

Fact Sheet

Utilization Management for Prescription Drugs Commonly Used by Older Adults: Wide State Variation Among Top Marketplace Plans

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This *Fact Sheet* examines prescription drug utilization management (UM) among the top 10 marketplace plans in all 50 states and the District of Columbia and finds considerable variation among states in UM for prescription drugs commonly used by adults 50 to 64. The percentage of covered drugs subject to UM increased in some states and decreased in others between 2016 and 2020, revealing a prescription drug UM patchwork with the potential to affect older adults.

Access to prescription drugs relied on by older adults enrolled in state individual health insurance plans may depend on the insurer's application of utilization management (UM). A recent analysis revealed wide variation among states in the percentage of drugs subject to UM. This means that for the 3.6 million adults ages 50 to 64 enrolled in health plans through their states' individual health insurance marketplace in 2019, the utilization management for common drugs often depended on where they lived.¹

To understand and document the variation in UM among states, AARP contracted with Avalere Health to examine the prevalence of prescription drug UM in the top 10 marketplace plans by enrollment in all 50 states and the District of Columbia.² The analysis focused on brand-name drugs in five therapeutic areas—antipsychotic, cancer, chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD), and diabetes—commonly taken by older adults. The examination uncovered considerable state variation in the percentage of covered drugs subject to UM (that is, the percentage of increase or decrease in covered drugs subject to UM) between 2016 and 2020.³

Utilization Management in Marketplace Plans

UM is a set of tools that an insurer can use to balance consumer access to appropriate medications and services while controlling costs.⁴ Marketplace plans, like most insurance plans, apply UM tools, such as prior authorization, quantity limits, and step therapy, to a subset of covered drugs based on the recommendations of a pharmacy and therapeutics committee. These drugs are part

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 (usually 30 days).

Step therapy: A requirement that a consumer try other, less expensive medications before a higher-priced medication can be dispensed.

of a plan’s prescription drug coverage from a list of drugs known as a formulary, which groups covered drugs in tiers with different cost sharing. The tiers typically reflect certain drug features, such as therapeutic class, whether a drug is brand or generic, and price.⁵

