Arthritis Foundation℠

Yes

January 29, 2016

Senator Orrin Hatch, Chair
Senator Ron Wyden, Ranking Member
U.S. Senate Committee on Finance

Senator Johnny Isakson, Co-Chair
Senator Mark Warner, Co-Chair
Chronic Care Working Group

Dear Senators Hatch, Wyden, Isakson, and Warner:

The Arthritis Foundation, on behalf of the more than 50 million adults and children in the U.S. living with arthritis, welcomes the opportunity to provide comments to the Senate Finance Committee on the Chronic Care Working Group policy options document. We applaud your efforts to improve the care of people with chronic diseases. Arthritis is a serious, debilitating chronic condition that affects more than 50 million adults and 300,000 children in the United States. Arthritis prevalence increases with age: 50% of Americans over 65 have some form of arthritis, and with 10,000 people aging into Medicare every day, the work of the Chronic Care Working Group is of particular importance to people with arthritis.

Overall, the policy options outlined in the document go a long way towards improving care for Medicare beneficiaries with chronic disease, and we appreciate the emphasis on coordinated and patient-centered care. Chronic diseases often do not exist in isolation, and people who suffer from diseases like arthritis often suffer from multiple chronic diseases. In fact, nearly half of people with arthritis have at least one co-morbid condition such as cardiovascular disease and diabetes.

Below are the Arthritis Foundation's comments on your policy options:

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

We support integration of care for people with chronic disease who also suffer from behavioral health disorders. Multiple studies have shown that people with arthritis have higher levels of depression and anxiety. In fact, a Centers for Disease Control and Prevention (CDC) study found that 1 in 3 people with arthritis suffer from depression and anxiety. However, only half of respondents with mental health issues had sought treatment. Untreated depression and anxiety can have a huge impact on the level of disability and functional limitations among people with arthritis.

Because of the association between pain and depression, self-management programs that seek to help patient cope with pain are an important component to integrating behavioral and physical health care. Physical activity is also an important component to overall management of arthritis, and likewise can have an impact on mental health. The CDC Arthritis Program provides grants to 12 states to fund evidence-based physical activity and self-management programs. **We recommend making this a covered benefit for Medicare beneficiaries and expanding the Arthritis Program into more states.**

Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

Adapting Medicare Advantage benefits to meet the needs of people with chronic disease is a critical component of making care truly patient-centered and personalized. As stated above, the evidence-based physical activity and self-management programs offered by the CDC Arthritis Program have made a measurable impact on improved function and health for people with arthritis. The Working Group is seeking comments on additional supplemental benefits not currently allowed that are related to chronic condition treatment or prevention of the progression of the chronic disease. Physical activity and disease self-management are vital to managing arthritis and preventing its progression, and we strongly encourage the Committee to make this a covered benefit for Medicare Advantage enrollees.

In developing a process by which chronic diseases are identified, we urge you to consider morbidity and disability, not just mortality, in your methodology. Arthritis is the leading cause of disability in this country and causes functional limitations for over 22 million Americans. In fact, people with arthritis report 2-4 times as many unhealthy days in a month than people without arthritis, and a recent CDC report showed that arthritis had a worse impact on social participation and work limitations than any other chronic condition.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

The Working Group is seeking comments on expanding supplemental benefits to MA enrollees. As stated above, the CDC Arthritis Program physical activity and self-management programs are specifically tailored to improve the health of people with arthritis, and should be offered as a supplemental benefit. They are evidence-based programs and as such should meet any criteria the Committee develops. Pain management is also an important aspect of improving the health of people with arthritis, and the Arthritis Foundation believes all people with arthritis should have access to timely, high quality, comprehensive pain management treatment, including physical therapy, acupuncture and alternative therapies. We encourage the Committee to ensure that comprehensive pain management services beyond therapeutic treatment are included as supplemental benefits.

Increasing Convenience for Medicare Advantage Enrollees through Telehealth

We support access to telehealth services for people with arthritis, and encourage the Committee to consider expanding the current Medicare telehealth program to a broader population. The CMS Comprehensive Care Joint Replacement model will begin implementation this year, and one component of the model is a waiver that eliminates the telehealth geographic and originating site requirements. We supported this waiver and encourage the Committee to monitor its implementation in order to determine ways to scale it up to the broader Medicare population.

Providing ACOs the Ability to Expand Use of Telehealth

As stated above, the Arthritis Foundation supports lifting the originating site requirement for telehealth services, and we encourage the Committee to coordinate efforts with CMS and the

Comprehensive Care Joint Replacement model to glean insights into how to effectively implement this change.

Study on Medication Synchronization

The Arthritis Foundation supports efforts to improve medication adherence and to remove barriers that make it difficult for people with chronic conditions to take their medications effectively. We agree that commissioning a study can help identify ways to better coordinate prescription drug dispensing, with an emphasis on ensuring that beneficiaries can pick up multiple prescriptions on the same day. We urge the Committee to go a step further in its effort to improve medication adherence, and include language from S. 776, the Medication Therapy Management Empowerment Act, which would make it easier for beneficiaries with a single chronic disease to access medication therapy management services.

Other policy options

There are several policy options not listed in the Working Group document that we urge the Committee to consider in its future policy documents and legislation.

Protect seniors from high out-of-pocket costs. Specialty tier cost-sharing requirements can translate to hundreds and even thousands of dollars in out-of-pocket costs each month for beneficiaries. A recent Kaiser study on Medicare Part D out-of-pocket costs among beneficiaries illustrates the challenges many people have accessing specialty medications. For three RA drugs that were included in the study, the annual out-of-pocket costs to beneficiaries ranged from $4,413 to $4,872; when the drugs are off-formulary, the cost sky-rockets to a median of $44, 218 and $48,298 for two of the drugs. This level of cost-sharing is unsustainable for many people, and can put these medications out of reach for many people, severely impacting a person's ability to be a functioning member of society.

