020, four members of Congress requested that the Government Accountability Office (GAO) study the effects of rebate walls on pharmaceutical pricing, competition, and innovation.<sup>79</sup> It does not appear that a GAO report has been completed. The next month, in July 2020, the House Appropriations Committee Report on the 2021 Financial Services and General Government Appropriations Bill<sup>80</sup> requested that the FTC prioritize investigations into manufacturers using anticompetitive rebate walls and submit a report regarding the agency's efforts to address rebate walls (leading to the May 2021 FTC Report on Rebate Walls<sup>81</sup>). The House Appropriations Committee also encouraged coordination between FTC, CMS, and FDA to optimize enforcement and consumer education activities regarding rebate walls.<sup>82</sup>

There has not yet been specific legislation introduced in Congress to ban the use of rebate walls and lawmakers could consider a legislative proposal to prohibit or limit the use of these practices to maximize competition and lower drug spending. Other recent actions have been taken to reform the use of rebates in general, aiming to at least partially resolve the issue of rebate walls. Although it does not specifically address rebate walls, the Trump Administration's rebate rule would have effectively banned rebates from Medicare Part D, replacing them with POS discounts. However, because of the impact of higher federal government subsidies of Part D premiums, and higher net drug prices, the rule was projected to substantially increase government costs and is on hold for the foreseeable future. There are other meaningful approaches to addressing rebate walls that we discuss in greater detail below.

### Antitrust Solutions

Policymakers could police anticompetitive rebate practices under the antitrust laws. The purpose of American antitrust law is to ensure market competition and to prohibit conduct that harms consumers,<sup>83</sup> and those laws offer an assortment of enforcement mechanisms to choose

from.<sup>84</sup> As is discussed herein, both the Sherman Act, the cornerstone statute of U.S. antitrust, and the more flexible Federal Trade Commission Act offer a variety of theories which could challenge anticompetitive rebate practices.

### Enforcement under the Sherman Act

Actions under the Sherman Act can be initiated by the Department of Justice, the Federal Trade Commission, state Attorneys General, and any private party that suffers harm from anticompetitive conduct.<sup>85</sup>

The FTC has already suggested that Sherman Act jurisprudence offers several theories that could be used to combat certain rebate walls.<sup>86</sup> The most promising approach would characterize rebate policies as an illegal “bundle” of discounts, offered exclusively to downstream distributors, that forecloses entry to rivals. Although selling goods at volume discounts is often regarded as an efficient practice that might lower production or transaction costs, many recognize that bundles can harm competition when they enable a firm to exclude equally or more efficient competitors from the market.<sup>87, 88</sup>

Even though a competitor’s inability to gain market share does not inherently signal anticompetitive exclusion, courts have recognized harmful exclusion when a monopolist “use[s] its power to break the competitive mechanism and deprive customers of the ability to make a meaningful choice.”<sup>89</sup> Thus, a successful challenge of a rebate wall under the Sherman Act must highlight the practice’s exclusionary impact and the resulting reduction in output, increase in price, or loss of innovation. Courts have recognized various approaches to ascertaining the anticompetitive potential of a rebate wall depending on whether the scheme centers on a single product or indication, a single product with multiple indications, or multiple products.

#### a. Basic Rebate Walls—Single Product, Single Indication

The principal difficulty in succeeding under the Sherman Act lies in distinguishing anticompetitive exclusionary conduct from procompetitive or permissible conduct, since so often the same conduct can be either procompetitive or anticompetitive, depending on the circumstances. This task is particularly challenging in basic rebate wall cases because the bundle’s primary effect—a price reduction on a single good—is presumed to benefit consumers. This presumption can be rebutted if rebating practices, even if it generates short-term discounts, are responsible for raising barriers to entry, deterring new entrants, or otherwise lessening the likelihood of long-term competitive pricing.

The anticompetitive effects of a basic rebate wall could be shown if it bundles existing power over an *incontestable* population to exclude competitors from a *contestable* population. In the biologics market, an incontestable population is composed of patients unwilling to switch drugs for reasons that would be unaffected by the presence of an adequate substitute; such reasons range from therapeutic stabilization to misperceptions of the efficacy of competitor to superior marketing or distribution. Producers of originator biologics often capture this incontestable



population from first-mover advantage, and the antitrust laws do not condemn it. However, if the originator then negotiates for preferred formulary placement to attract new patients, which constitute *contestable* demand, and the pursuit of those new patients is lined with substantial rebates, then the rebates might constitute a Sherman Act violation if they prevent the entry of biosimilars that nonetheless exhibit lower per-unit price.

