

W H I T E P A P E R

Arthritis

Joint Diseases and the Pathway to Dependency

Osteoarthritis · Rheumatoid Arthritis · Gout · Psoriatic · Spinal · Joint Replacement

A Complete Guide for Patients, Families, and Caregivers

Diagnosis · Biologics & Biosimilars · Joint Replacement · Care Costs · Long-Term Planning

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Sources: CDC, American College of Rheumatology, Arthritis Foundation, AAOS/AJRR, FDA, NIH/NIAMS, NIH ClinicalTrials.gov

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1. EXECUTIVE SUMMARY

Arthritis is the single most common chronic condition in older Americans, and it is the leading cause of disability in the United States. It is also the most underestimated driver of long-term care need. People know arthritis hurts. Fewer recognize that joint disease — through pain, stiffness, deformity, weakness, falls, and the cascade of post-surgical rehabilitation — is one of the most reliable pathways from independent living to assisted living to skilled nursing.

Today, 58.5 million American adults — 21.3% of the adult population — have diagnosed arthritis. That number is projected to reach 78 million by 2040. Among adults aged 75 and older, prevalence reaches 53.9%. In Florida, 27.5% of adults — approximately 4.3 million people — live with arthritis, and the state's older demographic profile means the functional consequences appear earlier and more heavily than in much of the country.

Arthritis is not one disease. Osteoarthritis (OA), the 'wear-and-tear' arthritis that affects approximately 33 million Americans, dominates the older population. Rheumatoid arthritis (RA) is a systemic autoimmune disease affecting 1.5 million. Gout has surged to 9.2 million cases and now exceeds RA in prevalence. Psoriatic arthritis, ankylosing spondylitis, lupus arthritis, and juvenile idiopathic arthritis round out a catalog of more than 100 forms of joint disease — each with its own treatment pathway, its own complications, and its own dependency profile.

Arthritis imposes \$303.5 billion in annual U.S. economic costs — \$140 billion in direct medical care, \$164 billion in lost earnings. Knee and hip arthritis are the #1 mobility disablers in older adults. 25.7 million adults — 43.9% of those with arthritis — already report arthritis-attributable activity limitation. Sources: CDC, NACDD, CareScout 2025.

This white paper is written for patients, families, and caregivers facing arthritis — from the first knee stiffness in the fifties through advanced joint disease and the long, expensive years of dependency. It covers:

- How each form of arthritis — OA, RA, gout, PsA, axial spondyloarthritis, lupus — produces a distinct dependency pathway
- The current medication landscape, including DMARDs, the ten FDA-approved Humira biosimilars, and the new dual IL-17A/F inhibitor Bimzelx (approved September 2024)
- Joint replacement surgery: 1 million annual Medicare TKAs, the rise of robotic and outpatient procedures, and what 92% home-discharge rates mean for recovery planning
- The 2024–2026 pipeline: disease-modifying OA drugs (DMOADs), CAR-T 'immune reset' for refractory RA and lupus, TYK2 inhibitors, and what to expect — and not expect — in the next five years
- The Medicare Part D \$2,000 out-of-pocket cap and how biosimilars are reshaping access to biologics
- The 11–17x falls risk that defines arthritis as a long-term care issue, not just a pain issue

- Long-term care insurance underwriting reality for arthritis applicants — and the planning window that closes once joint replacement is 'recommended' in the chart

2. UNDERSTANDING ARTHRITIS

Arthritis is an umbrella term covering more than 100 distinct conditions, all of which involve joint inflammation or joint damage. The conditions differ enormously in their cause, their natural history, their treatment, and their long-term care implications. For LTC planning, the differences matter more than the umbrella term.

The Major Types

Osteoarthritis (OA)

By far the most common form — approximately 32.5–33 million American adults. OA is a mechanical, degenerative disease of the joint: cartilage thins and erodes, bone underneath remodels, synovial inflammation develops, and pain and stiffness progress. It is strongly associated with age, prior joint injury, occupation, obesity, and genetics. Knees, hips, hands, and spine are the typical targets. OA is the leading reason for joint replacement surgery and the leading cause of mobility-related disability in older adults.

Rheumatoid Arthritis (RA)

A systemic autoimmune disease affecting approximately 1.5 million Americans by traditional estimates, with broader case-finding suggesting figures as high as 10.6 million. RA attacks the joint lining (synovium) symmetrically — wrists, knuckles, knees, ankles — but it is also a whole-body disease. RA increases cardiovascular mortality 2-fold, causes interstitial lung disease in 10–30% of patients, and can produce dangerous instability at the top of the cervical spine (C1–C2). RA is 2–3x more common in women and typically presents between ages 30 and 60.

Gout

A crystal-induced inflammatory arthritis caused by elevated uric acid (hyperuricemia). Approximately 9.2 million Americans have gout — recent estimates run as high as 12.1 million. Classically presents as a sudden, severe, exquisitely painful attack in the great toe (podagra), though knees, ankles, wrists, and elbows are also commonly involved. Gout is more common in men, in people with chronic kidney disease, in patients on diuretics, and in those with the metabolic syndrome. An acute flare can produce 3–10 days of complete immobility — a critical detail for any LTC planner.

