America's Health Insurance Plans

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The Honorable Orrin Hatch
Chairman, Senate Committee on Finance
104 Hart Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Senate Committee on Finance
221 Dirksen Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

America's Health Insurance Plans (AHIP) appreciates the opportunity to provide the Committee with recommendations and strategies to prevent opioid overutilization and treat addiction within Medicare and Medicaid in response to the Committee's February 2nd letter, where policy recommendations were requested.

AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

Drug overdoses are now the leading cause of death for Americans under 50 years of age, with 142 Americans dying every day from an opioid overdose. The crisis is multifaceted and continues to evolve with synthetic opioids (such as fentanyl) and heroin increasingly entering the market. Further complicating prevention and treatment efforts is the increased prevalence of HIV and Hepatitis C among illicit drug users, as well as new cases of these diseases emerging due to intravenous use.

AHIP members experience first-hand the complications and consequences of the opioid public health crisis, including those on our nation's most vulnerable populations. Though no one should be debilitated by unrelenting pain, no one should live with the disease of opioid addiction either. AHIP continues to work collaboratively with other national and regional stakeholder partners to help unravel and solve the nation's multi-faceted opioid crisis. Insurance providers continually work with Congress, state and community leaders, and health care providers to develop and implement the safest, most proven, and most effective policies and solutions that help people manage pain, prevent opioid misuse and abuse, and overcome the disease of addiction.

Further, AHIP has and continues to convene, as part of the AHIP Opioid Work Group, chief medical officers, behavioral health clinicians, pharmacists, and policy staff from more than 40 AHIP member organizations. Together with our plans, we launched the Safe, Transparent Opioid Prescribing (STOP) Initiative to support widespread adoption of clinical guidelines for pain care and opioid prescribing. As part of the STOP Initiative, we have developed the STOP Playbook, which provides practical examples of the various innovative strategies that health plans deploy to combat the opioid public health crisis. Namely, the Playbook provides examples of how health plans use a comprehensive approach that encompasses: (1) prevention; (2) early intervention; and (3) treatment and recovery. Taken together, these strategies reflect a high level of health plan innovation and our industry's commitment to solving the opioid health care crisis. *Our STOP Playbook is attached for your reference.*

Additionally, last fall, AHIP launched the STOP Measure – a robust, evidence-based methodology health plans can use to measure how provider practices compare to the Centers for Disease Control and Prevention (CDC) Guidelines for Prescribing Opioids for Chronic Pain. Health plans have consistently supported the CDC's Guidelines to promote evidence-based pain care and reduce unnecessary opioid prescribing. The STOP Measure takes these efforts much further by establishing an industry-wide approach to measuring performance against the CDC guidelines, tracking and reducing the number of opioid prescriptions. We recently released the first nationwide benchmark data for the STOP Measure to show the health care industry's progress in combatting the opioid crisis and to identify specific actions that can be taken to reduce addiction and abuse. *We have attached the STOP Measure baseline analysis for your review.*

Medicare & Medicaid Programs

Approximately 43 million seniors and individuals with disabilities are covered under the Medicare Part D program, with more than 17 million receiving their benefits through a Medicare Advantage (MA) plan and more than 25 million receiving their benefits through a stand-alone Prescription Drug Plan (PDP). The Part D program is based on a highly successful model that has increased consumer choice and market competition, improved access to prescription drugs, and reduced out-of-pocket costs for tens of millions of beneficiaries. Consumers are highly satisfied with these benefits.[1]

In addition, the Part D program has been shown to significantly improve the health outcomes of Medicare beneficiaries. A 2014 study found that beneficiaries with Medicare Part D coverage, on average, experienced 8 percent fewer hospital admissions, incurred 7 percent lower Medicare expenditures, and used 12 percent fewer total health care resources than beneficiaries without Part

[1] http://medicaretoday.org/wp-content/uploads/2017/08/2017-Senior-Satisfaction-Survey-Fact-Sheet.pdf

D coverage. This study found that taxpayer costs were reduced approximately $1.5 billion each year.[2]

While prescription drug coverage by Medicaid is optional, all states cover outpatient prescription drugs for most or all their Medicaid enrollees. Medicaid prescription drug spending accounted for $31.7 billion in 2015, about 5.8 percent of total Medicaid expenditures. While Medicare provides prescription drug coverage primarily for older adults, Medicaid is the primary source of prescription coverage for younger enrollees with limited incomes, complex medical needs, serious persistent mental illness, and/or substance use disorders.

