United States Senate
WASHINGTON, DC 20510
March 1, 2018

Marilyn Tavenner
President & Chief Executive Officer
America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004

Dear Ms. Tavenner:

We write to share our concern over the reported utilization of several industry practices that, when used in the context of pain management and substance use disorder treatment and recovery, may be counterproductive to efforts to address our nation's opioid epidemic. We urge you to reexamine your membership's current policies and procedures to identify and, more importantly, help rectify, any practices that could be contributing to or exacerbating our country's drug addiction crisis.

Our country continues to fight back against the worst drug overdose epidemic in its history. According to the Centers for Disease Control and Prevention (CDC), drug overdoses accounted for more than 63,600 deaths in 2016 – an average of 174 drug overdose deaths per day. These tragedies are not limited to one group of individuals; rather, deaths resulting from drug overdose continue to increase across all populations – men and women, young and old, urban and rural, and across all races. And the cost of this epidemic extends beyond the loss of human lives – according to a recent economic analysis conducted by the Council of Economic Advisors, the economic impact of this addiction crisis represents a loss of nearly $504 billion annually, a number roughly equivalent to three percent of the entire country's gross domestic product (GDP). Without additional investments and changes to the status quo, these numbers will only continue to increase at an exponential rate.

Despite these devastating statistics, the pain that drives many individuals to these addictive drugs in the first place remains a problem. A 2015 analysis by the National Institutes of Health (NIH) estimated that more than 25 million adults experience chronic pain and nearly 40 million adults experience severe levels of pain. These numbers will only continue to increase as our nation grows older. In order to make progress in our nation's fight against the addiction epidemic, we must do more to ensure all Americans – whether they are suffering from chronic or acute pain – have access to non-addictive pain management options.

Unfortunately, it is often much harder for an individual to seek non-addictive pain medications or non-pharmacologic treatment options at the outset of treatment than it is to get a prescription opioid. We understand that there are many reasons for this, including restrictions on benefit design, the high cost of alternative pain treatments, the limited availability and effectiveness of clinically proven alternatives, a lack of clinician awareness regarding alternatives, and ingrained prescribing practices. However, it is important to note that opioid prescribing decisions are not governed solely by clinicians. Health insurance coverage policies play a significant role when it comes to accessing non-addictive pain treatment options, which is why we are urging AHIP to look into the benefit design and internal practices of its members and take a more active role as it relates to preventing and treating addiction. If a clinician chooses to prescribe a non-addictive therapy to treat chronic pain, which is simply overridden by an insurance algorithm that defaults to the cheapest opioid alternative, an opportunity to turn the tide against addiction may be missed.

Recent news reports have raised serious concerns over a lack of insurer accountability when it comes to this epidemic. Take Ms. Lauren Kafka, for example. Ms. Kafka recently wrote about her experience recovering from surgery to correct a torn rotator cuff.[1] Her surgeon and two separate physical therapists recommended renting a cool-therapy device to help manage her pain throughout her recovery. Coverage for this device was denied by her insurance plan, leaving Ms. Kafka with two options: (1) pay out-of-pocket for the device rental; or (2) resort to the opioid painkillers covered by her insurance. Ms. Kafka made the decision to try to take the minimum number of pills necessary to aid in her recovery, and while she was able to pay out-of-pocket for the device rental fees to help decrease her dependence on opioids throughout her recovery, others in her situation may opt to elect only the covered drugs and find themselves at a higher risk for dependence.

Ms. Alisa Erkes, a patient with chronic abdominal pain, was forced to switch from using Butrans, a pre-dosed buprenorphine painkiller patch, to morphine when her insurance provider stopped covering the patch.[2] Though both buprenorphine and morphine are opioids, morphine is categorized as having a higher risk of abuse, dependence, and overdose. Similarly, Ms. Amanda Jantzi, a patient with a painful bladder condition, weaned herself off opioids using the non-opioid painkiller drug Lyrica, only to find that it was not covered by her new insurance policy when she switched employers.[3] While we recognize that Lyrica remains an expensive option with its own set of risks, this example highlights how substituting a traditional opioid may not always be appropriate in circumstances where another option may exist – whether it be pharmacologic or non-pharmacologic. In each of these examples, despite the efforts by both patients and providers to seek out non-addictive pain management options, it was the default policies of the insurers that dictated the available therapy – pushing each individual toward the cheapest and easiest fix: a potentially addictive opioid. Whenever possible, non-addictive options and drugs with a lower risk of addiction and/or abuse should be utilized.

An insurance policy's benefit design may also hinder access to non-pharmacological, or nondrug, pain management alternatives, which can provide valuable support and relief for patients in lieu of narcotics. Mr. Douglas Scott is one such patient who experienced opioid dependence following back and spine injuries from two car accidents.[4] Luckily, Mr. Scott's insurance covered treatment at a local clinic specializing in alternative pain management techniques, and he was able to be successfully weaned off of opioids. Evidence has shown that patients participating in such comprehensive pain rehabilitation programs can experience significant and sustained improvement in pain severity and functioning.[5] Unlike Mr. Scott, however, not all patients have coverage for such programs, which can cost upwards of $20,000; and we encourage AHIP to explore such options and encourage its membership to offer them to beneficiaries where clinically appropriate.