The notion that bundling incontestable demand with contestable demand within the same product market might violate the Sherman Act has received increased recognition in recent litigation, but courts have yet to determine that such conduct is a Sherman Act violation. For example, in *Eisai, Inc. v. Sanofi Aventis U.S.*, the Third Circuit acknowledged but explicitly dismissed such a theory for want of “concrete examples of anticompetitive consequences” demonstrating why as-efficient competitors were excluded. In particular, the court desired factual support that industry costs were so high that hypothetical as-efficient competitors had no means of obtaining market shares in the incontestable population.<sup>90</sup>

A similar ruling was reached in *In re EpiPen*.<sup>91</sup> There, the court followed *Eisai* in denying a plaintiff’s motion for summary judgment, reasoning that the evidence lacked quantification of non-contestable market share and contained testimony that payers could, and had, shifted product use away from the originator drug.<sup>92</sup> The court in *Pfizer Inc. v. Johnson & Johnson*—a case centering on Johnson & Johnson’s alleged rebate wall for its originator biologic, Remicade—did go so far as to uphold the incontestable demand theory against a defendant’s motion to dismiss. Still, the requisite factual support was attained only after the court resolved all factual allegations in favor of the plaintiff—a determination mandated by procedural posture. Thus, although *Eisai*, *In re EpiPen*, and *Pfizer* provide some guidance for plaintiffs seeking to contest a basic rebate wall, none demonstrate how plaintiffs should complete the difficult task of tying exclusionary claims to evidence that “incontestable demand is truly inelastic.”<sup>93</sup>

#### b. Rebate Walls from Single Products with Multiple Indications

A rebating scheme is more likely to be deemed anticompetitive if the bundle encompasses additional products and indications. Like basic rebate walls, the concern in multi-indication and multi-product bundles is whether a monopolist leverages existing demand—either for a product’s additional indication or for an additional product—to monopolize the market at issue. The greater the potential rebates across various markets, the greater a payer’s incentive to favor a monopolist over lower-priced competitors lacking equally diverse bundles. Courts have adopted two major approaches in determining whether a monopolists’ multi-indication or multi-product bundle improperly excludes competition: the discount-attribution test, discussed in *PeaceHealth* below, and the *LePage’s* standard, discussed in relation to multi-product bundles.

In *Cascade Health Solutions v. PeaceHealth*,<sup>94</sup> the Ninth Circuit articulated a “discount-attribution” test that conditions an antitrust violation on proof that a bundle was priced below a reasonable measure of cost. The dispute involved a hospital system that dominated the

market for tertiary care. The hospital offered bundled rebates on tertiary services to those insurers who made the hospital their sole provider for all services, including primary and secondary care for which there were competitive alternatives. The Ninth Circuit ruled that a multi-component rebate is anticompetitive only if it involves cost-shifting that amounts to predatory pricing, or temporarily offers a below-cost price to drive out competitors.

To assess whether a bundle is predatory, the Ninth Circuit developed the discount-attribution test, which calculates the sum of the rebates offered by the monopolist's bundle and then attributes the discount to the product receiving the alleged anticompetitive advantage. Only if the resulting price falls below a reasonable measure of cost—meaning that even equally efficient competitors would not be able to compete profitably—will the rebating practice be deemed exclusionary. Thus, for PeaceHealth's three-tiered bundle to be held anticompetitive, the price for primary and secondary services must have fallen below cost after factoring the entirety of the potential rebate to each, respectively.

The discount-attribution test has been increasingly favored by courts for its utility and reliance on ascertainable cost measures to identify competitive harm.<sup>95</sup> The standard is particularly applicable where, like in *PeaceHealth*, a product or service competes in multiple markets or has several indications. In such circumstances, a rebate in one market can be used to leverage sales in the others. Parties challenging rebate walls as anticompetitive multi-component bundles should expect courts to apply the discount-attribution test and prepare accordingly as the standard's price-cost rigidity may suppress otherwise viable claims of exclusion.<sup>96</sup>

### c. Bundling Products—Rebate Walls from Multiple Products

The potential for anticompetitive harm is likely greatest when the rebating scheme centers on multiple products. Such bundles derive their leverage from a monopolist's ability to rebate unique, essential goods that competitors do not offer, consequently incentivizing payers to exclude firms based on product offering.

The concern present in multi-product rebate walls is similar to the anticompetitive harm of antitrust "tying" cases. Tying occurs when a seller coerces buyers into purchasing two products by conditioning the acquisition of one product on the other, thereby forcing buyers to buy the "tied" product from that seller rather than from a more efficient rival. Bundling differs from tying in that there is no express condition that products must be purchased in conjunction. Instead, payers are only *incentivized* to buy packaged goods. They retain the ability to forgo cost savings and make separate product purchases.

