601 E Street, NW | Washington, DC 20049
202-434-2277 | 1-888-OUR-AARP | 1-888-687-2277 | TTY: 1-877-434-7598
www.aarp.org | twitter: @aarp | facebook.com/aarp | youtube.com/aarp

February 16, 2018

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20515

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20515

Dear Chairman Hatch and Ranking Member Wyden:

AARP welcomes the opportunity to respond to the Committee's request for information on the opioid epidemic. AARP, with its nearly 38 million members in all 50 states, the District of Columbia, and the U.S. territories is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

We share the Committee's concern about the ongoing opioid epidemic as older adults have unique risk factors that make them particularly susceptible to misuse of prescription opioid drugs. For example, older adults use more prescription drugs than any other age group. Eighty percent of adults age 65 and older have multiple chronic conditions such as diabetes or high blood pressure, and older adults have higher rates of pain, anxiety, and sleep disorders.[1] Treatment for these conditions often involves complex drug therapy that can require multiple prescriptions over long periods of time and may include appropriate use of prescription opioids. Thus, while we support and encourage efforts to curb misuse and abuse, AARP strongly believes that efforts to respond to the opioid epidemic must balance preventing and treating opioid abuse with ensuring appropriate access to prescription drugs for patients with legitimate medical needs.

[1] Dean https://www.aarp.org/content/dam/aarp/ppi/2017/07/prescription-drug-abuse-among-older-adults.pdf

Tailoring Solutions to Older Americans

Unique characteristics of the older adult population demand different or more nuanced solutions to opioid misuse and abuse. For example, due to coexisting physical and mental conditions, opioid abuse among older adults often goes unrecognized, undiagnosed or is misdiagnosed. Many providers have difficulty differentiating between abuse and conditions with similar symptoms like dementia and depression because they have not been trained to identify substance abuse and addiction among older populations. Further, diagnostic criteria used to identify prescription drug misuse and abuse often have not been validated on older adults and may be inadequate.

Consequently, we believe that developing diagnostic criteria to properly identify prescription drug abuse among older adults is an important first step to address the opioid abuse epidemic. In addition, health care professionals should be required to receive training that will help them recognize prescription drug abuse among this population.

Older opioid abuse patients also face unique treatment gaps that warrant attention. Traditional drug abuse treatment strategies such as medication and behavioral therapy may not be sensitive to the biological, psychological, and social changes that accompany aging.[2] Further, fewer than 20 percent of substance abuse treatment facilities reported having a program specifically designed for older adults in 2016.[3]

Finally, it is critical that older adults have adequate health coverage for substance abuse treatment. While parity laws currently require Medicare, Medicaid, and private insurance to cover mental and behavioral health treatment, there is evidence that access issues remain.[4] AARP urges the Committee to ensure enforcement of current parity laws and monitor access to substance abuse treatment across public and private insurance programs.

Legitimate Medical Needs

While AARP appreciates and supports efforts to reduce opioid abuse, we are concerned that efforts to detect and prevent overutilization may inadvertently result in older adults being unable to obtain necessary and appropriate medications. Increased monitoring and fear of prescription drug abuse and associated penalties have already pushed some providers to be more conservative in prescribing opioids, potentially limiting access.

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[2] Purvis https://assets.aarp.org/rgcenter/ppi/health-care/i41-illicit-drug.pdf

[3] SAMHSA, https://wwwdasis.samhsa.gov/dasis2/nssats/2016_nssats_rpt.pdf

[4] "Enforcement of Mental Health Care Coverage Lacking," The Pew Charitable Trusts, March 6, 2016, http://www.pewtrusts.org/en/research-and-analysis/ blogs/stateline/2016/06/03/enforcement-of-mental-health-care-coveragelacking.

AARP encourages the Committee to ensure that any new policies continue to allow older Americans access to the prescription drugs they need. We also encourage the Committee to continue investments in non-opioid pain management medication and techniques. AARP continues to be concerned that patients, including older adults currently have few alternatives to opioid medications.

Part D "Lock-In"

The Comprehensive Addiction and Recovery Act (CARA) provided authority for Medicare Advantage Prescription Drug (MA-PD) plans and Prescription Drug Plans (PDPs) to establish a drug management program limiting access to frequently abused drugs for people determined to be at risk of abusing those drugs. It also exempts certain beneficiaries from those drug management programs. CARA specifically exempts enrollees who are receiving hospice care and residents in long-term care facilities where frequently abused drugs are dispensed through a contract with a single pharmacy. CARA also gives CMS the authority to exempt other individuals, and CMS proposes to use that additional authority to exempt individuals with a cancer diagnosis.

AARP recommends that the Committee urge CMS to regularly re-evaluate which groups are exempted from CARA's drug management process and add groups as needed based on clear and convincing evidence. For example, many analyses of pain prevalence find that in addition to beneficiaries struggling with cancer-related pain at the end of their lives many patients with other conditions, such as congestive heart failure, chronic obstructive pulmonary disease, stroke, and ALS, also experience significant pain at the end of their lives.[5]

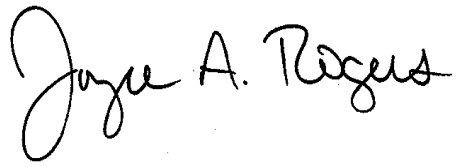
In addition, while AARP supports efforts to identify Part D enrollees who may be abusing opioid medications, we strongly believe efforts to address prescription drug abuse in Part D should also focus on prescribers and pharmacies. As has been well documented, patients typically do not begin abusing prescription drugs without help. Consequently, we strongly recommend strengthening and expanding programs for the education and training of health care professionals. More specifically, we suggest that efforts to "lock-in" Part D beneficiaries be accompanied by targeted education for prescribers and pharmacies to assist with the identification of at-risk individuals, enhance reporting to enforcement entities, and ensure that at-risk individuals receive appropriate medical care and behavioral health services.

We also believe that greater efforts should be made to connect enrollees with behavioral health services, case management and other community resources. Outreach to at-risk individuals, prescribing physicians, and pharmacists will be critical to addressing addiction issues and making appropriate referrals to get enrollees the assistance and counseling they need.

[5] http://www.clinicaladvisor.com/hospital-medicine/palliative-care-pain-management/article/603983/ and Colvin L, Forbes K, Fallon M; Difficult pain. BMJ. 2006 May 6332(7549):1081-3.

Thank you again for offering us the opportunity to submit AARP's thoughts and comments on efforts to combat the opioid epidemic. If you have any additional questions, feel free to contact me or contact Amy Kelbick on our staff at akelbick@aarp.org or 202-434-2648.

Sincerely,



Joyce A. Rogers
Senior Vice President, Government Affairs