Pittsburgh Business Group ON HEALTH

Cost and Utilization

Trends of Rheumatoid Arthritis Among PBGH Employer-Members

Introduction

In 2017, there were 989 PBGH members from 21 employer-members (0.5%) who had a primary diagnosis of rheumatoid arthritis (RA). The majority of patients were under the age of 65-years-old (82%), and about 68% were female[1] Globally, **RA is prevalent in about 0.3-1% of the population**, occurring most often in women during the most productive years of life.[2]

What is Rheumatoid Arthritis?

RA is a progressive condition where symptoms wax and wane. A patient may experience periods of remission altered by flares of debilitating joint pain and swelling that may or may not be predictable. If left untreated, tissue and bone damage often occur and progression of the condition may also affect the heart and lungs.[3] **The top three co-morbid conditions in Pennsylvania from Innovu data in 2016 were hypertension (43%), diabetes (15%) and respiratory conditions (15%).**[1]

Treatment

There is no cure for RA. The goal for treatment is a sustained state of clinical remission or low disease activity and consists of medications to treat the symptoms and prevent the disease from progressing, causing irreversible damage to the body. These drugs are referred to as Disease Modifying Antirheumatic Drugs (DMARDS). **Approximately 84% of PBGH members with RA are receiving DMARDs**[3]. The top two most costly medications for PBGH in 2016-2017 were: Humira = $9,983,282 and Enbrel = $4,903,5274, these agents are indicated for the treatment of RA among other autoimmune conditions.[5,6]

Recommendations

1. **Analyze your data.** Review data from Innovu or your health plan to determine the prevalence of members with RA and those receiving care from a rheumatologist.
2. **Be innovative.** Create innovative plan designs that provide RA patients with the option to see a rheumatologist during the work day or flexible work schedule.
3. **Enhance your benefits.** Add telehealth visits with rheumatologists as a covered benefit to monitor patients after they have confirmed the initial diagnosis during a live office visit.
4. **Collaborate with vendors.** Work with your disability carrier to evaluate the number of employees on disability with an RA diagnosis. Determine if the provider type for those individuals is a PCP or a rheumatologist and the length of work days lost. Depending on the data, make the adjustments to your plan design or internal policies as needed to support these individuals to receive access to the most appropriate care.
5. **Expand your offerings.** Health fairs are an excellent opportunity to screen for early detection of RA.
6. **Offer accommodations.** Provide work accommodations for RA patients during periods of flares. Another option, if available, is offering job retraining for tasks that are better suited to the patient's physical ability.
7. **Continually monitor adherence.** Ensure your company is participating in adherence programs offered by your PBMs or specialty pharmacy.

The Financial Impact of RA on PBGH Employer-Members

The costs associated with the treatment of RA are increasingly high for employer-members who have RA. Even with a relatively low prevalence[1], wage replacement associated with illness related absences, disability claims and lost productivity are often higher than any other condition.[7] **The pharmacy and medical treatment per member per month (PMPM) costs for PBGH employer-members in 2017 was $2,194.87 based on PBGH data (see Table 1) compared to $392.96 PMPM for non-RA patients. PBGH members paid a slightly lower PMPM when compared to Pennsylvania and national data available from 2016 (see Table 2).** While the PMPM benchmark for pharmacy and medical costs for PBGH employer-members has consistently been lower than both Pennsylvania and national benchmarks, short term disability (STD), and long term disability (LTD) are not available for comparison. The Integrated Benefits Institute (IBI) estimates patients with RA cost an employer an additional two workdays for illness absences with an average cost of $531; 62.4 lost workdays per RA claim for STD with an average cost of $16,900, and 198 lost workdays for LTD with an average cost of $41,200.[8] IBI data show 13% of employees with RA are on disability leave within six months of onset and 67% within 15 years. IBI published a summary of average workdays lost to STD and LTD by industry type nationally. Figure 1 includes industries represented in by PBGH members.

Assessment

Employers should create a benefit design that encourages healthcare providers to prescribe medications that will move patients into a lower disease activity level or complete remission.[9]

The American College of Rheumatology (ACR) guidelines state disease activity should be assessed during the majority of patient encounters.[9] The European League Against Rheumatism (EULAR) suggest assessments should be done monthly for patients with high or moderate scores and every 3-6 months for patients with low disease activity or in remission.[10] Physicians document assessments in the patient's medical record[11]; however disease activity information is often not typically reported to the health plan or the employer.

Prevalence and Diagnosis

Mary Chester M. Wasko, MD, MSc Division Director of Rheumatology at West Penn Hospital, Allegheny Health Network cautioned there are **other conditions that may present with similar symptoms to RA, which may result in miscoding of true RA patients.** RA symptoms are usually identified during the initial physician assessment; however, a second appointment is often necessary to confirm the diagnosis. Dr. Wasko recommends identifying RA patients by two diagnosis codes documented by a rheumatologist and prescribed a medication for the treatment of RA.