A successful challenge of a multi-product rebate wall hinges on a plaintiff's showing that a bundle rendered it such that no other rational, competitive choice existed. Such was the case in *LePage's Inc. v. 3M*,<sup>97</sup> where the Third Circuit found that a monopolist's bundled rebate left buyers with no choice as to purchase the dominant producer's good. In *LePage's*, the rebate was linked to the sum of the number of product lines in which buyers met purchasing targets. This rebate scheme prevented a single-product producer from reaching buyers with a

comparable product. The Third Circuit ruled that a bundle was illegal if it excluded “a potential competitor who does not manufacture an equally diverse group of products and who therefore cannot make a comparable offer.”<sup>98</sup>

The *LePage’s* standard presents the most plaintiff-friendly approach for challenging rebate walls because it allows an antitrust claim to succeed solely based on product offering and without quantifications of cost or demand. For this reason, scholars have warned that the test might chill some potentially efficient bundling,<sup>99</sup> and courts have consequently sought other approaches, the most prominent alternative being the discount-attribution test. Still, despite its critiques, the *LePage’s* standard should be helpful to rebate wall challengers hoping to sustain a claim against a wall composed of goods rebated at a price above cost.

### Enforcement Under the FTC Act

The FTC may also challenge rebate walls under Section 5 of the FTC Act,<sup>100</sup> which grants the Commission supplementary enforcement power over “unfair methods of competition in or affecting commerce.”<sup>101</sup> The authority to prohibit unfair methods of competition certainly includes the authority to enforce the Sherman Act, but it might include more expansive powers as well. For example, Section 5 has been held to authorize the FTC to prohibit conduct that has yet to harm competition but would if allowed to continue, such as an invitation to fix prices that ultimately is not accepted.<sup>102</sup> Although the scope of the FTC’s power under Section 5 is still a matter of debate, Chair Lina Khan has indicated an eagerness to investigate a wide range of alleged exclusionary conduct under Section 5.<sup>103</sup> Similarly, former Commissioner Rohit Chopra has expressed the need for the FTC “to pursue research and to conduct rulemakings that specify when certain pharmaceutical industry practices, such as PBM rebating, are unlawful under Section 5 of the Federal Trade Commission Act.”<sup>104</sup>

Rebate walls might be an appropriate target for Section 5 enforcement. Although many rebate practices may not conclusively cause competitive harm or lead to predatory pricing, they clearly erect entry barriers and have exclusionary consequences. If a further study by the FTC indicates that the agency is confident that rebate walls are harmful, they could fittingly invoke Section 5 powers and target rebate walls without shouldering the cumbersome evidentiary burden that accompanies a Sherman Act claim.

### Physician Guidelines and Changing Stakeholder Perceptions on Switching

As most biosimilars are physician-administered, the threat of rebate walls could be mitigated by changing provider notions and perceptions of switching from originators to biosimilars. While physician awareness and education to support biosimilar uptake have been increasing, there are still significant hurdles. Prescriber hesitations around mid-treatment switching, and confusion around the meaning and significance of the words “switching,” “similar,” and “interchangeable” can lead to continued demand for the higher-cost originator product. The misinformation sometimes directed towards biosimilars is inconsistent with the requirement that all approved biosimilars have no clinically meaningful differences from their originator

biologics and that according to the FDA, they can be prescribed for both treatment-naïve patients and patients that are already on the reference product.<sup>105</sup> Informed by the experience of some European countries that have almost entirely switched patients from the originator to the biosimilar, physician buy-in is key to achieving a large-scale market switch,<sup>106</sup> and real-world evidence and other data about the safety and efficacy of biosimilars can be effectively used to help overcome negative misperceptions about biosimilar switching. Additionally, national treatment guidelines or endorsements of biosimilar use have been key to some European countries' success in making large-scale switches to biosimilars.<sup>107</sup>

With mounting evidence on lack of adverse health outcomes from switching,<sup>108, 109</sup> professional medical colleges, societies, and physician organizations could support the switch to biosimilars and specify the conditions under which biosimilars should be used as first-line agents, giving providers the necessary encouragement to promote switching, which in turn, could help remove the threat of the traps. Moreover, patients are likely to be more open to switching to a biosimilar if the treatment switch decision is made by their care provider, instead of their insurance provider. The acceptance of biosimilars among all key stakeholders—providers, payers, and patients—should ultimately reach the level of acceptance of generic drugs. Originator companies should also assure they communicate accurately about biologics and biosimilars (including interchangeable biosimilars) and where necessary, the FTC should deter and address false or deceptive communications.

