NATIONAL INFUSION CENTER ASSOCIATION

The Nation's Advocacy Voice for In-Office Infusion

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University of Arkansas, Human Resources
222 Administration Building
Fayetteville, AR 72701

Subject: Arkansas Blue Cross Blue Shield Self-Administration Policy

To Whom It May Concern:

I represent the National Infusion Center Association (NICA), a nonprofit advocacy organization with a mission to protect, promote and expand patient access to infusion care. As the unifying voice for office-based infusion providers of all specialties, we spend a great deal of our time and resources pushing back against payer mandates that interfere with patients' abilities to receive infusions and other provider-administered therapies. Recently, Arkansas Blue Cross Blue Shield announced policy changes that will disrupt and restrict access to specialty medications. These changes will not only result in unhappy beneficiaries—many of whom I understand are **University of Arkansas** employees—but will also **increase the costs of healthcare for these beneficiaries as well as University of Arkansas.**

Specialty medications are some of the most innovative and life-changing treatments in modern medicine, and they are incredibly valuable to patients that need them. As such, specialty medications are very expensive, and we understand the desire to reduce the cost of care for these patients. Unfortunately, many of the policies aimed at reducing specialty medication expenditures end up increasing overall healthcare costs for patients who rely on these medications by either disrupting access to the lowest cost care settings or shifting coverage from the medical benefit to the pharmacy benefit. When patients lose access to care or struggle to afford medications, they may have to ultimately discontinue therapy. Individuals being treated with specialty medications are some of the nation's most vulnerable patients, and affordable access to treatment is critical to maintain disease control and remission. Uncontrolled autoimmune diseases result in significant physical, emotional and economic burden, far outweighing the costs of the specialty medications used to treat them.

Mandating self-administration shifts costs to the pharmacy benefit, often increasing patients' out-of-pocket responsibility and decreasing treatment adherence. While we appreciate the concern for reducing **University of Arkansas**'s medical benefit drug spend, shifting the burden to patients is not a viable solution as out-of-pocket (OOP) costs are one of the biggest drivers of medication non-adherence.[1] As OOP expenses increase, so does the likelihood that patients will stop their medication. One study showed that among patients prescribed a TNF-blocker (one class of medications largely affected by this policy), an OOP expense above $100 per month made patients significantly more likely to stop taking their medication; every $10 increase in weekly OOP expenses made patients 8% more likely to stop therapy, and when OOP expenses exceed $500 per month, patients are 700% more likely to abandon treatment.[2] With these linear relationships in mind, it is clear that reducing OOP expenses for specialty medications is absolutely essential to promote treatment adherence, which the literature clearly

[1] Miranda, A. C., Serag-Bolos, E. S., & Cooper, J. B. (2019). Cost-related medication underuse: Strategies to improve medication adherence at care transitions. *American Journal of Health-System Pharmacy*, 76(8), 560-565. https://doi.org/10.1093/ajhp/zxz010
[2] Gleason, P. P., Starner, C. I., Gunderson, B. W., Schafer, J. A., & Sarran, H. S. (2009). Association of prescription abandonment with cost share for high-cost specialty pharmacy medications. *Journal of Managed Care Pharmacy, 15(8)*, 648-658.

demonstrates results in decreased disease activity, better clinical outcomes, better physical ability, increased quality of life and decreased hospital costs.[3]

This policy will result in unnecessary waste of medication and healthcare resources. If a patient orders a specialty drug to be shipped to their home for self-administration, and subsequent lab results or assessment by the physician leads to the patient canceling treatment or requiring a change in dose, regimen, or medication, the drug-- which was already paid for by the patient and University of Arkansas-- may not be returned and must be discarded. Patients may also require additional visits to their physician's office to address issues such as adverse reactions, challenges with self-administration, or the need for dose escalation, all of which could be handled (or avoided altogether) with in-office administration.

The cost to manage these diseases is high; the costs when these diseases are undermanaged is much, *much* higher. When chronic diseases are poorly controlled, patients utilize more healthcare services and incur substantially higher costs. As formulary restrictions limit providers' ability to effectively manage their patients' conditions, and patients are disincentivized to adhere to their treatment plans due to untenable cost-sharing liabilities, patients will utilize more healthcare services and incur substantially greater costs. A recent analysis of beneficiaries with undermanaged rheumatoid arthritis showed that these patients' overall medical costs are 120% higher than other RA patients; hospital outpatient services for undermanaged patients are 240% higher.[4] It is important to keep in mind these figures do not address the impact to both employer and employee associated with decreased productivity and absenteeism, both of which can be anticipated when chronic illness is uncontrolled.

While these concerns reflect increased healthcare costs for patients and payers, University of Arkansas should primarily consider the costs to their employees' health. The bottom line is that utilization management strategies-- including forcing self-administration under the pharmacy benefit-- take a one-size-fits-all approach to cost containment, which simply doesn't work when caring for individuals with some of the most complex disease states associated with the highest economic burdens when undermanaged. When evaluating health plans for your employees, please consider that one-size-fits-all is not a viable approach for any other consumer industry, and it certainly isn't appropriate when the end product is a life and the cost of "not fitting" is paid with an employee's health and wellbeing. It is our hope that with complete information and real-world context, the University of Arkansas team will gain clarity on the best path forward for both the organization and its employees. I truly appreciate your time and attention in this matter, and I would be more than happy to make myself available for further discussion at your convenience.

Sincerely,

Kaitey Morgan, RN, BSN, CRNI
Director of Quality & Standards
NATIONAL INFUSION CENTER ASSOCIATION

[3] Heidari, P., Cross, W., & Crawford, K. (2018). Do out-of-pocket costs affect medication adherence in adults with rheumatoid arthritis? A systematic review. *Seminars in Arthritis and Rheumatism*, 48, 12-21. https://doi.org/10.1016/j.semarthrit.2017.12.010
[4] Cole, M., Vidulich, A., Francis, M., & Amodeo, K. (2020). Patients with undermanaged ra have higher medicare costs than other ra patients. In *Insights & Analysis*. Avalere Health. https://avalere.com/insights/patients-with-undermanaged-ra-have-higher-medicare-costs-than-other-ra-patients