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Utilization management for utilization management

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> TURN THE PAGE “We don’t (yet) have the silver bullet for dramatically lowering health-care spending while fulfilling the dictate to ‘do no harm’ to the patient”. This quote is straight out of We’ve Got You Covered: Rebooting American Health Care by Drs. Liran Einav and Amy Finkelstein. They go on to discuss solutions that seem […]

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“We don’t (yet) have the silver bullet for dramatically lowering health-care spending while fulfilling the dictate to ‘do no harm’ to the patient”. This quote is straight out of *We’ve Got You Covered: Rebooting American Health Care* by Drs. Liran Einav and Amy Finkelstein. They go on to discuss solutions that seem like a no-brainer on the surface but have tradeoffs that cannot be ignored.

- Can we just lower the prices of healthcare? We can, but there are tradeoffs we do not want to accept. As Drs. Einav and Finkelstein said, “When physicians are paid less, patients get less care.” “When drug prices are lower, fewer new drugs are developed.” In addition to preferring lower costs, we also prefer access to care and new drugs. Unfortunately, we don’t (yet) know the optimal price to produce the optimal amount of care and optimal amount of innovation. It is incomplete to calculate the cost savings from a price cut without considering the signals they send to the market.
- Can we cut administrative costs? We can, but we do not have great ways to identify the administrative costs that are wasteful versus the administrative costs that are helpful and necessary. Some level of administration is undoubtedly necessary and helpful. We don’t yet know how to identify the optimal administrative costs.
- Can we reduce unnecessary care? Well, that depends on how you define “unnecessary”. Evidence around previous attempts to reduce unnecessary care shows that both high-value and low-value care can be cut in these attempts.

There isn’t an “Easy” button for this so we should stop trying to press one. This isn’t to say we should stop looking for solutions. However, rather than looking for a blunt solution to lower healthcare spending, Drs. Einav and Finkelstein suggest “small, targeted solutions” that use evidence-based approaches to eliminate a specific pocket of waste without harm to patients. We need more evidence and more economics (acknowledging my bias) to inform these solutions before we try to implement some blanket policy that will have far-reaching consequences.

CRASH COURSE

One frequently used strategy intended to reduce unnecessary care is utilization management. Utilization management consists of different strategies payers can use with the intent of promoting appropriate prescription use while controlling costs. For those who want to learn more about utilization management, check out this new resource by the National Pharmaceutical Council. It’s a

great read for anyone wanting a quick and digestible primer on what utilization management is and how it has evolved over time.

Two common utilization management strategies are:

- Prior authorization – patient or provider must get permission from the payer before the payer will pay for it
- Step therapy – patient must try a cheaper treatment option first before "stepping" into a more expensive one

Although these strategies are intended to promote appropriate care and reduce unnecessary costs, defining "appropriate" and identifying "unnecessary" care is challenging in practice. Connecting this back to the book by Drs. Einav and Finkelstein, tradeoffs exist. Unintended consequences, such as treatment delays and reduced adherence (both of which can result in worse patient health outcomes), and administrative complexities (which can counterintuitively increase costs) can occur with utilization management.

For an interesting analysis on the costs of implementing utilization management for prescription drugs, check out this analysis by Scott Howell and colleagues. In 2021, they estimated that "payers spend approximately $6 billion annually administering drug utilization management". Although intended to control spending and promote appropriate utilization, its implementation is not without costs (financial and health-related).

Evidence-based tools have been needed to assess these tradeoffs and to promote the appropriate use of utilization management.

SO WHAT

Jason Shafrin and co-authors developed a quantitative score that measures the risk of utilization management to the patient. They call this score, which they acknowledge is still a proof of concept, the BURDEN score. The BURDEN score can be calculated for a specific treatment and considers 9 factors, including:

1. Severity of the disease the treatment is addressing
2. Reversibility of the disease without the treatment
3. Existence of alternative treatments for the disease
4. Treatment's potential for addiction or abuse
5. Treatment's short-term symptom relief
6. Treatment's rate of serious adverse events

7. Complexity of the treatment's route of administration
8. Treatment's dosing schedule
9. Level of clinical evidence demonstrating treatment's efficacy

A higher score indicates that utilization management might be more problematic for that eligible patient population. For a sample of 98 treatments (representing 30 different diseases and 13 different therapeutic classes), conditions with a higher BURDEN score were myasthenia gravis, multiple myeloma, and lupus nephritis. Conditions with a lower BURDEN score were acute migraine, depression, and high cholesterol.

When comparing the calculated treatment-specific BURDEN scores to real-world utilization management policies using data from the Specialty Drug Evidence and Coverage (SPEC) database, the authors found that at least one plan implemented some type of utilization management for every treatment in their sample. (Note: 29 treatments were able to be included in this portion of their analysis.)

The good news is they found a correlation between a higher BURDEN score and a lower use of utilization management. Treatments with a higher BURDEN score were 22% less likely to have a utilization management restriction. This is encouraging news, although there is room for improvement.

As the authors note, "some treatments saw frequent utilization management implementation despite the potential consequences for plan members". Treatments for myasthenia gravis had the highest calculated BURDEN score, yet 100% of the plans imposed some form of utilization management for the myasthenia gravis treatments in the sample. The authors also note "instances in which step therapy was implemented at a high rate for severe diseases with few treatment alternatives."

As stated by Drs. Einav and Finkelstein, in the absence of a "silver bullet for dramatically lowering health-care spending while fulfilling the dictate to 'do no harm' to the patient," we need "small, targeted solutions" to eliminate a specific pocket of waste without harm to patients. These solutions should be data-driven and evidence-based. The tradeoffs must be considered when coming up with these solutions. I am encouraged by data-driven tools such as those developed and piloted by Jason Shafrin and co-authors to inform decision-making and the quantitative consideration of these tradeoffs.

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