Issue Brief

Global Coalition on Aging

Utilization Management Post-Inflation Reduction Act and the Threat to Healthy Aging

October 2024

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Overview

Over the last one hundred years, the population of the United States aged 65 and older has grown nearly five times faster than the total population, with much of this longevity due to advancements in health and medicine.[1]

By 2030, one in five Americans will be a part of this age group, and eligible for Medicare, with a projected annual acute care cost of $259.8 billion, which will only rise as the cohort grows older.[2]

To control costs, many payers like health plans and Pharmacy Benefit Managers (PBMs), including those that serve Medicare patients, have been implementing a series of tools collectively known as utilization management (UM) over the past decade.[3]

While UM is meant to control the costs of healthcare by assessing a given service or drug's medical necessity prior to its provision, it can also reduce patient and provider choice and access, delay necessary and optimal treatment, and ultimately harm a person's health and ability to age healthily – and moreover, it may not actually save health system costs.[4] [5]

Common Methods in Utilization Management

Step therapy directs patients to try payer preferred medications before "stepping up" to the drug prescribed by their provider as the best treatment from the start. Lengthy and dangerous trial and failure periods are often associated with step therapy.

Prior authorization directs providers to receive the payer's pre-approval to cover a medication.

Quantity limits limit how much or how often a patient can have their prescription filled at once, leading to potential non-adherence.

Non-medical switching occurs when plans or PBMs exclude a medication from formulary or adversely increase the medication's cost-sharing tier, forcing patients, who already stable on their doctor prescribed medication, to switch to an alternative medication for non-clinical reasons.

Mandatory generic substitution compels patients to use the generic versions of medications when available. If they want the branded version, the difference must be paid out-of-pocket.

The Inflation Reduction Act (IRA) was signed into law in 2022, with the goal of minimizing healthcare costs for the government and for patients and shifting those costs to drug manufacturers and private insurers.

This requires Medicare Part D, which covers prescription drugs for its beneficiaries, to undergo a substantial redesign of the standard Part D benefit, with incremental changes made over the next few years including capping out-of-pocket costs for patients.[6]

However, compared to the current Part D benefit, insurers will now have a 4-fold increase in liability in the catastrophic phase of the IRA's redesigned Part D benefit. This means that insurers will likely attempt to offset their increased liabilities by restricting access to medicines through more aggressive UM practices such as prior authorizations, step therapy, and formulary exclusions in the coming years.

The Impacts of Utilization Management

UM has been increasing each year even before the IRA, decreasing access to drugs for patients through measures like step therapy and prior authorization, which are often used in tandem.[7] This has had significant impact on drugs that are new, such as biologics for oncology, but is not limited to those, with a recent study showing that on average, 31.9% of drugs in Medicare Part D were restricted in some way in 2011, growing to 44.4% of drugs by 2020.

As Medicare prepares to implement the Part D redesign and set prices on drugs selected for the Drug Price Negotiation Program, the true impact of UM is yet to be felt, and CMS has not described how they plan to "monitor practices that may undermine enrolled access to selected drugs." [8]

> *Utilization management often prioritizes cost control over patient care, leading to fragmented services and compromised outcomes as efficiency gains come at the expense of individual needs and needed treatment. Recently, Cancer Support Community conducted an analysis of commercial claims data and found that step therapy only reduced healthcare costs for a small fraction of patients, and any savings need to be weighed against possible worse clinical outcomes."*
>
> **Daneen Sekoni, MHA**, Vice President, Policy & Advocacy, Cancer Support Community (CSC)

UM Disproportionately Impacts Older Americans

According to the National Council on Aging, nearly 95% of older Americans have at least one chronic condition and nearly 80% have two or more. As a result, more than half of Americans over 65 (54%) report taking four or more prescription drugs, compared to 32% of those 50-64, 13% of those 30-49, and 7% of those 18-29.[9] Part D subscribers are older Americans experiencing multiple co-morbidities and navigating an already complex and confusing healthcare system. Ongoing UM practices jeopardize older Americans' ability to efficiently access the medicines they need and therefore threaten healthy, dignified aging.

44.4% of prescription drugs under Medicare Part D were restricted in some way as of 2020.

> *UM that does not align with clinical guidelines undermines healthy aging because it prioritizes payer cost savings over the health outcomes and quality of life for older adults. The increasing overuse and abuse of UM interferes in the practice of medicine, rations access to prescribed medicines for older adults, and ultimately discriminates against those who need more care—which is the opposite purpose of having health care coverage."*
>
> **Sue Peschin, MHS**, President & CEO, Alliance for Aging Research

UM Disadvantages Already Disadvantaged Populations

UM practices are shown to disproportionately impact traditionally underserved populations the most, which is true in both commercial plans and Medicare. A recent study by the Institute for Patient Access found that Black and Hispanic patients with chronic kidney disease and cardiovascular disease have their claims rejected 48% and 40% more frequently than white patients.

This UM barrier had real impact on subsequent health events – the same group of Black and Hispanic patients who faced medication claim rejections was found to have disproportionately higher emergency room visits and hospitalizations compared to white patients.[10] The perpetuation or increase in health disparities due to UM is not just a risk – it is the unfortunate reality.