Psoriatic Arthritis (PsA), Ankylosing Spondylitis (AS), and the Spondyloarthropathies

Approximately 1 million Americans have psoriatic arthritis, an inflammatory arthritis that occurs in roughly 30% of patients with psoriasis. Ankylosing spondylitis and the broader category of axial spondyloarthritis affect the spine and sacroiliac joints and can produce, in severe cases, a fused, rigid spine. These conditions share a genetic association (HLA-B27) and respond to similar biologic therapies.

Lupus Arthritis and Juvenile Idiopathic Arthritis

Systemic lupus erythematosus affects approximately 1.5 million Americans, and roughly 90% have joint involvement at some point. Juvenile idiopathic arthritis (JIA) is the most common rheumatic disease in children — approximately 300,000 U.S. cases. JIA can either burn out or persist into adult disability; long-term joint damage from poorly controlled JIA is a quiet contributor to early LTC need.

Demographics and Disparities

- Prevalence in adults 75+ reaches 53.9% — more than half
- Women are more affected than men for OA (62% of OA cases) and dramatically more for RA (2–3x)
- Men have higher gout prevalence — roughly 4:1 over premenopausal women
- Black and Hispanic adults experience more severe pain and greater functional limitation despite somewhat lower prevalence
- Lower income is strongly associated with worse arthritis outcomes — fewer joint replacements, more disability
- Rural areas, including much of the Southeast, show higher arthritis-attributable activity limitation

The Florida Context

Florida's arthritis profile is heavy and consequential. Approximately 27.5% of Florida adults — about 4.3 million people — have diagnosed arthritis. The state ranks 25th nationally in arthritis prevalence but its older age structure means the functional burden is substantially higher than the prevalence number suggests. For LTC planners working in Florida — and especially in Southwest Florida's retirement communities — every client conversation should assume some degree of arthritis and ask the right questions before submitting an application.

Why the Numbers Will Keep Rising

Three forces guarantee arthritis will be a larger problem in 2040 than in 2026:

- Population aging — 75+ is the highest-prevalence cohort and the fastest-growing demographic
- Obesity — each unit of BMI above normal accelerates OA progression; the obesity epidemic feeds the OA epidemic
- Survival improvement — patients with RA, lupus, and other systemic rheumatic diseases now live longer with the disease, accumulating more joint damage over decades

The CDC projects 78 million arthritis cases by 2040 — a 33% increase over current levels. The LTC implications are profound.

3. THE COMPLICATIONS THAT DRIVE DEPENDENCY

This section is the clinical heart of why arthritis matters for long-term care planning. Each form of arthritis produces a different dependency profile. Taken together, these are the mechanisms by which a knee twinge at 55 becomes an assisted living move at 78.

3.1 Knee Osteoarthritis — The #1 Mobility Disabler

Knee OA is, in functional terms, the single most disabling form of arthritis in the United States. Approximately 30% of adults over 45 have radiographic knee OA, and a substantial fraction are symptomatic. Knee OA progresses from mild pain with activity, to pain at rest, to instability and giving-way, to the radiographic 'bone-on-bone' picture (Kellgren-Lawrence Grade 4) that defines surgical candidacy.

LTC dependency link: Knee OA directly affects every weight-bearing ADL — walking, stair-climbing, transferring from chair to standing, getting in and out of the bathtub or shower, getting on and off the toilet. A patient with bilateral knee OA who declines or postpones joint replacement enters a predictable decline: less walking, more weight gain, more pain, more deconditioning, and eventually a wheelchair and an assisted living move.

3.2 Hip Osteoarthritis

Hip OA is less common than knee OA but disproportionately disabling. It compromises the ability to put on socks and shoes, to sit on or rise from a low surface (toilet, sofa, car seat), and to walk distance. Women with hip OA have approximately 3x the falls risk of women without. Severe hip OA frequently precipitates the falls and hip fractures covered in our Falls white paper.

LTC dependency link: Hip OA produces bathing, toileting, and dressing impairments earlier in the disease course than knee OA does. It is one of the most reliable triggers for in-home help and, ultimately, for assisted living.

3.3 Hand Osteoarthritis

Often dismissed as cosmetic — the Heberden's and Bouchard's nodes that mark older hands — hand OA is one of the most underappreciated drivers of IADL loss. The thumb base (CMC joint) is particularly common and particularly disabling: grip strength fails, fine motor control deteriorates, and the simplest medication management — opening a pill bottle, pushing through a blister pack, drawing up insulin — becomes impossible.

LTC dependency link: Hand OA is the earliest ADL warning many planners miss. When a client says 'I can't open the pickle jar anymore,' the implication is not just kitchen frustration — it is medication

management, dressing (buttons, zippers, shoelaces), and personal hygiene. Topical diclofenac is now the preferred first-line treatment per ACR guidelines.

3.4 Rheumatoid Arthritis: Joint Destruction and Systemic Disease

RA, untreated or undertreated, is a destructive disease. The first 3–12 months — the 'window of opportunity' — determines the long-term trajectory. Patients started early on methotrexate, biologics, or JAK inhibitors do dramatically better at 10 and 20 years than those treated late.