Current Solutions in Medicare & Medicaid

We applaud and share the Committee's commitment to reducing the number of addictive substances in communities, preventing misuse and abuse of opioids, and compassionately treating those suffering from opioid and substance use disorders within the Medicare and Medicaid programs. We also applaud Congress for passing into law the Comprehensive Addiction and Recovery Act of 2016 (CARA), which included a provision that allows the use of lock-in programs in Medicare. A lock-in program is a utilization management tool used to limit whom can prescribe opioids for a beneficiary (i.e., selected prescribers of opioids), and where a beneficiary can access coverage for opioids (i.e., selected pharmacies), or both. Pursuant to CARA, the Centers for Medicare and Medicaid Services (CMS) released the MA/Part D Proposed Rule in November of 2017, offering a proposed implementation plan for these programs. More recently, in the CY 2019 Advance Notice and Call Letter, CMS proposed additional policy changes aimed at reducing opioid overutilization in Medicare.

The recently proposed Medicare implementation plan for CARA and opioid safeguard provisions in the Medicare Advantage CY 2019 Call Letter are likely to become effective tools to reduce prescription opioid use, misuse, and abuse among Medicare beneficiaries. Since these programs are still in the early implementation-stage, AHIP recommends a watchful wait-and-see approach, where Congress monitors ongoing progress, investigates incremental improvements, and acts only when it finds such improvements as necessary.

While variations exist from state to state, Medicaid programs in many states have implemented programs aimed at screening and early intervention, overdose prevention, and improved access to medication assisted treatments (MAT) for Medicaid enrollees. However, Medicaid managed care plans offer coverage and services that are largely determined by a state's Medicaid plan. While health plans work closely with states to help inform this process, the decisions around program structure, including pharmacy/prescriber lock-in requirements and other prevention and treatment methods provided, ultimately lie with the states.

[2] Kaestner, Robert, Long, Cuiping, Alexander, G. Caleb. Effects of prescription drug insurance on hospitalization and mortality: Evidence from Medicare Part D. National Bureau of Economic Research Working Paper 19948. February 2014.

MA/Part D Proposed Rule (November 2017)

As part of its CARA implementation plan, CMS included the following proposals:

- Allow plan sponsors to implement drug management programs informed by regular Overutilization Monitoring System (OMS) reports to identify beneficiaries who are at-risk of misusing or abusing opioids and to limit their coverage to frequently-abused drugs (i.e., opioids);
- Allow implementation of lock-in programs where beneficiaries would be limited to a single prescriber and/or a single pharmacy for obtaining frequently-abused drugs;
- Require that drug management programs use evidence-based clinical guidelines, implemented in consultation with Medicare plan sponsors, and robust case management to identify at-risk beneficiaries and the appropriate limit to coverage of frequently-abused drugs; and
- Gather stakeholder feedback on which additional drug categories (i.e., benzodiazepines, sedatives, and other high-risk medications) to add to the list of frequently-abused drugs, currently composed of opioids only.

AHIP has provided CMS with comments and some recommendations on the proposed CARA implementation plan, including the following:

- The limitations placed on the plan sponsor's ability to lock a beneficiary to a prescriber may be too restrictive in many instances (e.g., a mandatory waiting period before limiting a beneficiary to a single provider);
- Plan sponsors should be able to go above and beyond proposed guidelines in identifying at-risk beneficiaries and limiting their coverage to frequently abused drugs (i.e., concurrent benzodiazepine and opioid use); and
- CMS should consider looking at ways to ease potential burdens and challenges in operationalizing the program.

Opioids Provisions in the CY 2019 Advance Notice and Call Letter

As part of the CY 2019 Advance Notice and Call Letter, CMS proposed several additional provisions aimed at stemming and preventing opioid misuse and abuse among Medicare beneficiaries, including the following:

- Limit the dispensing of first time opioid prescriptions (i.e., opioid naïve beneficiaries) for acute pain to a 7-day supply, with or without a maximum dosage threshold;
- Flag the concurrent use of "potentiator" drugs such as gabapentin and pregabalin for future OMS reports;
- Implement changes to existing Pharmacy Quality Alliance (PQA) endorsed opioid measures used by CMS;

- Introduce a new PQA-endorsed measure that identifies the concurrent use of benzodiazepines and opioids ("double threat") as part of the CMS Patient Safety reports;
- Apply a hard edit whenever a patient reaches a 90 Morphine Milligram Equivalent (MME) dose over the past 90 days with a 7-day allowance; and
- Apply a soft edit whenever a potentially inappropriate duplication in opioid therapy is detected.

