Statement of

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United States House Ways and Means Committee

The Opioid Crisis:

Removing Barriers to Prevent and Treat Opioid Abuse and Dependence in Medicare

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Thank you Chairman Roskam, Ranking Member Levin and members of the Health Subcommittee for holding today's hearing on the opioid abuse epidemic. I appreciate your leadership in bringing a diverse group of stakeholders together to discuss ways we can further our efforts to address the challenges posed by the opioid abuse epidemic facing our nation. I appreciate the opportunity to share Aetna's perspective on this critical public health issue.

Aetna is a leading diversified health company that provides individuals, employers, health care professionals, and others with innovative benefits, products, and services. We serve over 38 million individuals in the United States and around the world.

I currently serve as the company's Executive Vice President and Chief Medical Officer (CMO), a role I have held since 2014. In my capacity as CMO, I lead clinical strategy and policy across Aetna's lines of business and am responsible for driving clinical innovation to improve member experience, quality, and cost in all areas of the health care delivery system. Prior to my role at the company, I served as Chief Executive Officer and Dean of Penn State Hershey Medical Center and Health System. Prior to this, I served as Chief Executive Officer and Dean of the Robert Wood Johnson Medical School. I am an active licensed physician and pulmonologist who still cares for patients at the West Haven VA Hospital.

The opioid epidemic is the leading public health issue facing our nation, negatively impacting the lives of thousands of American families. The Centers for Disease Control and Prevention (CDC) has estimated that in 2016, 64,000 Americans died of drug overdoses—three times the rate in 1999 and up 21% from 2015. Furthermore, America's addiction crisis has led to a two-year consecutive decline in our country's life expectancy, an alarming demographic trend we haven't witnessed since the 1960s.[1]

Aetna understands the importance of fighting the opioid epidemic. Aetna's goal is to help its members who are struggling with addiction return to a productive life free of opioids. Aetna's various business segments are working to support this goal and to prevent future opioid dependency, while aligning with the evolving legal and regulatory guidance surrounding the opioid epidemic. Aetna is also committed to working with state and federal officials to advocate for legislative and regulatory solutions to enable greater public-private partnerships in addressing

[1] Santgaban, Laura. "The opioid crisis is driving down U.S. life expectancy, new data shows." PBS. December 21, 2017.

this epidemic. Furthermore, the Aetna Foundation is, where possible, supporting state and local programs that are aimed at combatting this national crisis.

Aetna is taking a holistic approach to addressing the opioid epidemic. The various segments of Aetna's business—including our Commercial, Medicaid and Medicare product lines—are all striving to help our members struggling with addiction and to prevent future opioid dependency. To that end, Aetna has established an "Enterprise-Wide Opioid Taskforce"—which I chair—with the objective of driving a multi-faceted strategy to help stem the tide of over-use. We have developed a strategy focused on: preventing misuse and abuse; intervening when we identify at-risk provider and member behavior; and supporting members by providing access to evidence-based treatments.

Aetna is focused on helping its members avoid unnecessary opioid use and effectively manage opioid use when needed. In doing so, Aetna is striving—where possible and appropriate—to increase the use of alternative therapies for members' pain relief, such as physical therapy, chiropractic/osteopathic manipulative treatment, massage (in conjunction with physical therapy), cognitive behavioral therapy, and other effective alternative modalities. For members who are dealing with chronic pain, Aetna supports a multi-disciplinary treatment approach, including both outpatient and inpatient treatment programs that consider physical, social, and behavioral factors.

I am pleased to share with the Committee highlights of Aetna's efforts to fight the opioid epidemic. Specifically, we believe our important efforts in our Commercial lines of business, for example, can inform how the Centers for Medicare and Medicaid Services (CMS) regulates Medicare Advantage (MA) and Part D plans to allow for similar programs in the Medicare space.

At Aetna, we are taking a number of steps to address the opioid epidemic. For example, we are leveraging formulary and plan design as tools to reduce opioid misuse and encourage evidence-based treatment. While regulatory and contractual requirements affect the specifics of Aetna's approach by state and product line, Aetna is using these tools to ensure that appropriate prior authorization and quantity limits support the proper use of opioids for pain management and that alternative non-opioid treatments are available. As of January 1, 2018 in our commercial business, Aetna is limiting initial opioid prescriptions for acute pain to a seven day

supply, as well as a limit of 90 milligrams of morphine equivalency per day. These stricter daily and length of coverage limits will help reduce the potential for abuse and risk of addiction.

In our commercial business, Aetna requires prior authorization for all opioids for acute pain beyond the seven day initial fill, and also requires prior authorization for all opioids used for the treatment of chronic pain. These guardrails ensure that additional opioids are used for the shortest possible duration and only when the benefits of use outweigh the risks, aligning with CDC guidelines. The prior authorization requirement ensures that for longer term use in treating chronic pain, the physician and member have a treatment and monitoring plan in place to help prevent excessive side effects and possible future addiction.

