Spotlight

Trends in Utilization Management of Prescription Drugs in Top Marketplace Plans

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Under the Affordable Care Act (ACA), millions of uninsured or underinsured individuals gained access to qualified health insurance through the federal and state-based health insurance marketplaces. Nationally, adults ages 50 to 64 have consistently composed the largest segment of enrollees in the health insurance marketplaces, representing around one-third of all enrollees since 2014.1 Among the many important benefits of marketplace coverage to adults ages 50 to 64 is prescription drug coverage. According to a 2019 poll, three-fourths of adults ages 50 to 64 reported taking at least one prescription drug, compared to half of adults ages 30 to 49 and nearly 4 in 10 adults ages 18 to 29.2 Moreover, 32 percent of adults ages 50 to 64 reported taking four or more prescriptions.

Yet, even when an individual has health coverage, access to drugs is not always straightforward. Marketplace plans, like most other health plans, apply utilization management (UM) tools to manage access to and the cost of certain prescription drugs—to balance drug spending and appropriate consumer access.3 Meanwhile, some drug companies, health care providers, and consumers have raised concerns about UM and supported efforts to limit its use.4

AARP contracted with Avalere Health to examine prescription drug UM in the top 10 marketplace plans by enrollment (between 12,000 and 1.5 million individuals in each state between 2016 and 2020) in all 50 states and the District of Columbia.5 The analysis focused on brand name drugs in five therapeutic areas—antipsychotics, cancer, chronic obstructive pulmonary disease (COPD), cardiovascular disease, and diabetes—commonly taken by older adults.6 This Spotlight discusses and examines UM trends in these top 10 marketplace plans between 2016 and 2020.

Background on Utilization Management

Utilization management is a broad term that describes the variety of tools an insurer might use to help ensure a consumer has...
access to proper care and required services while controlling costs. In the context of prescription drugs, insurers can use UM to prevent overutilization and underutilization of medications, promote patient safety, and strike a balance between offering consumers access to a range of brand name drugs and limiting a plan’s exposure to the high prices associated with these drugs. Three of the most commonly used UM tools are quantity limits, step therapy, and prior authorization.

In practice, a Pharmacy and Therapeutics (P&T) Committee of medical professionals, provides insurers with evidence-based advice on the medications that a plan may elect to include in its drug formulary (i.e., its list of covered drugs), including which covered drugs receive UM. P&T Committees often meet and make decisions behind closed doors: Consumers and other stakeholders have little insight into the decision-making process.

Neither the tools of UM nor the use of them is new. As prescription drug formularies have evolved, health plans have applied certain drugs to UM. Over time, the structure of UM tools and the frequency with which insurers and pharmacy benefit managers (PBMs) applied these tools evolved to meet the changing demands of the prescription drug market, including the availability of an increasing number of expensive drugs. Today, more than 94 percent of plans report using UM to manage costs and access.

The ACA did not change the UM process for plans. Marketplace plans, like most commercial plans, set and follow self-prescribed criteria for UM. The ACA did, however, require oversight of UM. The law required that a P&T Committee review each plan’s overall UM policies as well as the criteria that plans use to determine which tool applies to each drug.

Utilization Management Trends in Top 10 Marketplace Plans

The current analysis examined the extent of a plan’s coverage of brand name drugs in the five key therapeutic areas as well as the application of UM on those drugs. Between 2016 and 2020, plans annually determined which drugs to cover in a therapeutic area and which of these drugs would have UM. These determinations show trends in both the percentage of covered drugs with UM and the particular UM tools used by plans.

Intensity of UM among Covered Drugs

In 2020, the top 10 marketplace plans applied UM to a higher share of covered drugs than they did in 2016. While more brand name drugs came on the market in most therapeutic areas over the period, plans actually decreased the number of brand name drugs they covered. As new drugs entered the market, brand name drugs lost patent exclusivity, and as therapeutic equivalents became available, plans adjusted the range of covered drugs available to consumers.

Common Utilization Management Tools

- **Prior authorization**: A requirement that a provider or consumer seek approval from an insurer before the dispensing of a medication.
- **Quantity limits**: A restriction on the amount of a medication available to a consumer in a certain period of time (usually 30 days).
- **Step therapy**: A requirement that a consumer try other, less expensive medications before a higher priced medication can be dispensed.
The share of covered brand name drugs by the top marketplace plans declined from 2016 to 2020 (figure 1). In all five therapeutic areas, plans reduced the percentage of brand name drugs that they covered. The reduction was over 15 percentage points for all therapeutic areas and 19 percentage points for cancer drugs.

From 2016 to 2020, the number of covered brand name drugs with UM in each therapeutic area did not change dramatically. The average number of covered drugs among the top 10 plans increased in three areas (cancer, COPD, and cardiovascular disease) and decreased in two area (antipsychotics and diabetes). However, the shrinking pool of covered brand name drugs over the same period resulted in a higher percentage of covered drugs with UM for four therapeutic areas (figure 2). Diabetes drugs increased by 8 percentage points and cancer drugs increased by 17 percentage points.