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[1] https://www.npr.org/sections/health-shots/2017/11/25/566032620/the-insurance-company-paid-for-opioids-but-not-cold-therapy

[2] https://www.nytimes.com/2017/09/17/health/opioid-painkillers-insurance-companies.html?_r=0

[3] https://www.nytimes.com/2017/09/17/health/opioid-painkillers-insurance-companies.html?_r=0

[4] https://www.nytimes.com/2016/06/23/business/new-ways-to-treat-pain-without-opioids-meet-resistance.html

[5] https://insights.ovid.com/pubmed?pmid=18804915

Lastly, we note reports that some insurance coverage plans appear to act as a barrier to accessing medication-assisted treatment (MAT) for individuals who are working to overcome addiction. Medical necessity requirements, high deductibles and copayments, prior authorization rules, and low reimbursement rates can delay and deter treatment, despite the wealth of evidence demonstrating the effectiveness of MAT. Furthermore, insurers that do cover MAT seldom cover all three Food and Drug Administration (FDA)-approved medications - methadone, buprenorphine and naltrexone – which are not interchangeable in their indications and uses. Similar hurdles exist for access to residential rehabilitation centers and detox facilities, for which insurers will often require "medical necessity" before covering care.

For example, Mr. Sean Mattos, a patient struggling with addiction, unsuccessfully went through two outpatient addiction programs before entering a residential facility, only to find that his insurer would not cover the full duration of treatment he required.[6] Despite agreement by his overseeing clinicians that he was not ready to leave the facility, Mr. Mattos was forced to call his insurer while in treatment to request coverage to remain under the facility's care, before ultimately paying $8000 of the $23,000 bill out of pocket. In response to such unfortunate situations and a desire to remedy them, we appreciate that multiple major insurers have recently lifted their prior authorization requirements for MAT – a step forward in reducing barriers to care. However, such efforts must be replicated and expanded across the industry in order for them to make a meaningful difference.

While we appreciate the work AHIP is already doing to help address this epidemic, and we are encouraged by recent industry led efforts to reevaluate some policies in light of the addiction epidemic, we remain concerned by the rules and authorization requirements that may be employed by insurance companies that could potentially limit beneficiary access to non-addictive and alternative pain management options as well as addiction treatment options. In order to effectively address this ongoing epidemic, we believe insurance companies must take additional steps to ensure they are playing a more active role in addiction prevention and treatment and providing beneficiaries full access to the range of clinically appropriate services available. Eliminating cost-sharing requirements for overdose reversal drugs is not enough. Insurer policies such as prior authorization, drug tiering, abrupt formulary changes, preferred pricing lists, restrictions or additional cost-sharing requirements for non-pharmaceutical interventions, lengthy and burdensome appeals process, and other clinician incentives can be insurance tools that, when used improperly, may harm efforts to combat addiction and should be reviewed to avoid furthering the current epidemic.

It is time for insurance industry leaders like AHIP to reexamine these policies in light of the substance/opioid use disorder and update your coverage policies in a way that maximizes the accessibility and affordability of a wide range of safe alternatives to narcotics. The insurance industry is on the front line of this epidemic, and we need your help identifying what policies are working and what barriers to less-addictive pain treatment options and substance use disorder treatments exist.

[6] http://www.modernhealthcare.com/special/opioid-addiction

Recognizing there is a difference in the way insurers are able to design their benefits across commercial, Medicare, and Medicaid books of business, we respectfully request that you respond to the following questions by March 30, 2018:

1. What internal policies and procedures does AHIP encourage member organizations to have in place that may create a barrier to accessing affordable non-addictive or less addictive pain treatments, including those that are non-pharmacological?

2. What flexibilities does AHIP encourage member organizations to offer to ensure that individuals struggling with acute or chronic pain receive the least addictive pain treatment option, in a timely manner?

3. What internal policies and procedures does AHIP encourage member organizations to have in place that may create a barrier to accessing affordable options for medication-assisted treatment and other behavioral therapy options for addicted individuals?

4. What flexibilities does AHIP encourage member organizations to offer to ensure that individuals struggling with substance use disorder receive the proper treatment, in a timely manner?

5. What non-pharmacological alternative pain therapies, such as acupuncture, does AHIP encourage member organizations to offer to beneficiaries? Do alternative pain therapy options vary by benefit design? If so, are there any barriers or restrictions preventing the use of alternative or innovative pain therapy options in federal programs, such as Medicare or Medicaid?

6. How often does AHIP encourage member organizations to review and update its list of approved pain management options and services, both pharmacological and non-pharmacological? As less addictive treatment options become available, how quickly are member organizations able to cover them?

7. How often does AHIP encourage member organizations to review and update its list of approved addiction treatment options and services, both pharmacological and non-pharmacological? As additional substance use disorder treatments become available, how quickly are member organizations able to cover them?

