NATIONAL ALLIANCE action brief

Rheumatoid Arthritis

Inflammatory conditions such as rheumatoid arthritis (RA) typically rank among the top three most costly conditions for specialty drugs, along with cancer and multiple sclerosis. RA is a chronic, inflammatory autoimmune disease that causes a range of symptoms, including stiffness and swelling in the joints,[1,2] particularly in the hands, feet and knees.[2] RA is a form of arthritis that is immune mediated and attacks healthy tissue. If left untreated, this condition can cause significant permanent damage to tissues in the joints, often leading to short- or long-term disability, or in some cases, forcing employees to stop working completely.

WHAT'S THE ISSUE?

- Approximately 1.6 million Americans are living with RA.[3] Women are two to four times more likely than men to suffer from RA,[4] which can develop at any time during adulthood, but usually occurs between 40 and 70 years of age.[1]
- If left untreated, tissue and bone damage often occur and progression of the condition may also affect the heart and lungs.[5] Patients with RA have an increased risk for heart disease, diabetes, infections, malignancies, and mental health conditions.[6]

Individuals with RA respond to medication differently depending on factors such as the severity of their disease and how quickly treatment is initiated after the onset of symptoms. RA is a progressive condition and while there is no cure, the primary target for RA treatment is a sustained state of clinical remission or low disease activity.[7]

WHY EMPLOYERS SHOULD BE CONCERNED

Although the prevalence of RA is not as high as some conditions, the costs of medical, pharmacy, and disability claims are often significantly higher than the costs associated with more prevalent conditions. In 2013, RA costs accounted for $10.6 billion in direct medical costs and $36.7 billion in indirect costs annually.[8] Employees with RA also have a higher likelihood of disrupted work and missing work days.[9]

Impact on

Disability: Short-term disability claims for RA are twice as likely as non-RA short-term disability claims to reach their plan's maximum benefit duration. Additionally, while claims for most conditions that require long-term disability are able to close within one to three years, up to 24% of RA claims remain open for longer than ten years.[10] Full work disability is also a large consideration, with 13% of employees with RA facing some form of disability at six months and up to 67% at 15 years from the onset of RA.[11]

Pharmacy: Costs for RA medications, which include ingredient costs, taxes, dispensing fees, and administrative fees, increased by 25% in 2015,[12] and this class of medication has topped specialty drug spending for seven years in a row. These costs can become prohibitive quickly for the employer and employee alike: Milliman, Inc. projected that the average prescription cost for a commonly used RA biologic drug known as a TNF inhibitor will be just under $5000 per month in 2016.[13] Additionally, some medications in this class are administered by a healthcare professional, administered in either a physician's office or a hospital outpatient setting, with costs that typically differ significantly by place of service.

GETTING THE RIGHT CARE

Early diagnosis, appropriate treatment,[14] and adherence is important to reduce the rate of decline in function or permanent damage and allow patients to maintain daily life functions including work. Compared to those with other forms of arthritis, 40% more individuals with RA report needing help with personal care.[15]

Diagnosis

Unfortunately, diagnosis of RA may take up to two years from the time a patient begins having symptoms until the diagnosis is confirmed.[16] Factors contributing to this delay include[17] patients waiting to seek treatment initially, either due to unclear symptoms or financial barriers, and delays with practitioner as no single test exists to diagnose RA. Diagnosis is based primarily

on physical assessment in combination with laboratory tests. The early symptoms of RA may mimic conditions such as other forms of arthritis, lupus or gout, delaying referral from primary care to rheumatologist while this is ruled out. A rheumatologist should be consulted if it is unclear which diagnosis should be considered.[18] Barriers should be reduced to begin diagnosing and treating this condition as soon as possible to halt disease progression.

Treatment

Non-steroidal anti-inflammatory drugs (NSAIDs) and steroids focus on controlling symptoms of RA, but not the long-term damage. Conventional synthetic Disease Modifying Anti-Rheumatic Drugs (csDMARDs) are considered first-line treatments for RA to help stop the body from attacking the joints. Individuals with low disease activity may be controlled with one DMARD, however, as the disease progresses, the dose of these medications may need to be increased and additional medications may need to be added.

Newer therapies including biologic disease-modifying anti-rheumatic drugs (bDMARDs) have been shown to be more effective in preventing damage, but are significantly more expensive than csDMARDs.[19] The bDMARDs may be administered as an injection by the patient or health care provider, or infused by a health care provider in a physician's office. Purchasers should consider the types of treatment and the method of administration to truly understand all of the costs associated with RA therapy and create the appropriate value-based insurance designs. This includes access to effective therapies when clinically appropriate.