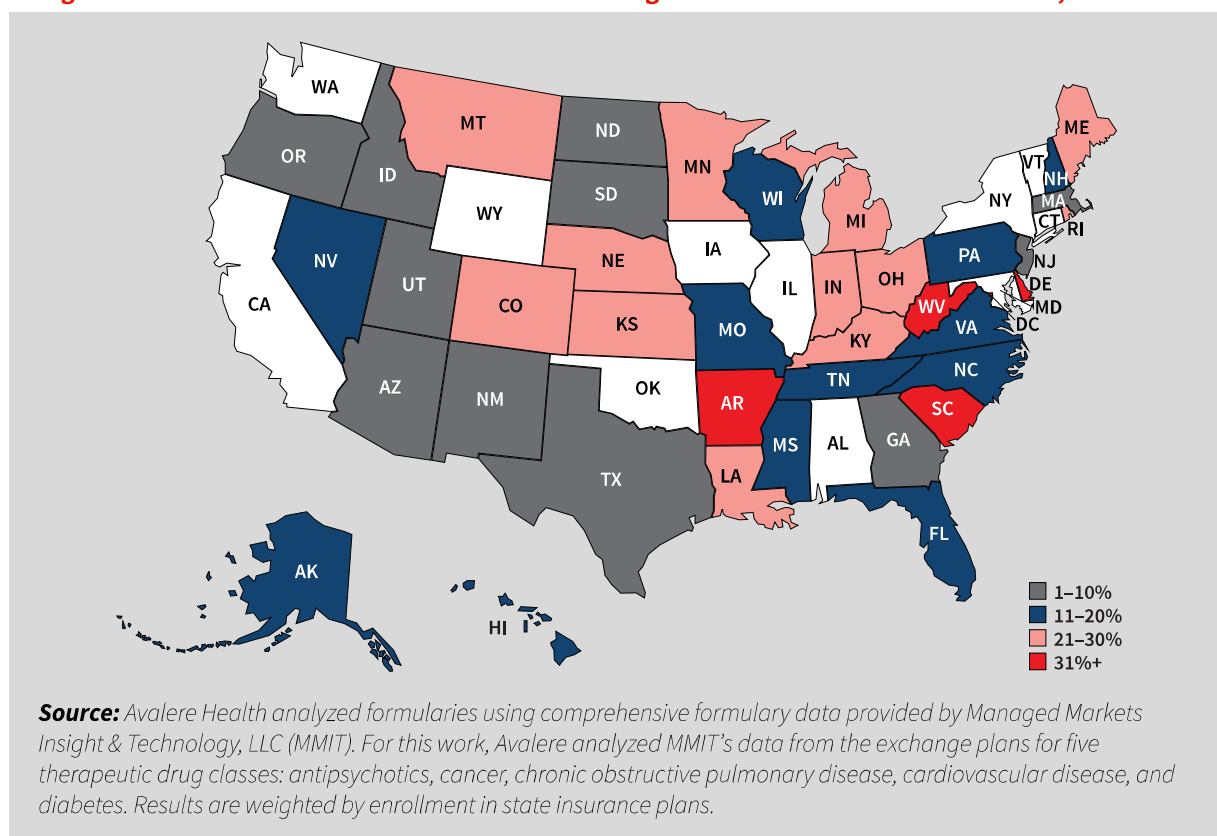
Insurers claim UM helps prevent overutilization and underutilization of medications, promotes patient safety, and strikes a balance between offering consumers access to a range of drugs and limiting a plan’s exposure to the high prices associated with these drugs.⁶ Meanwhile, some drug companies, health care providers, and consumers have raised concerns that UM creates unnecessary barriers to access and have supported efforts to limit its use. Evidence shows that when appropriately designed, UM can enhance coverage and provide consumers with access to drugs supported by clinical evidence.⁷

Finding the appropriate design is a balancing act. In marketplace plans that increase UM significantly, consumers may encounter additional challenges in accessing certain drugs. In plans that decrease UM significantly, plan and consumer costs (i.e., premiums) may increase and/or consumers may begin overutilizing certain drugs. Neither situation benefits consumers.

UM Varied in All States

Older adults in many states saw UM increase for commonly used drugs in the selected classes in the top marketplace plans, but some living in other states saw UM decrease for certain drugs. Between 2016 and 2020 the top marketplace plans in 39 states and the District of Columbia had increases in the percentage of covered brand-name drugs in included therapeutic classes subject to UM (figure 1). The increases, which reflect changes in coverage of

FIGURE 1
Range of Increases in Covered Brand-Name Drugs with UM in Selected Classes, 2016–2020



antipsychotic drugs with UM decreased by more than 25 percentage points in five states. The percentage of covered COPD drugs or CVD drugs with UM decreased by at least 20 percentage points in four states. In addition, 9 of the 11 states had UM decreases of at least 10 percentage points among covered drugs in more than one therapeutic class.

Disproportionate Impact of UM

Some chronic conditions are more prevalent among certain racial and ethnic groups, which can stratify the impact of UM.⁸ For example, this analysis found that UM for covered brand-name diabetes drugs increased an average of 8 percentage points between 2016 and 2020. In 16 states and the District of Columbia, increases were more than 25 percentage points, and in 4 states they were 50 percentage points or more. Meanwhile, the risk of Black adults having a diagnosis of diabetes is 77 percent higher than for White adults, and the risk for Hispanic adults is 66 percent

higher.⁹ Thus, the increased use of UM for diabetes drugs may have greater implications for Black and Hispanic adults than for other racial and ethnic groups.

Conclusion

Most adults ages 50 to 64 do not decide where to live based on what health insurance plans are available to them. Yet, they may encounter completely different UM for the covered drugs they need to remain healthy, depending on where they live. Additionally, changes in UM for covered brand-name drugs have the potential to affect certain racial and ethnic populations with disproportionately high rates of chronic diseases. Overall, the changes in UM among covered drugs may affect adults ages 50 to 64, and variation in the top marketplace plans in each state may require some older enrollees to pay close attention to whether and how UM could impact access to covered drugs in their marketplace plan.