Table 1: 2017 PMPM RA Pharmacy and Medical Costs for PBGH Members vs Members without an RA Diagnosis

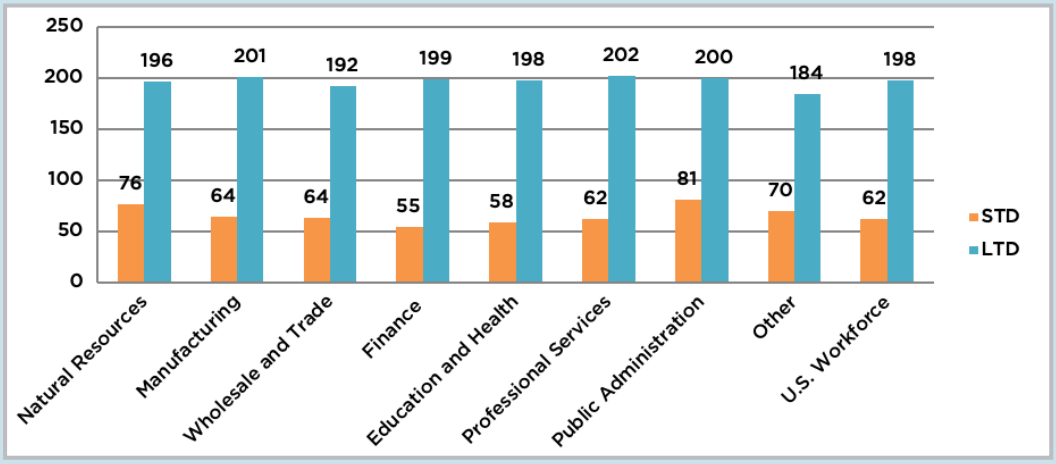
Medical	Pharmacy	Total
Members with an RA Diagnosis		
$1,405.85	$798.01	$2,194.87
Members without an RA Diagnosis		
$326.23	$66.73	$392.96

Source: InnovuLLC, InnovuLens™

Table 2: 2016 PMPM RA Pharmacy and Medical Costs for PBGH Members vs State and National Benchmarks

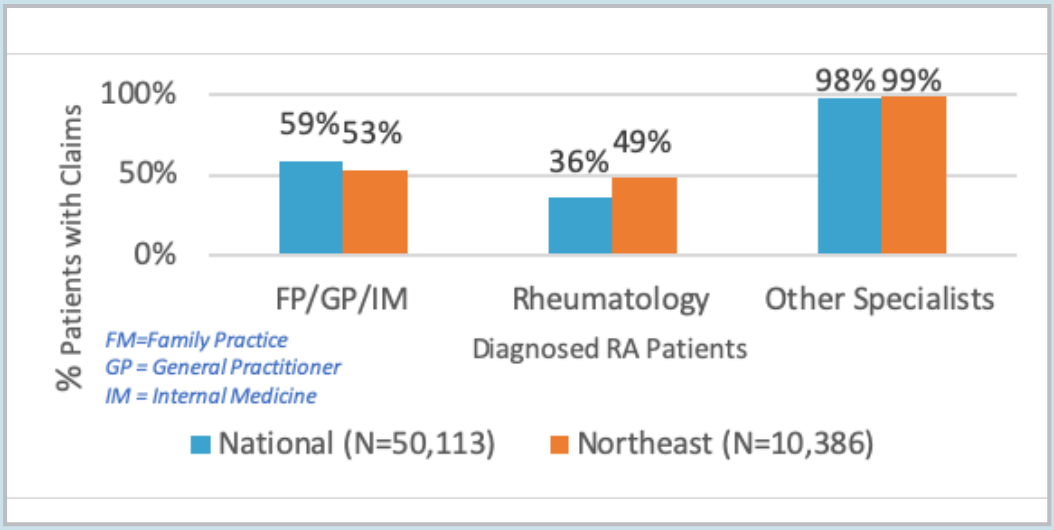
	PBGH	Pennsylvania	National
Total	$1,755.52	$1,884.82	$1,868.76
Pharmacy	$705.87	$971.16	$877.18
Medical	$1,253.51	$1,310.29	$1,332.32

(Figure 1) Average Workdays Lost/Year to Disability by Industry Type



Adapted from the Integrated Benefits Institute for PBGH industries, Health and Productivity Benchmarking database, 2011-2015.

(Figure 2) Physician Utilization Among Diagnosed RA Patients National Data



An analysis of national health plan claims data from the IQVIA Real-World Data Adjudicated Claims - US Database of over 50,000 patients with RA from 2016-2017 indicate that approximately 40% of the patients with RA received care from rheumatologists during the one-year follow up period.[12] (Figure 2) The reasons for the relatively low utilization of rheumatologists are not clear. RA patients may be seeking care from other specialists for their co-morbid conditions; or access to a rheumatologist may not be convenient. The 2015 American College of Rheumatology Workforce study estimated there were about 5,000 specialists that care for patients with RA across the United States and 327 in Pennsylvania.[13] In Pittsburgh, there are approximately 60 rheumatologists.[14] Patients with insurance are guaranteed access to a rheumatologist; however, because of the limited number of rheumatologists, there is a national access delay in obtaining immediate appointments. For example, in rural areas such as Erie, PA, which is identified as a traditionally underserved area, primary care MDs may be the only clinical resource available to diagnose RA. The lack of ability to change the shortage of rheumatologists makes the benefit design structure more critical in influencing non-RA specialists who are treating RA patients. Limited access to RA specialists can extend the time to diagnosis, and to receiving medications that will achieve remission or low disease activity, which is the goal recommended by the ACR.

Limitations

Medical and pharmacy data serve as a guide to evaluate cost and utilization trends; however, they are not enough to assess whether an RA patient is receiving the appropriate diagnosis and care. Additional data must be included for a comprehensive review:

1. **Provider Type** National data suggest patients may be receiving treatment from more than one physician channel. Differences in provider and healthcare channel type may have an impact on an RA patient's outcomes and the costs associated with treatment.
2. **Disability and Family Medical Leave** Patients on STD, LTD and FMLA are not accounted for in this analysis. This information is critical to identify the true prevalence of RA and the full scope of treatment patterns within PBGH members. The expansion of FMLA coverage could result in RA patients using this benefit to provide them with additional time to get their condition under control and at a manageable level.
3. **Disease Severity/Remission Status** Clinicians utilize various standardized scoring methods to assess the degree that a patient is responding to treatment. These data are documented in the patients' medical record, which are not available through medical claims.

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