## Interchangeability and Pharmacy Substitution

The advent of interchangeable biosimilars could be a partial solution for the rebate trap problem as it could provide pharmacies with the freedom to switch based on economics, similar to their ability to substitute a generic for its reference branded product, which could facilitate fast market share growth for lower-priced biosimilars, helping to overcome the rebate trap.<sup>110</sup>

However, this impact is going to be limited to pharmacy biosimilars where interchangeability plays a role, whereas most biosimilars are physician-administered and unlikely to pursue this regulatory designation. Additionally, sponsors of pharmacy biosimilars might have a limited appetite to pursue interchangeability given that the switching studies that the FDA expects to be included in an application for a new interchangeable product are very costly. At the time of writing this paper, very few companies have publicly disclosed their intention to pursue interchangeability and only two products very recently achieved it. The first was Semglee (insulin glargine-yfng), a biosimilar to the insulin Lantus, a relatively simple biologic.<sup>111</sup> In October 2021, the FDA granted interchangeability to Cyltezo, a biosimilar to the blockbuster Humira (adalimumab), a monoclonal antibody. However, Cyltezo (and other adalimumab biosimilars) may not come to market until 2023 as a result of intellectual property protections and legal settlements with Humira's manufacturer.

Given the growing clinical evidence on switching, the FDA can play a role in paving the way for more interchangeable biosimilars to promote their adoption and help overcome rebate walls. For instance, in cases of products where the evidence of clinical equivalence supporting

interchangeability is strongest, the FDA should be open to not requiring the switching studies it currently requires from biosimilar sponsors seeking the interchangeability designation in addition to the existing requirements to demonstrate biosimilarity. A product could be established as biosimilar and interchangeable based on the data package submitted to demonstrate biosimilarity. However, in cases of more complex biosimilars or if there are specific immunogenicity concerns, studies with at least three switches may still offer important information for the use of the product in the U.S. health care setting. Pairing greater flexibility in the requirements for interchangeability with requirements to collect postmarket, real-world data on the approved interchangeable product would be instrumental to ensuring that the product is safe and effective. Alternatively, the FDA could consider outlining a process of approving a product as a biosimilar and then utilizing postmarket real-world data collection to demonstrate interchangeability.<sup>112</sup> Sponsors already collect real-world data to justify why payers should use their products so formal postmarket regulatory requirements to collect real-world data would not be a significant additional burden.<sup>113</sup> These approaches would provide data to clinicians that want to ensure therapies are safe and effective while minimizing the need for burdensome and perhaps unnecessary clinical trials that may deter applicants from seeking an interchangeable designation for a biosimilar product that is already required to demonstrate no clinically meaningful differences between it and the originator product.<sup>114</sup> Lastly, with over ten years since the passage of the U.S. biosimilar pathway, only two interchangeable products on the market, and the confusion that interchangeability potentially creates, Congress could also revisit the need for this statutory designation.

But even with interchangeability, rebate walls may still be hard to overcome because the uptake of a biosimilar may be modest as prescribers become more familiar with the product, especially in the early stages of market development, practically not allowing a full or near-complete market switch.<sup>115</sup> As discussed earlier, state laws are still restrictive in the large molecule space<sup>116</sup> and therefore, educational efforts would be critical to influencing prescribers' behaviors to support interchangeable biosimilars and permit their use when they are available. If providers are hesitant to allow substitution of these interchangeable products for their reference biologics, their uptake might be modest and rebate walls will continue to stand.

## Facilitating Greater Biosimilar Entry

The abbreviated licensure pathway for biosimilars allows for shorter and less costly development and therefore more entry and broader access to important biologic therapies if the originator loses market share and prices are reduced. The efficient development of biosimilars, or the extent to which the FDA can determine that the biosimilar has no clinically meaningful differences from its reference product without requiring large, lengthy, and costly clinical trials, is therefore important for reducing development costs and times and fostering more biosimilar competition.<sup>117</sup> With the growing experience of biosimilar development and use, it has been suggested that comparative clinical efficacy studies may be unnecessary in the development of most biosimilars as they contribute little additional evidence of biosimilarity<sup>118</sup> and extensive analytical testing and a pharmacodynamic (PD) study may be sufficient in most

cases.<sup>119</sup> The FDA could consider a tailored biosimilar clinical development approach without the routine need for comparative efficacy studies, and continue to introduce product-specific flexibilities as it did with insulins,<sup>120</sup> in line with the agency's Biosimilar Action Plan from 2018, which acknowledges a need for biosimilar development programs to be more efficient and to reduce the size of clinical trials.<sup>121, 122</sup> The U.S. biosimilar approval pathway could also be accelerated with increased use of real-world evidence from Europe (that has the most extensive experience to date with the use of biosimilars) regarding the safety and efficacy of biosimilars, which has not detected differences in the nature, severity, or frequency of adverse events versus the originator biologic. The FDA can take additional steps to streamline biosimilar approval pathways to make biosimilar market entry more efficient,<sup>123</sup> thereby fostering a more robust and competitive market of biosimilars that could help shift market shares away from higher-cost biologics.

