

# Osteoarthritis & Rheumatoid Arthritis

# KNOW YOUR RIGHTS

## Osteoarthritis and Rheumatoid Arthritis Diagnosis and Treatment

Osteoarthritis and rheumatoid arthritis are two of the most common forms of arthritis. Both can cause joint pain and stiffness and may require treatment for patients to maintain their quality of life.

Osteoarthritis is the more common form of arthritis, affecting more than 30 million Americans.<sup>1</sup> It develops gradually when cartilage, the tissue that cushions the joints, is worn down and the bones begin to rub together. The most common symptoms are stiffness, decreased range of motion, swelling, and pain. Osteoarthritis pain most commonly occurs in the hands, knees, hips, lower back, and neck.

Older age, joint injury and overuse, obesity, weak muscles, genetics and gender all can all increase the chances of developing the osteoarthritis.<sup>1</sup> Most patients rely on a combination of different treatments and therapies to combat the progressive condition.

Unlike osteoarthritis, rheumatoid arthritis is an autoimmune disease. It causes inflammation in the lining of the joints, most commonly the hands, knees, and ankles. Sometimes rheumatoid arthritis can present in different systems and organs, such as the circulatory system, eyes, lungs, or heart. Rheumatoid arthritis is much less common than osteoarthritis, affecting approximately 1.5 million people.<sup>2</sup>

Rheumatoid arthritis tends to cycle through symptom flare ups and remission. Initial symptoms often include pain, swelling, or stiffness in more than one joint, weight loss, fever, and fatigue. Risk

factors that can increase risk include older age, gender, genetics, smoking, obesity, and early life exposures.<sup>3</sup>

Both osteoarthritis and rheumatoid arthritis can seriously impact a person's health, work, and quality of life. People experiencing symptoms of either condition should see a health care provider, who can diagnose and initiate a treatment plan, if necessary.

Just as symptoms and impact vary from patient to patient, so do treatment needs. Osteoarthritis treatments may include a combination of medication, physical and occupational therapy, and injections into the affected joints.<sup>4</sup> Severe cases may require realignment surgery or joint replacements. Treatment for rheumatoid arthritis varies based on the severity of the symptoms and how long the patient has had the disease. Nonsteroidal anti-inflammatory drugs (NSAIDs), steroids, disease-modifying antirheumatic drugs, biologic agents that target the immune system, physical therapy, and surgery are all among treatment options.<sup>4</sup> Some people may require such high doses of NSAIDs that the drug poses a gastrointestinal (GI) risk. In those cases, GI-protectant versions are available. Treatment decisions should be made together by patients and doctors, not dictated by insurers' rules that are aimed to protect company profits.

Health insurance companies can take a number of steps to reduce their costs related to diagnosis and treatment. This can mean your health plan may not cover certain treatments prescribed by your doctor, or the plan may require you to take a number of steps before your treatment is approved.

The good news is that there are state and federal laws in place that may protect you from these practices.

To find out if your health insurer delayed or denied the osteoarthritis or rheumatoid arthritis treatments prescribed by your doctor, ask yourself the following questions:



## Step Therapy

*Did my insurer make me try a different treatment before covering the osteoarthritis or rheumatoid arthritis medication or therapy that my doctor prescribed?*

This practice is called “step therapy” or “fail first” because it requires patients to try other treatments first and demonstrate that they do not work or are intolerable. Your insurer may require you to try and fail on a different medication or therapy before covering the one prescribed by your care team.<sup>5</sup> A recent study showed that more than 70 percent of rheumatoid arthritis patients had plans with step therapy, which led to decreased treatment of effectiveness.<sup>6</sup> Step therapy policies may be against federal or state laws if your insurer treats you and others with similar diagnoses differently because of your health condition.<sup>7</sup> Additionally, you may be entitled to an exception from the step therapy process.



## Nonmedical Switching

*Is my insurer forcing me to take a different medication, even though my current osteoarthritis or rheumatoid arthritis treatment is working, by refusing to cover it any longer or increasing my copay?*

This practice is referred to as “nonmedical switching.” It occurs when your insurer (not your health care professional or pharmacist) forces you to switch from your current medication to a different (but not a generic equivalent) medication by either refusing to cover your drug any longer or increasing the out-of-pocket cost of your drug.<sup>8</sup> Research found patients with rheumatoid arthritis who were switched to a less expensive medication experienced a greater increase in Medicare payments the following year as compared to patients who were not switched.<sup>9</sup> Nonmedical switching may violate certain states’ consumer protection laws.<sup>10</sup>



## Prior Authorization

*Do I need to get my insurer's approval before I can begin or continue my prescribed osteoarthritis or rheumatoid arthritis treatment or therapy?*

This practice is called “prior authorization.” It happens when your insurer requires you or your doctor to get your insurer’s approval before the treatment is covered. Approval is based on the insurer’s standards, which may be inconsistent with medical standards of care. Patients with osteoarthritis and rheumatoid arthritis may be treated with infusions, which often require prior authorization and can lead to treatment delays. For example, a study looked at the time between when an infused medication was prescribed for a rheumatologic condition and when the patient received the therapy.<sup>11</sup> Those patients whose insurance company required a prior authorization, 71% of cases, waited longer to get their infusion. Prior authorization policies can delay or interrupt care, waste time, and complicate medical decisions, as well as negatively impact clinical outcomes.<sup>12</sup> These policies can violate state and federal laws if applied in a certain manner.