Furthermore, Aetna understands the important role that Medication-Assisted Treatment (MAT) plays in treating opioid use disorder. Aetna seeks to support its members who are recovering from opioid dependency and/or are at risk of an opioid overdose. To that end, in its commercial business, Aetna has removed prior authorization requirements on generic drugs that treat opioid addiction, including oral buprenorphine/naloxone and generic dosages of Suboxone and Subutex.

Aetna continues to look for ways to intervene when it identifies at-risk behavior with members. Per CDC, the Substance Abuse and Mental Health Services Administration (SAMHSA), the World Health Organization, and the American Medical Association (AMA) Opioid Task Force recommendations, physicians should consider co-prescribing naloxone—a lifesaving, highly effective opioid overdose reversal agent — to patients who are at an increased risk of an overdose. In light of these recommendations, effective January 1, 2018, Aetna became the first and only national payer to waive copays for Narcan for its fully-insured commercial members once their deductible is met. We hope that this copay waiver will increase access and remove possible financial barriers to the use of naloxone. In order to further increase access in regions particularly hard-hit by the opioid epidemic, Aetna donated 720 doses of Narcan to first responders in the Northern Kentucky and Appalachia regions in August 2017 in support of community efforts to prevent deadly opioid overdoses. Aetna employees also led an educational training event for first responders and community members. And last December, Aetna donated 408 Narcan kits to Howard County, Maryland.

In order to promote prescriber education and prevent potential overprescribing, in 2016, Aetna sent letters to the top 1% of opioid prescribers within their respective specialties, to make them aware of their outlier prescribing patterns. These approximately 1,000 opioid "super-prescribers" were also provided the 2016 CDC guidelines for the use of opioids for the management of chronic pain. Last year, Aetna also sent 480 individualized letters to "super-prescriber" dentists and, in collaboration with the American Association of Oral and Maxillofacial Surgeons, sent 249 letters to "super-prescriber" oral surgeons.

Also, in our commercial business, Aetna is in the process of implementing a pilot program to provide coverage of Exparel—a non-narcotic pain injection used in patients following wisdom teeth extraction (or other dental surgery)—to its fully insured plans in lieu of opioid pills. By providing safer alternatives for pain control, fewer opioids are prescribed, and we can avoid the risk of misuse and diversion of unused pills.

Within Aetna's Medicare business, we have also been taking strides to be part of the opioid solution. Before I turn to specific examples, it's important to consider the structural framework of the Medicare program itself. The Medicare population, including seniors and the qualified disabled, receives their benefits in multiple ways. For example:

1. Some are enrolled in fee-for-service (FFS) Medicare, stand-alone Part D, and have a supplemental policy through an employer or a purchased Medigap plan;
2. Others are enrolled in a Medicare Advantage-Prescription Drug Plan (referred to as an "MA-PD") which combines a Medicare Advantage health plan with an integrated prescription drug plan;
3. Others who are lower income or dual-eligible have both Medicare and Medicaid, and still get their drug benefit through Medicare Part D;
4. Furthermore, certain Medicare retirees obtain coverage through a Medicare employer group waiver plans (EGWP), but often the employers choose another entity to provide the drug benefit.

Aetna believes the best way to manage Medicare beneficiaries' health is through a fully integrated model, such as MA-PD, that coordinates Medicare, Medicaid (if applicable), and drug

benefits. Evidence shows that integrated medical and drug plans are better for the consumer and provide quality service at lower cost.[2] However, structural barriers exist even within MA-PDs that limit Aetna's ability to impose opioid utilization management restrictions (such as requiring non-opioid pain management prior to the use of opioids). And with added flexibility, even more can be done to address beneficiaries' overall healthcare needs, including health, wellness, pain management, addiction, and drug utilization.

As a Medicare Managed Care Organization (MCO), Aetna's Individual Medicare formularies are governed by regulations and guidance from the CMS. CMS's regulatory framework is designed to protect Medicare members' access to prescription drugs, to ensure timely delivery, and to minimize disruption of members' drug therapies. Accordingly, MCOs like Aetna are limited in their ability to make formulary and utilization management changes to limit the use of opioids.

Despite these constraints, Aetna has taken steps to promote appropriate prescribing and coordination of care for its Medicare members who utilize opioid drug therapies. As a general matter, Aetna has instituted, with CMS approval, utilization management tools in its Medicare formularies to assist Aetna's members in receiving appropriate opioid medication when necessary, while preventing inappropriate use and/or addiction. Aetna's Medicare plan system implementation also contains point of sale pharmacy messages to pharmacists in support of opioid use controls, as well as retrospective utilization programs to support physician appropriate prescribing and coordination of care.

