AMERICAN COLLEGE OF RHEUMATOLOGY

POSITION STATEMENT

SUBJECT: Access to Care

PRESENTED BY: Committee on Rheumatologic Care

FOR DISTRIBUTION TO: Members of the American College of Rheumatology
Pharmaceutical Councils/Representatives
Professional Pharmacists' Associations
Medical Review Organizations, e.g., AMCRA
Medicare Carriers/Private Insurers
State Insurance Commissioners

BACKGROUND:

The Mission of the American College of Rheumatology (ACR) includes advocacy for excellence in the care of people, both adult and children, with arthritis, rheumatic and musculoskeletal diseases. The College is deeply concerned over access to care barriers as they affect the ability of a patient with arthritis or other rheumatic disease to obtain affordable, high quality, high value healthcare. This Position Statement is divided into three parts, each addressing one of three key access to care problem areas:

1. Access to adequate and affordable health insurance.
2. Access to a rheumatologist.
3. Access to affordable medications for arthritis and rheumatic disease.

PROBLEM 1: Lack of Access to Adequate and Affordable Health Insurance

Forty five million citizens are without health insurance including 9 million children. Not only does this affect their health and the economic health of their community but also their longevity.[1] The Institute of Medicine estimates that 18,000 Americans die prematurely each year due to the effects of lack of health insurance. The uninsured would achieve a 5-15% reduction in mortality if they received continuous health insurance.[2] Patients with arthritis or other rheumatic diseases are particularly vulnerable and without treatment many become disabled. Extending coverage to the uninsured will save lives and save money.[3]

POSITION:

All Americans should be covered by continuous health insurance that encourages high quality health care including care for chronic arthritis and rheumatic diseases. We recommend that this coverage have the following features:

- No preexisting illness exclusions

31 o Access to arthritis specialists and coverage for services that are uniquely valuable to
32 arthritis patients including therapeutic water exercises, physical and occupational
33 therapy, and appropriate radiologic imaging for early detection and prevention purposes.
34 o Coverage of health educational activities for chronic arthritis patients realizing the
35 importance of education in the management of chronic rheumatic diseases
36 o Recognition of the difficulties of travel for arthritis patients. Laboratory, radiological
37 services and infusion services should be conveniently available near the source of the
38 patient's medical care.
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40 **PROBLEM 2. Lack of Access to a Rheumatologist**
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42 There is a shortage of rheumatologists and underserved areas with long waiting lists in many areas. This
43 shortage is expected to worsen in the future without increases in funding for education and training.
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45 **POSITION:**
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47 The ACR recommends the following:
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49 o Increased funding for arthritis and rheumatic disease care and research with attention to
50 support for the recruitment and retention of researchers and academic rheumatology teachers
51 o Increased graduate medical education support for training more rheumatologists and for
52 programs that train nurses and other health professionals to specialize in rheumatic care.
53 o Since rheumatologists provide primary care to patients with rheumatic diseases,
54 rheumatologists should not be placed in a higher tier associated with higher copays, which
55 results in limited patient access.
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58 **PROBLEM 3. Lack of Access to Affordable Medications for Rheumatic Disease**
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60 Effective drug therapies are now available for many of the serious disabling rheumatic diseases. Access
61 to these therapies has been restricted due to their cost even when the patient has health insurance.
62 Barriers to patients include excessive co-pays and various administrative barriers whereby the insurance
63 company and formulary committees restrict utilization, often making therapeutic decisions in place of
64 the patient's physician. Many patients are simply going without needed medications because of cost.
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66 **POSITION:**
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68 The ACR believes that a prescription drug benefit should be a basic component of all health insurance
69 plans and should include arthritis medications so that appropriate arthritis medications are available to
70 all patients. It should include the following principles:
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72 o The patient's physician should make the therapeutic decisions with the patient without undue
73 intrusion by formulary committees or other administrative personnel not involved in the patient's
74 management.

75 o Patient's health and welfare should be primary. Physicians should be cognizant of cost
76 implications and societal obligations. These obligations can be addressed in part by participation
77 in a primary role in formulary recommendations and policy making.
78 o Prescription drug formulary development should take into account many rheumatic diseases
79 have no FDA approved medications and therefore always involve rheumatologists when
80 reviewing and evaluating drugs for arthritis and rheumatic diseases.
81 o Prompt and simple mechanisms for formulary exceptions should be readily available when
82 clinically appropriate. Many life threatening rheumatic diseases are rare, and as a consequence
83 have no FDA approved medications labeled for use in those particular diseases. There is,
84 however, evidenced based consensus in the rheumatology community that certain medications
85 can greatly reduce morbidity and death in these rare diseases. For less common diseases where
86 FDA approval may be lacking, peer reviewed literature should determine the standard of care for
87 medication coverage.
88 o When no medication coverage is available, pharmaceutical companies should be encouraged to
89 provide available medication through indigent programs so that no patient should become
90 disabled due to lack of medication.

91 **REFERENCES:**

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