Second, the role of patents has been central to biosimilars' pace of entry into the market. Originator manufacturers file and obtain large numbers of patents, sometimes as many as hundreds (many of which are often filed after the product has already been approved by the FDA<sup>124</sup>), to protect an individual biologic, making it difficult for biosimilar competitors to enter and compete. Moreover, the biologic patent resolution system (known as the "patent dance") is significantly more difficult for biosimilars to navigate<sup>125</sup> than the Hatch-Waxman process for small-molecule generics. Addressing biologic patent "thickets" that inappropriately thwart competition, such as by making reforms at the U.S. Patent and Trademark Office (USPTO) to promote the issuance of better patents, or by Congressional action, is key to fostering a more vibrant biosimilar market.

While more flexible approval pathways and the mitigation of patent barriers are not complete or direct solutions to anticompetitive rebate walls, these are steps that can help biosimilars succeed in the U.S. Increasing biosimilar entry is a critical component of the overall price reduction strategy for costly biologic therapies, and with more competition and lower prices, originator market power would be diminished, potentially changing buyers' economics in favor of biosimilars.

## Conclusion

By limiting the entry of lower-cost biosimilars, rebate walls lead to higher drug costs, diminished product choices, reduced innovation, and lower quality of care for patients. As more biosimilars continue to be approved by the FDA and launched onto the market with the potential to curb biologic drug spending, policymakers should carefully examine rebate wall practices and take action to address them so that biosimilars' savings potential can be fully realized. The ability of payers to move market shares from the originator product to the biosimilar is key to overcoming rebate walls. But structural and perception-related barriers that exist in the U.S. market are currently keeping biosimilars from reaching their potential and limiting their ability to generate additional savings. Educational strategies and real-world evidence should continue to be developed to build awareness of biosimilars, their safety, effectiveness, and the cost savings opportunities that they offer. Antitrust laws could also

provide several enforcement mechanisms that policymakers could use to challenge anticompetitive rebate walls, including both the Sherman Act and the Federal Trade Commission Act. Further analysis of legislative approaches to prohibit the use of rebate walls and encourage utilization of lower-cost biosimilars while achieving lower net costs should also be considered, as well as additional drug pricing and payment reforms to help biosimilars succeed and reduce overall U.S. drug spending. Finally, policymakers should continue to promote reforms that would facilitate more biosimilar introductions into the market, including streamlining biosimilar approval pathways to make biosimilar entry more efficient and addressing patent barriers that deter biosimilar entry, to enable a more competitive landscape for biologics.

## Disclosures

**Mark B. McClellan, MD, PhD, is an independent director on the boards of Johnson & Johnson, Cigna, Alignment Healthcare, and PrognomiQ; co-chairs the Guiding Committee for the Health Care Payment Learning and Action Network; and receives fees for serving as an advisor for Arsenal Capital Partners, Blackstone Life Sciences, and MITRE.**

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<sup>1</sup> U.S. Food and Drug Administration (FDA), “What Are ‘Biologics’ Questions and Answers.” Center for Biologics Evaluation and Research, February 28, 2019, <https://www.fda.gov/about-fda/center-biologics-evaluation-and-research-cber/what-are-biologics-questions-and-answers>.

<sup>2</sup> IQVIA Institute for Human Data and Science, “Biosimilars in the United States 2020-2024: Competition, Savings and Sustainability,” October 2020, <https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/iqvia-institute-biosimilars-in-the-united-states.pdf>.

<sup>3</sup> For example, IQVIA modeling suggests that savings from biosimilars will exceed \$100 billion in total over the next five years, although there is significant uncertainty around price and volume factors. IQVIA, “Biosimilars in the United States 2020-2024: Competition, Savings and Sustainability.”

<sup>4</sup> Sonia Tadjalli Oskouei and Andrew R. Kusmierczyk, “Biosimilar Uptake: The Importance of Healthcare Provider Education.” *Pharmaceutical Medicine* 35, no. 4 (July 1, 2021): 215–24. <https://doi.org/10.1007/s40290-021-00396-7>.

<sup>5</sup> See, e.g., Nitzan Arad et al., “Originator Biologics and Biosimilars: Payment Policy Solutions to Increase Price Competition While Maintaining Market Sustainability in Medicare Part B,” Duke University Margolis Center for Health Policy, October 2021.

<sup>6</sup> Federal Trade Commission (FTC), “Joint Statement of the Food & Drug Administration and the Federal Trade Commission Regarding a Collaboration to Advance Competition in the Biologic Marketplace,” February 3, 2020, [https://www.ftc.gov/system/files/documents/public\\_statements/1565273/v190003fdaftcbiologicsstatement.pdf](https://www.ftc.gov/system/files/documents/public_statements/1565273/v190003fdaftcbiologicsstatement.pdf).