Appendix

Percentage of Covered Brand-Name Drugs in Selected Classes with UM in Top 10 Plans, by State

State	2016	2020	State	2016	2020	State	2016	2020
AK	66%	77%	LA	55%	85%	OK	82%	76%
AL	75%	56%	MA	46%	53%	OR	67%	75%
AR	35%	85%	MD	37%	34%	PA	51%	65%
AZ	70%	76%	ME	48%	74%	RI	55%	83%
CA	62%	45%	MI	50%	80%	SC	35%	69%
CO	65%	90%	MN	55%	78%	SD	55%	59%
CT	69%	67%	MO	69%	84%	TN	35%	49%
DC	11%	42%	MS	69%	85%	TX	70%	75%
DE	49%	86%	MT	64%	89%	UT	82%	92%
FL	62%	78%	NC	53%	64%	VA	62%	74%
GA	77%	84%	ND	48%	51%	VT	53%	42%
HI	14%	31%	NE	38%	64%	WA	69%	68%
IA	77%	58%	NH	72%	85%	WI	58%	76%
ID	68%	71%	NJ	73%	74%	WV	44%	85%
IL	84%	78%	NM	54%	58%	WY	43%	35%
IN	55%	85%	NV	71%	88%			
KS	21%	51%	NY	69%	59%			
KY	64%	89%	OH	52%	81%			

- 1 Jane Sung et al., *Enrollment and Coverage Trends for Americans Ages 50 to 64 in the Nongroup Health Insurance Market* (Washington, DC: AARP Public Policy Institute, March 2021), doi:[10.26419/ppi.00099.007](https://doi.org/10.26419/ppi.00099.007).
- 2 For this analysis, Avalere utilized its PlanScape® database of commercial payer formularies, provided by Managed Markets Insight & Technology, LLC (MMIT), and the Centers for Medicare & Medicaid Services (CMS) 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 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.
- 3 Craig M. Hales et al., “Prescription Drug Use Among Adults Aged 40–79 in the United States and Canada,” *NCHS Data Brief*, no. 347 (2019), <https://www.cdc.gov/nchs/products/databriefs/db347.htm>.
- 4 “Utilization Management Accreditation,” NCQA, accessed January 25, 2022, <https://www.ncqa.org/programs/health-plans/utilization-management>.
- 5 Christy Ciccarello et al., “ASHP Guidelines on the Pharmacy and Therapeutics Committee and the Formulary System,” *American Journal of Health-System Pharmacy* 78, no. 10 (2021): 907–18, doi:[10.1093/ajhp/zxab080](https://doi.org/10.1093/ajhp/zxab080).
- 6 Centers for Medicare & Medicaid Services, “Prescription Drug Benefit Manual, Chapter 7: Medication Therapy Management and Quality Improvement Program” (Rev. 11, Issued February 19, 2010), Sec. 60.1, <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/dwnlds/Chapter7pdf>.
- 7 Steven D. Pearson et al., *Cornerstones of “Fair” Drug Coverage: Appropriate Cost-Sharing and Utilization Management Policies for Pharmaceuticals* (Boston, MA: Institute for Clinical and Economic Review, September 2020), <https://icer.org/wp-content/uploads/2020/11/Cornerstones-of-Fair-Drug-Coverage--September-28-2020.pdf>.
- 8 *AARP Chronic Conditions: A Call to Action Health for Reform* (Washington DC: AARP Public Policy Institute, March 2009), https://assets.aarp.org/rgcenter/health/beyond_50_hcr.pdf.
- 9 Kenneth E. Thorpe et al., “The United States Can Reduce Socioeconomic Disparities by Focusing On Chronic Diseases,” *Health Affairs Forefront*, August 17, 2017, doi:[10.1377/forefront.20170817.061561](https://doi.org/10.1377/forefront.20170817.061561).

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