> *UM can exacerbate health inequities by imposing barriers to care that disproportionately affect marginalized communities, deepening disparities and undermining equitable access to essential health services, ultimately resulting in disparate health outcomes throughout vulnerable populations."*
>
> **Maisha Standifer, PhD,** Director, Population Health, Satcher Health Leadership Institute, Morehouse School of Medicine

More than half of Americans over 65 (54%) report taking four or more prescription drugs.

Black and Hispanic patients with chronic kidney disease and cardiovascular disease have their claims rejected 48% and 40% more frequently than white patients.

UM Delays Life-Saving Treatment

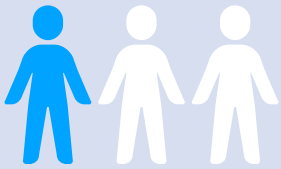
A patient experiencing delayed treatment or negative health effects because they cannot access the right drug could have downstream effects, with associated cost on the healthcare system that could have been prevented. With conditions where even a slight delay in appropriate treatment could mean the difference between life and death, there is even more at stake.

One-third of cancer patients and their caregivers report experiencing delays in care due to UM practices, and physicians treating cancer report that these delays are occurring more and more regularly – with over 70% expressing that UM practices significantly and negatively impact their practice of medicine.[11]

UM Adds Cost & Complexity Across the Healthcare System, with the Greatest Burden Falling on Patients and Caregivers

Beyond the potential health consequences, UM strategies increase administrative burden for patients, their families, and caregivers, and for health care professionals and staff. In addition to increasing administrative burden, excessive administrative hurdles caused by UM also diminish clinical autonomy, lower job satisfaction, and exacerbate the feelings of burnout for healthcare providers, jeopardizing the resilience of the healthcare workforce.[12]

UM Negatively Impacts Patient Care



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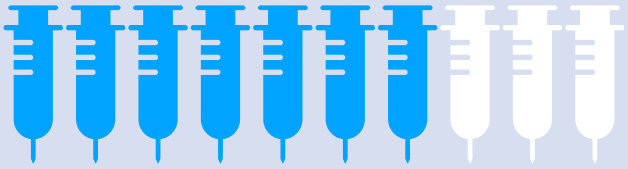
of cancer patients and their caregivers report experiencing **delays due to UM strategies**



70%

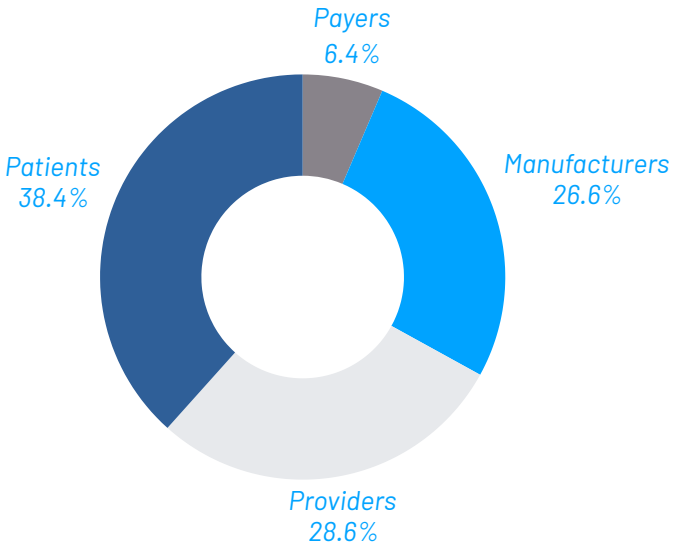
of physicians indicate that UM practices are **significantly and negatively impacting their ability to deliver care**

The time spent on administrative duties, combined with potential costs associated with the increased time it takes for a patient to access needed treatment, any cost savings from UM are likely negated. In 2021, researchers found that payers, manufacturers, physicians, and patients spend $93.3 billion each year on implementing, contesting, and navigating UM strategies, with patients and caregivers bearing the brunt of those costs.[13]

> *Healthcare providers and patients do not benefit from the increased administrative burden caused by utilization management strategies. Paperwork increases, as does its complexity, detracting from both the time and resources available for patient care."*
>
> **Anthony Paravati, MD, MBA,**
> Radiation Oncologist, Kettering Health Center, Ohio

Overall, UM's benefit to patients, providers, and the healthcare system is not well-substantiated. While it is touted as a cost-saving measure, there is limited comprehensive evidence to support this claim because of the wide range of impacts UM creates on the wider healthcare system that are not often considered in official calculations and are likely just shifted onto different actors in the system. What is clear, are the negative impacts that it can create on patients' access to drugs, the delay in accessing appropriate treatment, the high administrative burden, and the creation and exacerbation of existing health disparities.

Share of Cost Burden Associated With Implementing, Contesting, and Navigating Utilization Management



Source: Howell et al, 2021

In 2021, researchers showed that payers, manufacturers, physicians, and patients spend a combined $93.3 billion dollars per year addressing UM stategies.

The Bottom Line

Utilization management should be reconsidered as a cost-saving method due to its potentially harmful impact on patients, access to medicine, health equity, healthy aging, and the unclear benefits to the broader healthcare system. Instead, there are a myriad of other solutions that hold promise to deliver value-based care to those who need it – such as strengthening preventative health programs, building a robust caregiving workforce, and developing and improving access to innovative and effective new therapies and devices.

As the population grows older, it's clear that we need to implement programs and leverage tools that can reduce unnecessary spending – but the tradeoff must not risk the healthy aging of our population.

Endnotes

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