<sup>7</sup> Citizen petitions allow interested parties to initiate administrative proceedings at the FDA by asking the Commissioner to issue, amend, or revoke a regulation or an order, or to take any other administrative action. In a September 2019 statement and the FDA’s Drug Competition Action Plan, The FDA recognizes that companies may use citizen petitions as an anticompetitive tactic to delay FDA action on a generic or other abbreviated application. The final guidance, Citizen Petitions and Petitions for Stay of Action Subject to Section 505(q) of the Federal Food, Drug, and Cosmetic Act, establishes the intention of the FDA to refer anticompetitive use of citizen petitions to the FTC to increase transparency thereby reducing hurdles to drug development and approval. See: U.S. Food and Drug Administration (FDA), “FDA In Brief: FDA issues final guidance to address ‘gaming’ by the use of citizen petitions,” September 18, 2019, <https://www.fda.gov/news-events/fda-brief/fda-brief-fda-issues-final-guidance-address-gaming-use-citizen-petitions?>.

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<sup>46</sup> FTC, “In Response to a Request for Comments on FDA’s Guidance for Industry on the ‘Nonproprietary Naming of Biological Products; Draft Guidance for Industry; Update,’” Comment of the Staff of the Federal Trade Commission, 84 Fed Reg. 8534 (Mar. 8, 2019), Submitted May 6, 2019, [https://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-staff-comment-fda-department-health-human-services-its-updated-guidance-industry-nonproprietary/ftc\\_comment\\_to\\_fda\\_2019\\_biologics\\_naming\\_guidance\\_5-6-19.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-fda-department-health-human-services-its-updated-guidance-industry-nonproprietary/ftc_comment_to_fda_2019_biologics_naming_guidance_5-6-19.pdf).

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<sup>83</sup> See, U.S. Department of Justice (DOJ), “Mission,” DOJ Antitrust Division (last updated July 20, 2015), <https://www.justice.gov/atr/mission>, (“The goal of the antitrust laws is to protect economic freedom and opportunity by promoting free and fair competition in the marketplace.”); and FTC, “The Antitrust Laws,” FTC Competition Guidance, <https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/antitrust-laws> (stating that the basic objective of the antitrust laws is “to protect the process of competition for the benefit of consumers, making sure there are strong incentives for businesses to operate efficiently, keep prices down, and keep quality up”).

<sup>84</sup> FTC, “The Antitrust Laws.”

<sup>85</sup> A private party bringing an antitrust action must prove that the challenged conduct is causing a cognizable injury to the plaintiff. Public enforcers, like the FTC, DOJ, and state attorney generals, need only prove that the targeted conduct causes market harm. See, Phillip E. Areeda and Herbert Hovenkamp, *Antitrust Law*, ¶ 303, at 62 (4th ed. 2014). By tradition, anticompetitive conduct in the pharmaceutical sector is policed by the FTC, not the DOJ.

<sup>86</sup> FTC, “Potential legal theories that might apply in an antitrust challenge to a rebate wall include exclusive dealing, bundling, and tying.” Federal Trade Commission Report on Rebate Walls, [https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-report-rebate-walls/federal\\_trade\\_commission\\_report\\_on\\_rebate\\_walls.pdf](https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-report-rebate-walls/federal_trade_commission_report_on_rebate_walls.pdf).

<sup>87</sup> *Cascade Health Solutions v. PeaceHealth*, 515 F.3d at 908–09 (quoting 909 Brief for United States as Amicus Curiae at 14, *3M Co. v. LePage’s Inc.*, 542 U.S. 953) (“There is insufficient experience with bundled discounts to this point to make a firm judgment about the relative prevalence of exclusionary versus procompetitive bundled discounts.”).

<sup>88</sup> The court discussed this hypothetical in *Ortho Diagnostic Sys., Inc. v. Abbott Labs., Inc.* :

“Assume for the sake of simplicity that the case involved the sale of two hair products, shampoo and conditioner, the latter made only by A and the former by both A and B. Assume as well that both must be used to wash one’s hair. Assume further that A’s average variable cost for conditioner is \$2.50, that its average variable cost for shampoo is \$1.50, and that B’s average variable cost for shampoo is \$1.25. B therefore is the more efficient producer of shampoo. Finally, assume that A prices conditioner and shampoo at \$5 and \$3, respectively, if bought separately but at \$3 and \$2.25 if bought as part of a package. Absent the package pricing, A’s price for both products is \$8. B therefore must price its shampoo at or below \$3 in order to compete effectively with A, given that the customer will be paying A \$5 for conditioner irrespective of which shampoo supplier it chooses. With the package pricing, the customer can purchase both products from A for \$5.25, a price above the sum of A’s average variable cost for both products. In order for B to compete, however, it must persuade the customer to buy B’s shampoo while purchasing its conditioner from A for \$5. In order \*1207 to do that, B cannot charge more than \$0.25 for shampoo, as the customer otherwise will find A’s package cheaper than buying conditioner from A and shampoo from B. On these assumptions, A would force B out of the shampoo market, notwithstanding that B is the more efficient producer of shampoo, without pricing either of A’s products below average variable cost.”