8. Does AHIP encourage member organizations to have a fail-first, stepped, or medical necessity standard for non-addictive, including non-pharmacological, or abuse-deterrent options for pain management?

9. Does AHIP encourage member organizations to have a fail-first or medical necessity standard for medication-assisted treatment or other behavioral therapy options for individuals who have a substance use disorder?

10. When reviewing coverage appeals from beneficiaries, members, or providers, at what level of appeal does AHIP encourage member organizations to implement a clinician review? How quickly are appeals escalated for individuals struggling with severe pain needs? How quickly are appeals escalated for individuals struggling with access to addiction services?

11. When it comes to opioids and other controlled substances, does AHIP encourage member organizations to implement a unique set of internal policies or controls?

12. What is the typical difference, if any, in cost-sharing for members/beneficiaries using non-addictive, including non-pharmacological pain management approaches vs. potentially addictive therapies across AHIP members?

13. What is the typical cost-sharing amount for members/beneficiaries using medication-assisted treatment options or other behavioral therapy options for AHIP members? Do any of your members offer addiction treatment options to beneficiaries without cost-sharing requirements?

14. Do the majority of AHIP members cover all three medication-assisted treatment drug options (methadone, buprenorphine and naltrexone)? Does AHIP encourage its members to cover all three forms of medication-assisted treatment?

15. Recognizing there are always ways to improve these processes, are there other plan designs or benefit flexibilities you could implement to improve access to less addictive pain management options or the full range of treatment options?

16. Are there any additional factors that Congress should be aware of as it considers the nation's substance abuse/opioid crisis?

It is critical that we ensure access to clinically appropriate, non-addictive pain management options for all Americans across all payers as well as comprehensive coverage for the full range of addiction treatment services, from medication-assisted treatment options to inpatient and outpatient therapy.

Thank you for your attention to this matter. We look forward to working with you on policies that will make it as easy for an individual to access addiction treatment and non-addictive remedies for pain as it is for them to access opioids in the first place.

Sincerely,

Sherrod Brown
United States Senator

Edward J. Markey
United States Senator

Jeanne Shaheen
United States Senator

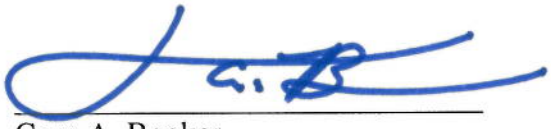
Tammy Baldwin
United States Senator

Margaret Wood Hassan
United States Senator

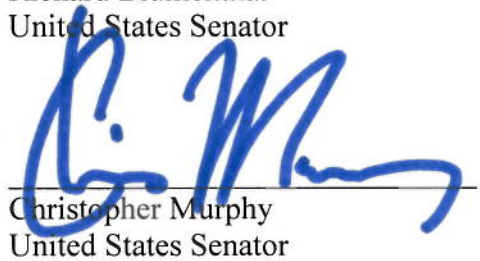
Sheldon Whitehouse
United States Senator

Chris Van Hollen
United States Senator

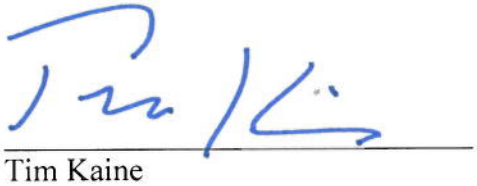
Richard Blumenthal
United States Senator



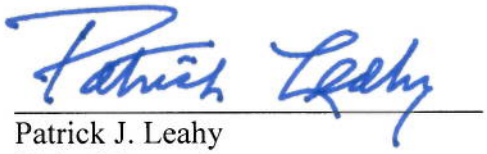
Cory A. Booker
United States Senator



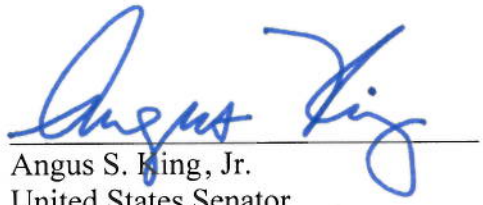
Christopher Murphy
United States Senator



Tim Kaine
United States Senator

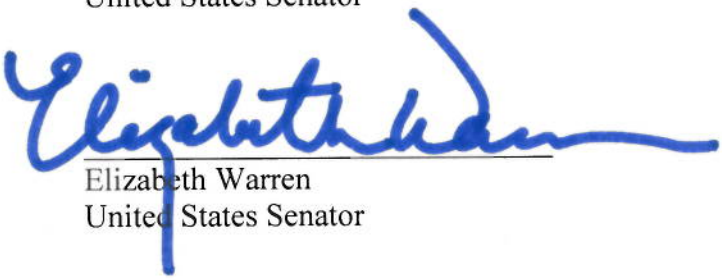


Patrick J. Leahy
United States Senator



Angus S. King, Jr.
United States Senator

Dianne Feinstein
United States Senator



Elizabeth Warren
United States Senator