**FIGURE 1**

**Percentage of Covered Drugs, by Therapeutic Area**

<table>
<thead>
<tr>
<th>Therapeutic Area</th>
<th>2016</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotics</td>
<td>57%</td>
<td>60%</td>
</tr>
<tr>
<td>Cancer</td>
<td>68%</td>
<td>85%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>67%</td>
<td>61%</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>45%</td>
<td>46%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>53%</td>
<td>61%</td>
</tr>
</tbody>
</table>

**Source:** Avalere Health analyzed formularies using comprehensive formulary data provided by Managed Markets Insight & Technology, LLC (MMIT). For this work, Avalere analyzed MMIT’s data from the exchange plans. Results are enrollment weighted.
Application of Certain UM Tools

As insurers increased the percentage of covered brand name drugs with UM, they also showed preference for certain UM tools (figure 3). While the top 10 marketplace plans applied each of the three dominant UM tools—step therapy, prior authorization, and quantity limits—to a set of brand name drugs in each of the five therapeutic areas, the plans favored two particular tools over the study period: prior authorization and quantity limits. In 2020, plans applied either quantity limits or prior authorization to only 9 percent of covered drugs. Plans used prior authorization in combination with other UM tools slightly more frequently (17 percent) than they used quantity limits in combination with other tools (16 percent). Plans applied these tools with similar frequency in 2016.

The data also show a preference for certain tools in certain therapeutic areas. Between 2016 and 2020, the top 10 marketplace plans applied prior authorization to more than half of covered cancer drugs, which are complex and typically have a high price tag. Additionally, plans applied quantity limits to slightly less than one-third of covered COPD drugs, many of which are aerosolized and require proper dosage management to avoid misuse or waste.13

Utilization Management Trends Raise Questions

The trends identified in this analysis show that consumers faced an increasing concentration of UM from 2016 to 2020. Not only did the top 10 marketplace plans apply UM to more covered brand name drugs in four of the five therapeutic areas across the period, but they also subjected a consistently high percentage of drugs in certain therapeutic areas to certain UM tools. These trends, meant to manage utilization and spending, require further scrutiny to better understand if and how UM might limit appropriate access for enrollees ages 50 to 64. In the meantime, the following policy changes warrant consideration to help consumers navigate prescription drug UM under their plans:

Improved Transparency—Consumers encounter UM largely without explanation. Not only do insurers set formularies, and fix UM, without consumer input, but they also do not share the motivations and evidence behind these actions.14 Insurers, PBMs, and P&T Committees should improve transparency about formulary decisions and how UM decisions are made about particular drugs and ensure that consumers have access to these data.

FIGURE 3
2020 Average Percentage of Brand Name Drugs Covered by UM Tools

<table>
<thead>
<tr>
<th>Therapeutic Area</th>
<th>Step Therapy Only</th>
<th>Prior Authorization Only</th>
<th>Quantity Limits Only</th>
<th>Prior Authorization and Step Therapy</th>
<th>Step Therapy and Quantity Limits</th>
<th>Prior Authorization and Step Therapy, Quantity Limits</th>
<th>Prior Authorization, Step Therapy, and Quantity Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotics</td>
<td>3%</td>
<td>4%</td>
<td>4%</td>
<td>6%</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Cancer</td>
<td>0%</td>
<td>23%</td>
<td>3%</td>
<td>2%</td>
<td>0%</td>
<td>30%</td>
<td>5%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>1%</td>
<td>5%</td>
<td>21%</td>
<td>3%</td>
<td>1%</td>
<td>8%</td>
<td>2%</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>0%</td>
<td>7%</td>
<td>11%</td>
<td>3%</td>
<td>0%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4%</td>
<td>3%</td>
<td>8%</td>
<td>6%</td>
<td>8%</td>
<td>4%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Source: Avalere Health analyzed formularies using comprehensive formulary data provided by Managed Markets Insight & Technology, LLC (MMIT). For this work, Avalere analyzed MMIT’s data from the exchange plans. Results are enrollment weighted.
**Improved Efforts to Help Patients Navigate UM**—The ACA requires that all marketplace plans make public an accurate list of covered prescription drugs with any UM restrictions. However, enrollees must know where to search and how to search, and be capable of navigating the document once they obtain it. A 2020 survey showed that many individuals enrolling in marketplace plans found it difficult to identify a health plan that met their needs (38 percent) and to compare costs under different plans (33 percent). If these UM trends continue, insurers could consider new ways to communicate with enrollees about which covered drugs receive UM and how to access drugs with UM.

**Base Formularies on Drug Value**—Among the factors that influence prescription drug UM is the price of drugs. Insurers and PBMs should support prescription drug price reforms and aggressively pursue reforms that address unjustifiably high prices. Furthermore, these entities should work with policy makers to enact drug pricing policies that encourage P&T Committees to maintain clinical criteria as the foundation for balancing costs with appropriate care.

**Finding Balance**

Utilization management can play an important role in managing health care costs and patient safety, but stakeholders must structure it in a way that ensures appropriate access to necessary medications. The collaborative efforts of stakeholders to adjust UM policies can help ensure that if and when UM is applied, it enhances coverage rather than limits it and provides consumers the broadest access to drugs supported by clinical evidence.

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5 For this analysis, Avalere utilized its PlanScape® database of commercial payer formularies, provided by Managed Markets Insight & Technology, LLC, and the Centers for Medicare & Medicaid Services Health Insurance Exchange Public Use Files. Avalere identified the top 10 marketplace plans in each state and the District of Columbia by enrollment for the years 2016 through 2020 and examined the application of utilization management tools on covered brand name drugs (including multiple- and single-source brands) in five therapeutic areas. PlanScape® did not include the demographic information of enrollees. In some states in some years, Avalere identified less than 10 marketplace plans for analysis. Also, the universe of covered brand name drugs examined in each area in each year was based on data available to Avalere. In addition, Avalere weighted the analysis by enrollment to determine the share based on the total possible plan and drug combinations.


15 45 C.F.R. § 156.122.


17 Pearson et al., *Cornerstones of “Fair” Drug Coverage*. 