*Ortho Diagnostic Systems, Inc. v. Abbott Laboratories, Inc.*, 920 F.Supp. 455, 467 (S.D.N.Y. 1996), as corrected (Mar. 22, 1996).

<sup>89</sup> *Eisai, Inc. v. Sanofi Aventis U.S., LLC*, 821 F.3d 394, 404 (3d Cir. 2016) (Quoting ZF Meritor, 696 F.3d at 285).

<sup>90</sup> *Eisai, Inc. v. Sanofi Aventis U.S., LLC*, (2016).

<sup>91</sup> In re EpiPen (Epinephrine Injection, USP) Marketing, Sales Practices & Antitrust Litigation, 507 F. Supp. 3d 1289 (D. Kan. 2020).

<sup>92</sup> In re EpiPen (Epinephrine Injection, USP) Marketing, Sales Practices & Antitrust Litigation, 507 F. Supp. 3d 1289 (D. Kan. 2020).

<sup>93</sup> This is the critical presumption made by the *Pfizer* court in refusing to grant Johnson & Johnson’s motion to dismiss as it related to contestable and incontestable demand. *Pfizer Inc. v. Johnson & Johnson*, 333 F. Supp. 3d 494, 504 (E.D. Pa. 2018).

<sup>94</sup> *Cascade Health Solutions v. PeaceHealth*, (9th Cir. 2008).

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<sup>95</sup> There is no consensus on a definitive measurement of cost. For a chart detailing the various circuit outlooks see: “PREDATORY PRICING: APPROPRIATE MEASURE OF COST BY US CIRCUIT COURT CHART, PRACTICAL LAW CHECKLIST,” Thomson Reuters Westlaw, 8-522-4213, <https://us.practicallaw.thomsonreuters.com/8-522-4213>.

<sup>96</sup> Note, however, that parties have quibbled as to how the discount-attribution test should be applied. For example, in one case, the plaintiff asserted that the best approximation of market realities would entail applying the test only to the contestable share of the relevant product market. The court, hesitant to open the simplicity of the discount-attribution test to the uncertainty associated with quantifying contestability, rejected this approach in ruling for the defendant. Thus, although the discount-attribution test offers a reliable means of assessing rebating practices, its price-cost rigidity may suppress otherwise viable claims of exclusion. *Inline Packaging, LLC v. Graphic Packaging Int'l, LLC*, 351 F. Supp. 3d 1187, 1211 (D. Minn. 2018), *aff'd*, 962 F.3d 1015 (8th Cir. 2020).

<sup>97</sup> *LePage's, Inc. v. 3M*, 324 F.3d 141, 144 (3d Cir. 2003).

<sup>98</sup> *LePage's, Inc. v. 3M*, (3d Cir. 2003).

<sup>99</sup> One scholar argued:

“The *LePage's* approach is problematic for at least two reasons. First, the approach may force consumers to subsidize less efficient competitors and thus runs counter to a policy of vigorous competition in which firms succeed or fail based solely on their relative efficiencies... A second problem with the *LePage's* approach is that its focus on product line breadth threatens to chill bundling, a business practice that frequently creates efficiencies and provides benefits to consumers.”

Thomas A. Lambert, “Evaluating Bundled Discounts,” 89 *Minn. L. Rev.* 1688, 1722-23 (2005).

<sup>100</sup> 15 U.S.C. § 45(a) (1914).

<sup>101</sup> 15 U.S.C. § 45(a)(1) (“Unfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce, are hereby declared unlawful.”)

<sup>102</sup> See, e.g., *In re U-Haul Int'l, Inc.*, 150 F.T.C. 1, 53 (2010); *In re Valassis Commc'ns, Inc.*, 141 F.T.C. 247 (2006).

<sup>103</sup> *Statement of Chair Lina M. Khan Joined by Commissioner Rohit Chopra and Commissioner Rebecca Kelly Slaughter on the Withdrawal of the Statement of Enforcement Principles Regarding “Unfair Methods of Competition” Under Section 5 of the FTC Act*, FTC (July 1, 2021), [https://www.ftc.gov/system/files/documents/public\\_statements/1591498/final\\_statement\\_of\\_chair\\_khan\\_joined\\_by\\_rc\\_and\\_rks\\_on\\_section\\_5\\_0.pdf](https://www.ftc.gov/system/files/documents/public_statements/1591498/final_statement_of_chair_khan_joined_by_rc_and_rks_on_section_5_0.pdf).