As an example, under the point of sale messaging, a dispensing pharmacist will receive an alert when a member has a product like Suboxone in their recent drug history fills and is attempting to fill an opioid prescription. The alert is meant to inform the pharmacist that he or she should assess whether a different non-opioid pain medication would be a more appropriate treatment before filling the prescription.

In addition, Aetna has aligned its targeting criteria—by which it identifies high dose opioid users for potential intervention—in Medicare more closely with CDC guidance on high dose, high risk utilization of opioids. Beginning this year Aetna Medicare's targeting criteria

[2] Smith-McLallen, Aaron. "Effects of Pharmacy Benefit Carve-In on Utilization and Medical Costs: A Three Year Study." Benefits Magazine. February 2012.

decreased from a 120 milligram morphine equivalent dose threshold to 90 milligrams. This change will help target a greater number of at-risk members for potential intervention.

Aetna is committed to continuing to work with Congress and CMS to highlight areas of opportunity for change to better combat opioid abuse. There are a few specific areas where we believe Congress and CMS can make changes:

Limit Initial Opioid Prescriptions to 7-Day Supply

While Aetna now limits initial fills of acute opioid prescriptions to a 7-day supply in our Commercial business, current Medicare rules preclude Part D plans from unilaterally limiting the duration of a prescription (though patients or prescribers may request a shorter fill than prescribed). In other words, in most states that do not have pharmacy-specific rules to this effect, standalone Part D and MA-PD plans cannot limit a prescription fill to only seven days because of safety or potential abuse concerns, without a member or prescriber's request.

We are encouraged that CMS—in its recently released 2019 MA and Part D Advanced Notice and Call Letter—is proposing significant steps to allow MA and Part D plans to take more action to prevent over prescribing of prescription opioids. Specifically, we strongly encourage CMS to finalize provisions that allow additional point-of-sale edits and supply limits of prescription opioids that limit initial prescribing to a 7-day supply, in alignment with CDC guidelines.

Ensure Success of Medicare Part D Lock-in

We support CMS' continued efforts to address the opioid epidemic and believe the implementation of CARA, and the adoption in Part D of a lock-in mechanism (by which a member can be "locked in" to one pharmacy to prevent "pharmacy shopping"), will provide Part D sponsors with a critical tool to help curtail inappropriate abuse of opioids and other medications. However, there are several critical changes CMS should make in implementing the Medicare lock-in program to ensure its success. First, we believe Part D sponsors must retain the ability to use point of sale claims edits to address other frequently abused drugs, including those often used concurrently with opioids. Second, sponsors must also be allowed to continue to apply point of sale edits when a member is identified by their prescriber as potentially at-risk, even if they do not meet the CMS criteria. Third, we also believe plans should be allowed to

maintain the locked-in status of a member until notified by the applicable provider that the member is no longer at risk. Arbitrarily terminating these important limitations after one year without a clinical reason, we believe, unnecessarily puts members at risk of relapsing.

Modernize Privacy Regulations

As a practicing physician, I understand and respect the importance of privacy as it relates to health care. However, I also believe that certain privacy regulations limit the ability for MCOs, like Aetna, and health providers to securely exchange relevant information about a patient's history with substance abuse, addiction, or mental health. We at Aetna believe these barriers warrant further review and updating.

We strongly support modernizing privacy regulations, 42 CFR Part 2, to provide access to a patient's entire medical record, including substance use disorder records and to ensure that providers and organizations have all the information necessary to provide safe, effective, high quality care.

Care coordination for members with a substance use disorder is of utmost importance. The current outdated rule poses a serious safety threat to those with substance use disorders due to risks from drug interactions and co-existing medical problems. In addition, these outdated regulations run counter to new, innovative delivery care models where providers must use patient data and analytics to manage the health of a population and identify patients for targeted outreach.

To this end, Congress should expeditiously pass bipartisan legislation introduced in both chambers by Representatives Mullin and Blumenauer in the House (H.R. 3545) and Senators Manchin and Capito in the Senate (S. 1850) to align this outdated regulation with already strict HIPPA standards.

In conclusion, Aetna is deeply committed to doing its part to reverse the trend of opioid misuse, abuse, and overdoses across the nation. We have already lost far too many of our friends, family, and community members to this unprecedented health crisis. We will continue to enhance our programs to reduce inappropriate opioid prescribing, encourage the use of non-opioid pain treatment modalities, and promote evidence-based recovery for our members struggling with opioid use disorder. We look forward to continuing to play a productive role in

the dialogue with the Committee and with other policymakers to help find solutions to this epidemic. Thank you again for your leadership on this issue and for inviting Aetna to be here today.