## Adverse Tiering

*Do I have to pay a high copay for certain medications that treat my condition?*

This practice is called “adverse tiering.” It can be used by insurers to shift much of the cost for newer or innovative therapies to patients by placing expensive drugs on specialty tiers. One recent study assessed how Medicare Part D covered biologic disease modifying drugs, which are used by one in four Medicare beneficiaries with rheumatoid arthritis. Researchers found nearly all plans required a percentage coinsurance for these biologics – rather than a fixed copayment. The coinsurance was, on average, 30% of the drug’s cost – a high out-of-pocket cost to seniors.<sup>13</sup> Certain tiering policies may also violate certain federal and state laws if used in a discriminatory way.<sup>14</sup>





## **Copayment Accumulators**

*If I receive coupons or discounts to help pay for my medication copays, does my insurer prohibit those coupons or discounts from counting toward my annual deductible?*

This policy is known as a “copayment accumulator.” Copayment accumulators force patients to pay more out-of-pocket when copayment assistance runs out and the insurance deductible has not been met. It’s reported that more than half of rheumatoid arthritis drugs are purchased with the help of copay coupons, so the use of copay accumulator programs has the potential to harm millions of patients.<sup>15</sup> These policies are frequently buried in the fine print of insurance contracts and may violate state consumer protection laws.<sup>16</sup>

# My insurer refuses to cover an OA or RA treatment or therapy that my health care professional prescribed to me. **What can I do?**

If your insurer refuses to cover your treatment, here are three steps you can take to change your insurer's decision:

- Appeal the decision;
- Request an external review; or
- File a complaint.

## How do I appeal the decision?

If your insurer denies your claim, you have the legal right to an internal appeal.<sup>17</sup> This means you can ask your insurer to conduct a full and fair review of its decision. To appeal the denial, you should do the following:

**Review the determination letter.** Your insurer should have sent you a determination letter to tell you that it would not cover your claim. Review this document so you can understand why your insurer denied your claim and how you can appeal the denial.

**Collect information.** Collect the determination letter and all other documents the insurance company sent you. This includes your insurance policy and your insurer's medical necessity criteria. "Medical necessity criteria" refers to your insurer's policy for determining whether a treatment or service is necessary for your condition.<sup>18</sup>

**Request documents.** If you did not receive the determination letter or do not have your policy, the medical necessity criteria, or the instructions and forms for filing an appeal, call the insurer's customer service representative and ask for these documents. The company website will list the toll-free telephone number to call.

**Call your health care professional's office.** The health care professional's office or clinic has people on staff to help with the appeal process. They will tell you how to fill out the forms to request an appeal, write an appeal letter on your behalf, or handle the appeal request for you.

**Submit the appeal request.** It is important for you or your health care professional's office to submit the appeal request as soon as possible along with the letter from the health care professional and all additional information the insurer requested.

**Once you file an appeal request, expect to wait up to 30 days to hear back from the insurance company regarding a treatment you hope to receive.** It can take up to 60 days for a response if you received the treatment and are waiting for reimbursement.

**Follow up.** Follow up with your insurer regularly until you hear back. Be sure to keep a record of the name of any representative you speak with about the appeal, the date and time you spoke with that person, a confirmation number for the call, and a summary of your discussion.

## What if my insurer denies my appeal?

Under law, you are entitled to take your appeal to an independent third party for an "external review," which means the insurance company no longer gets the final say over whether to approve a treatment or pay a claim. The situation applies if the insurer denies your appeal or if your medical situation is urgent and waiting would jeopardize your life or ability to function.

## How do I request an external review?

To trigger an external review, file a written request with the independent organization within 60 days of the date your insurer sent you a final decision. The process should take no more than 60 days. However, in urgent situations requiring an expedited review, the process should take no longer than four business days. To find out whom to contact in your state to request an external review, please go to [www.CoverageRights.org](http://www.CoverageRights.org).

## How do I file a complaint?

If your insurer denies your coverage after the external review process, you can file a complaint with the insurance commissioner or attorney general in your state. To determine whom to contact and how to submit the complaint, please go to [www.CoverageRights.org](http://www.CoverageRights.org).



Your complaint should include the following information:

- The name, address, email address, and telephone number of the person filing the complaint (“Complainant”);
- The name of the insured individual, if different from the Complainant;
- The names of any other parties involved in the claim (for example, the plan administrator or pharmacy benefit manager);
- The name of the insurance company and the type of insurance;
- The state where the insurance plan was purchased;
- Claim information, including the policy number, certificate number, claim number, dates of denial, and amount in dispute;
- The reason for and details of the complaint; and
- What you consider to be a fair resolution.

You should also submit the following supporting documents with your complaint:

- A copy of your insurance card;
- Copies of coverage denials or adverse benefit determinations from your insurer;
- Copies of any determinations made by internal and external reviewers;
- Any materials submitted with prior appeals and complaints;
- Supporting documentation from your health care professional;
- A copy of your insurance policy; and
- All responses from your insurer.<sup>19</sup>

## What happens after the insurance commissioner or attorney general receives my complaint?

The insurance commissioner or attorney general will assign someone to research, investigate, and resolve your complaint.<sup>20</sup> That person will examine your account, records, documents, and transactions.<sup>21</sup> He or she may question witnesses, request additional documents from other parties, and hold a hearing.<sup>22</sup> If the insurance commissioner or attorney general determines that the insurer violated laws or regulations, he or she may order the insurer to give you the requested coverage or compensate you.<sup>23</sup>

## Whom should I call if I have any questions about filing a complaint?

To determine whom to call in your state, please go to [www.CoverageRights.org](http://www.CoverageRights.org).

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