<sup>104</sup> *Statement of Commissioner Rohit Chopra Regarding the Commission's Report on Pharmacy Benefit Manager Rebate Walls*, FTC (May 28, 2021), <https://www.ftc.gov/public-statements/2021/05/statement-commissioner-rohit-chopra-regarding-commissions-report-pharmacy>.

<sup>105</sup> Richard Mark Kirkner, “FDA's Gottlieb Aims to End Biosimilars Groundhog Day.” *Managed Care Special Report Biosimilars Can They Clear the Obstacles?* (January 2019): 5-6.

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<sup>106</sup> Thomas Meek, “Nordic Countries near Complete Switch to Biosimilar Remicade,” *APM Health Europe*, May 2, 2016, [https://www.apmhealthurope.com/libre\\_story.php?numero=47642](https://www.apmhealthurope.com/libre_story.php?numero=47642).

<sup>107</sup> Meek, “Nordic Countries near Complete Switch to Biosimilar Remicade.”

<sup>108</sup> Hans C. Ebbers, Michael Muenzberg, and Huub Schellekens, “The Safety of Switching between Therapeutic Proteins,” *Expert Opinion on Biological Therapy* 12, no. 11 (November 1, 2012): 1473–85,

<https://doi.org/10.1517/14712598.2012.711308>.

<sup>109</sup> See also, from the experience and guidance of Europe and Canada: European Medicines Agency (EMA) and European Commission (EC), “Biosimilars in the EU: Information guide for healthcare professionals,” (October 2019), [https://www.ema.europa.eu/en/documents/leaflet/biosimilars-eu-information-guide-healthcare-professionals\\_en.pdf](https://www.ema.europa.eu/en/documents/leaflet/biosimilars-eu-information-guide-healthcare-professionals_en.pdf);

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- <sup>110</sup> Stanton R. Mehr, and Richard A. Brook. “Factors Influencing the Economics of Biosimilars in the US.” *Journal of Medical Economics* 20, no. 12 (December 2, 2017): 1268–71. <https://doi.org/10.1080/13696998.2017.1366325>.
- <sup>111</sup> “FDA Approves First Interchangeable Biosimilar Insulin Product for Treatment of Diabetes.” FDA, July 28, 2021, <https://www.fda.gov/news-events/press-announcements/fda-approves-first-interchangeable-biosimilar-insulin-product-treatment-diabetes>.
- <sup>112</sup> Brian Canter et al., “Revisiting Interchangeability to Realize the Benefit of Biosimilars,” Duke University Margolis Center for Health Policy, October 2021.
- <sup>113</sup> Babette S. Edgar et al., “Overcoming Barriers to Biosimilar Adoption: Real-World Perspectives from a National Payer and Provider Initiative,” *Journal of Managed Care & Specialty Pharmacy* 27, no. 8 (August 2021): 1129–35, <https://doi.org/10.18553/jmcp.2021.27.8.1129>.
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- <sup>118</sup> Webster: “No biosimilar that has been found to be highly similar to its reference by both analytical and human pharmacokinetic studies has ever failed to be approved because it was found not to be clinically equivalent to its reference in a powered [efficacy] study”
- <sup>119</sup> Marie-Christine Bielsky et al., “Streamlined Approval of Biosimilars: Moving on from the Confirmatory Efficacy Trial,” *Drug Discovery Today* 25, no. 11 (November 1, 2020): 1910–18, <https://doi.org/10.1016/j.drudis.2020.09.006>.
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- <sup>121</sup> Martin Schiestl et al., “The Path Towards a Tailored Clinical Biosimilar Development,” *BioDrugs* 34, no. 3 (June 1, 2020): 297–306, <https://doi.org/10.1007/s40259-020-00422-1>.
- <sup>122</sup> FDA, “Biosimilars Action Plan: Balancing Innovation and Competition,” July 2018, <https://www.fda.gov/media/114574/download>.
- <sup>123</sup> For example, recent research has found biosimilar approval in the U.S. to require testing standards similar to those required for *new* small-molecule drugs, and that most comparative efficacy trials for biosimilars appeared to often be larger, longer, and more costly than pivotal trials for new small-molecule drugs. See Thomas J. Moore et al., *Assessment of Availability, Clinical Testing, and US Food and Drug Administration Review of Biosimilar Biologic Products*, 181 *JAMA INTERN. MED.* 52 (2021).
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- <sup>125</sup> For descriptions of the so-called “patent dance” between biologic and biosimilar manufacturers, see Jeffrey Wu & Claire Wan-Chiung Cheng, *Into the Woods: A Biologic Patent Thicket Analysis*, 19 *CHI.-KENT J. INTELL. PROP.* 93, 105–106 (2019)