The Arthritis Foundation has two recommendations to help mitigate the adverse financial effects to Medicare beneficiaries who depend on specialty drugs.

1. The Medicare definition of a specialty drug is any drug over $600. This number has not been updated in 5 years, even though the average specialty drug cost is over $1,000. The 2016 Methodological Changes and Call Letter on Part D do not update this definition. We recommend that the Working Group analyze the specialty drug and cost-sharing trends over the last ten years to determine a more reasonable definition of specialty drug that accounts for current market prices.
2. Out-of-pocket costs for specialty drugs can be stabilized by limiting cost-sharing in specialty tiers. The Patients' Access to Treatment Act (PATA), introduced in the House by Reps David McKinley (R-WV) and Lois Capps (D-CA), would limit specialty tier cost-sharing to the non-preferred brand drug tier (usually tier 3). While this bill only applies to the private insurance market, the objectives of the bill are applicable to public insurance markets, and we recommend the Working Group use PATA as a model for beneficiary cost-sharing protections.

Strengthen the appeals process. A consistent, reliable and transparent appeals process should be a critical component of Medicare Part D. The process itself should be timely and transparent, and there should be greater emphasis on consumer education. Currently, there are concerns among patient groups and CMS surrounding non-compliance with the exceptions and appeals requirements for Part D, which include ensuring enrollees receive accurate and clear information related to their denials. Further, less than 17% of Part D coverage denials are appealed for redetermination. This may be due in part to a lack of awareness by beneficiaries about the appeals process or the difficulty beneficiaries face in navigating the appeals process. For example, pharmacy notices currently do not include personalized information on why a prescription was not filled, which misses a key opportunity to educate patients on the ability to file an appeal.

The 2016 Methodological Changes and Call Letter on Part D moves towards a stronger appeals process by requiring more information about denials in coverage denial notices, and improving information about denials at the point-of-sale. CMS is exploring other policies such as developing an appeals tracking system to better determine whether plans are providing adequate access to Part D drugs, and triggering an appeal for a denial at the point-of-sale. However, there are other issues in the appeals process that merit attention, such as specialty tier drug exclusions from appeals requirements. The fact that all Medicare Part D plans have specialty tiers for the first time in 2015 means that any Medicare beneficiary who relies on specialty medications could be denied an important tool to help them access the drugs they need.

1. The Working Group and the Committee should consider S. 1488, the Part D Beneficiary Appeals Fairness Act, introduced by Senators Nelson (D-FL) and Susan Collins (R-ME), which would allow exceptions to apply to all drug tiers, including specialty tiers.

Ensure a stable transition into Medicare. As previously discussed, arthritis is a complex, chronic disease, and it can take many years to find the right treatment protocol for any given patient. Therefore, it is imperative that patients have the ability to remain on their medications when they transition into Medicare. Unfortunately, many Medicare beneficiaries find that their current drugs are not available on their new formulary when they switch from private insurance to Medicare Part D, which can cause them to lose access to drugs they rely on to maintain their health. Further, co-pay cards – which many people with arthritis rely on to preserve access to their medications – are not allowed in Medicare Part D. While we understand that there are federal policies against the use of co-pay cards in government health programs, we remain concerned that the lack of access to co-pay cards limits the options available to beneficiaries to receive cost-sharing assistance.

We recommend that the Working Group:

1. Design a policy that protects Medicare beneficiaries from non-medical switching when they transition into Medicare or when they switch Part D plans. At a minimum:
    a. In circumstances where an insured is changing health insurance plans, the new plan should not require the patient to repeat step therapy when that person is being treated for a medical condition by a prescription drug, provided that the drug is appropriately prescribed and is considered safe and effective for the patient's condition.
    b. When a health insurance plan changes formulary design, the plan should not limit or exclude coverage for a drug if the drug previously had been approved for coverage by

the plan for a medical condition of the enrollee and the patient's physician continues to prescribe the drug for the medical condition.

2. Analyze the impact of the prohibition of co-pay cards in Part D and consider policies that will expand the availability of cost-sharing assistance to Medicare beneficiaries.

Monitor utilization management techniques for discrimination. As you may know, there have been some challenges with Health Exchange plans discriminating against people with chronic diseases by placing all drugs for a given disease in specialty tiers. Most of the attention to-date has focused on the HIV/AIDS population, but RA is 1 of 4 disease areas CMS has identified to monitor for these types of discriminatory practices among qualified health plans (QHPs), per the 2016 final letter to issuers in the Federally-Facilitated Marketplace.

Several other utilization management techniques have become increasingly common by insurers to control the costs of treating people with chronic conditions like arthritis, including step therapy, and prior authorization. While the Arthritis Foundation does not oppose these techniques, we also believe there should be patient safeguards, and limits placed on them. For example, a patient should not be required to go through a step therapy process twice for the same drug, and prior authorization requests should be completed within 48 hours of submission or receive automatic approval.

We recommend that the Working Group commission a GAO report to assess the prevalence and impact of utilization management techniques like step therapy and prior authorization in Medicare Part D. This would be an important step in determining whether discriminatory practices are occurring and the prevalence of such practices.

Again, thank you for the opportunity to provide comments to the Chronic Care Working Group policy options document. We look forward to future opportunities to work with you to address the chronic care needs of people with arthritis. Should you have any questions or if we can be of assistance in any way, please contact me at 202-887-2910 or spreiss@arthritis.org.

Sincerely,

Sandie G. Preiss

Sandie Preiss
National Vice President, Advocacy and Access
Arthritis Foundation