MEASURING UP (eValue8™ data)

- All plans manage RA through either specialty pharmacy or disease management programs.
  - 75% manage RA through integrated patient-centered care.
  - 25% report using specialty pharmacy vendors.
  - 90% proactively monitor member compliance on RA drugs through refill claims and make that information available to care managers.
- Almost all plans monitor the use of DMARDs; 96% provide reminders to members when there is a gap in adherence, but only 64% notify the member's physician.
- Telephonic outreach and follow-up with members and physicians is the most common approach used to identify adherence gaps.

TAKE ACTION

ACTION ITEM #1: Understand how RA affects your covered lives and assess the total cost of care by examining medical and pharmacy claims for treatment, short- and long-term disability data, and if possible, absence and productivity metrics.

- Gather metrics from your plan such as RA prevalence, percent receiving treatment by a physician (primary care and rheumatologist), and hospital visits associated with RA. If it would help you better understand your population, consider requesting these data reported out separately for employees, dependents, and retirees, as well as for all combined. Request from your health plan and specialty pharmacy vendors disease management measures such as percent categorized with low disease activity or in remission. When you request claims data, be sure to also request cost data for these claims.
- Obtain data from your PBM and health plan about the medications being utilized in the treatment of RA in your population. Be sure to request data on your **total spend** for these medications, including any associated drug administration or facility fees.
- Work with short-term and long-term disability vendor(s) to obtain data on duration of claims for RA and percent reaching maximum benefit (if historical data are available). This will provide a better assessment of the impact of RA on your population and allow evaluation of efforts to improve health and reduce cost.

Action Item #2: Adopt value-based purchasing strategies that help remove barriers to early diagnosis and treatment, including medication adherence.

- Adopt benefit strategies such as allowing telephonic referrals or removing requirements for primary care referral to the rheumatologist. It is also important to confirm that rheumatologist practices are available in your provider networks. If a rheumatologist is not available within the contracted network, consider designing a cost share for an out- of-network provider that is comparable to what is set for in-network providers.
- Reduce barriers that may prevent your employees and their dependents from filling or refilling prescriptions by reducing financial burden on those with RA. Avoid placing both traditional therapies and newer biologic treatments in a specialty tier or in a tier with significant coinsurance that may impact adherence. Consider having lower or no co-pays tied to use of preferred providers or sites of care.
- Reduce co-pays for participation in disease management programs, and make sure your disease management vendor is implementing strategies that may reduce disability leave.

Action Item #3: Provide education on RA signs and symptoms as well as information on specific coverage and benefits to engage patients in doing their part to manage and reduce the burden of RA.

- Consider working with health plan or other vendors to target education to the specific needs of those with RA and common comorbidities, such as heart disease and diabetes.

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TAKE ACTION (continued)

- Encourage health plan or vendors to establish a targeted management strategy for those affected to help ensure they are receiving appropriate care and utilizing benefits accordingly.

Action Item #4: Consider workplace policy and environment changes that may make it easier for employees to return from disability leave or other forms of absence.

- Offer flex time to allow employees with RA the ability to start later in the day, giving them time to work through morning pain and stiffness.
- Identify return-to-work models or tools that are aimed at transitioning employees back to the workforce after short-term disability in such a way as to maximize productivity.

Action Item #5: Engage key stakeholders in adopting a "Treat To Target" (T2T) strategy for the management of RA to improve quality of care, help better manage costs, and enhance patient satisfaction.

- Ask your plans and provider groups to take a T2T approach to the management of patients with RA. T2T includes shared decision making and setting a target of low disease activity or clinical remission, the routine assessment of disease activity using one of the American College of Rheumatology's recommended RA disease activity assessments and timely adaptation of treatment if established targets are not being reached.
- Engage health plans and rheumatologists to design an action plan for adopting a T2T strategy for patients with RA.
- Consider providing incentives for completing a RA disease activity assessment between visits and sharing their assessment with their rheumatologists on the day of their scheduled office visits.
- Engage specialty pharmacies to train patients how to assess their RA disease activity and share this information with their rheumatologists to assist in increasing the capture of RA disease activity.

Action Item #6: Leverage local collaborations to lead community change.

- Employer-based health coalitions serve as vehicles for improving workforce and community health at the local level by leveraging the voice and power of their employer members to achieve the most value for every health care dollar spent.
- For additional information on specialty medications such as those mentioned in this Action Brief, contact the National Business Coalition on Health or your local business coalition.

Endnotes

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National Alliance would like to acknowledge the support it has received from Pfizer, Inc. in the form of clinical expertise and funding to produce this Action Brief.