Solutions in Medicaid

Although lock-in programs can now be used to protect Medicare beneficiaries, these programs have already been implemented in most states' Medicaid programs and have been shown to reduce prescription opioid misuse and abuse among Medicaid enrollees. Though variations exist among the states, the use of lock-in programs has shown dramatic results. For example, according to a study evaluating the impact of implementing the Medicaid Lock-In Program (MLIP) in North Carolina, the MLIP resulted in both a lower average number of opioid prescriptions filled per month and a lower number of pharmacies visited to obtain those prescriptions.[3] Also, for states that reported savings from the use of lock-in programs, the average reported savings was $3.13 million in FY 2016 and $7.88 million in FY 2015.[4,5]

Proposed Policy Recommendations

Our STOP Playbook (attached) outlines some potential policy solutions to consider as they relate to prevention, early intervention, and treatment of opioid use disorders. Insurance providers continue to expand and refine a comprehensive, multi-faceted approach for combatting the opioid crisis encompassing: (1) prevention; (2) early intervention; and (3) treatment and recovery. Though more detailed descriptions can be found in the STOP Playbook, some examples include:

- Promoting the CDC's opioid prescribing recommendations, including non-opioid pain care, cautious opioid prescribing, and careful patient monitoring;
- Encouraging provider education on evidence-based pain care and how to screen people for risk of addiction;
- Educating consumers and communities on the risks of opioids;
- Leveraging medical management tools, such as step therapy and prior authorization, to ensure patients receive safe, effective access to care at an affordable cost;
- Facilitating coordination between physicians and pharmacies when patients are "doctor shopping" or "pharmacy shopping" and receiving prescription opioids from multiple providers;

[3] http://www.jpain.org/article/S1526-5900(16)30155-9/pdf
[4] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/2016-dur-summary-report.pdf
[5] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/2015-dur-summary-report.pdf

- Analyzing pharmacy claims to identify prescription patterns that may indicate overuse or misuse to inform early interventions;
- Providing patients struggling with opioid use disorder access to evidence-based treatment, including medication assisted treatment (MAT), counseling, and recovery support; and
- Improving access to treatment services such as counseling, peer support services, and community-based support groups.

In consultation with our members, AHIP has identified some potential ways that Congress could improve upon and advance the ongoing efforts by CMS and plan sponsors:

- For non-integrated arrangements in Medicare and Medicaid, eliminate unnecessary restrictions and allow for data sharing;
- Codify that CMS should use notice-and-comment rule-making processes or the Advance Notice and Call Letter to seek input on, and to finalize changes to, various components of the CARA, OMS, and Drug Utilization Review (DUR) programs (e.g., additions to list of frequently abused drugs, changes to clinical guidelines);
- Provide CMS and plan sponsors the ability to access state prescription drug monitoring programs, with state authorization, to obtain more comprehensive information on Medicare beneficiaries identified as being at-risk;
- Modernize the statute governing 42 C.F.R. Part 2 to allow the confidential sharing of information on substance use diagnosis and treatment information to improve patient safety, quality, and care coordination, as is done with any other chronic illness under HIPAA;
- Require that Medicare beneficiaries receive, at the point of sale, a government notice indicating the potential and likely dangers of opioid use and the legal consequences for inappropriate diversion of opioid products;
- Investigate the role that telehealth could play in providing behavioral and mental health services to Medicare beneficiaries; and
- Provide Medicaid managed care organizations with more formulary autonomy and flexibility to create stronger leverage to negotiate lower drug costs.

AHIP believes that much of the necessary foundation has been created in the Medicare and Medicaid programs through the collaborative efforts of Congress, CMS, states, many health care stakeholders, and plan sponsors. We recommend that Congress continue to monitor the progress of this critical work, investigate incremental improvements, and act only when it finds such improvements are necessary.

Again, we thank you for the opportunity to provide these comments. If you have any questions, or would like to request more information, please contact Kate Berry at kberry@ahip.org.

Sincerely,

Marilyn B. Tavenner
President and CEO

Attachments:

STOP Playbook: How Health Plans are Tackling the Opioid Crisis
STOP Measure: Safe and Transparent Opioid Prescribing to Promote Patient Safety and Reduced Risk of Opioid Misuse