Modern RA care has transformed outcomes but RA remains a systemic disease. Interstitial lung disease affects 10–30%. Cardiovascular mortality is roughly doubled. Cervical spine involvement (atlantoaxial subluxation) can produce dangerous instability at the C1–C2 level requiring surgical fusion or careful management during any neck-flexion event including dental work and intubation.

LTC dependency link: Severe RA produces hand deformity (ulnar deviation, swan-neck, boutonnière) that destroys fine motor function; foot deformity that destroys ambulation; cervical instability that requires constant care; and pulmonary and cardiac complications that add their own dependency loads. RA on biologics with no ADL limitation is a very different LTC underwriting picture than RA with deformity and Prednisone — see Section 10.

3.5 Gout: The Episodic Total-Immobility Disease

Gout differs from other arthritis in pattern: acute attacks of 3–10 days of complete immobility, followed by symptom-free intervals that lengthen with effective urate-lowering therapy. Untreated gout, however, progresses to chronic tophaceous gout — chalky deposits in joints and soft tissue — with permanent functional impairment.

LTC dependency link: A single gout attack in an older adult living alone can be a crisis — patient cannot walk to bathroom, cannot reach the kitchen, cannot drive to urgent care. Recurrent gout in someone with marginal balance is a falls risk. Chronic tophaceous gout with multiple involved joints can produce sustained ADL loss.

3.6 Psoriatic Arthritis and Axial Spondyloarthritis

Psoriatic arthritis combines joint disease with skin disease — and the skin disease itself complicates personal care. Axial spondyloarthritis and ankylosing spondylitis progressively limit spinal mobility; in severe cases the spine fuses into a fixed forward-flexed position that makes any task overhead, behind, or to the side impossible. Bimekizumab (Bimzelx) — the first dual IL-17A/F inhibitor — was FDA-approved in September 2024 for both PsA and axial spondyloarthritis, expanding the biologic toolbox.

3.7 Falls: The Cascade That Defines LTC

This is the connection most underappreciated in arthritis care. Participants with arthritis show 11–17x higher risk of gait and balance deficits compared to people without arthritis. A patient with hip OA, knee OA, lower back pain, or RA in the lower extremities is on the threshold of the falls cascade described in our Falls and Fractures white paper:

- Fall → injury (fracture, head trauma, laceration)
- Hospitalization → deconditioning
- Post-hospital → SNF or home health
- Fear of falling → reduced activity → further deconditioning
- Repeat falls → loss of independent ambulation → full ADL dependency

LTC dependency link: Hip fractures in arthritis patients carry 20% one-year mortality and >50% loss of pre-fracture functional status. The hip fracture itself is rarely the end-state event; it is the threshold across which dependency accelerates. Arthritis treatment that maintains lower-extremity strength and balance is, in a real sense, falls prevention.

3.8 The Osteosarcopenia Triple Hit

In older adults, arthritis rarely travels alone. The dangerous combination — increasingly recognized as 'osteosarcopenia plus arthritis' — combines:

- Osteoarthritis — joint pain and stiffness
- Sarcopenia — age-related muscle loss
- Osteoporosis — bone loss, fracture risk

Each condition accelerates the others. OA causes pain, which causes inactivity, which accelerates muscle loss (sarcopenia), which reduces bone loading and accelerates osteoporosis. The endpoint is a fragile, deconditioned older adult one fall away from a hip fracture and a SNF admission.

3.9 Post-Joint-Replacement Recovery

Joint replacement surgery — when timed right — restores function and slows the decline. But surgery itself is a predictable LTC utilization event. Uncomplicated primary TKA or THA generates 2–4 weeks of home health, 6–12 weeks of outpatient PT, and return to independence within 6–12 weeks. About 92% of patients now discharge directly home rather than to a SNF — a major shift over the past decade.

Complicated cases drive SNF use: bilateral simultaneous replacement, revision surgery, patients without a capable home caregiver, periprosthetic joint infection (PJI), and patients with multiple comorbidities. A PJI requiring a 2-stage revision can leave a patient essentially non-ambulatory for months — this is exactly the event that triggers an LTC claim if coverage is in place.

4. DIAGNOSIS AND MONITORING

Arthritis diagnosis is part history, part physical examination, part imaging, and — for inflammatory arthritis — part laboratory testing. Getting the type right is essential because OA, RA, gout, PsA, and lupus require fundamentally different treatments.

History and Physical

The first diagnostic step is the pattern. OA typically presents with insidious, asymmetric joint pain that worsens with use and improves with rest; morning stiffness is brief (less than 30 minutes). RA is symmetric, with prolonged morning stiffness (often more than an hour), and often involves the small joints of the hands and feet. Gout is sudden, severe, monoarticular, and often nocturnal. Axial spondyloarthritis presents with chronic back pain that improves with exercise and worsens with rest — the opposite of mechanical back pain.

Laboratory Testing

For inflammatory arthritis the key tests are:

- Rheumatoid factor (RF) and anti-CCP antibodies — supportive of RA, with anti-CCP being more specific
- ESR and CRP — markers of inflammation
- ANA — screen for lupus and connective tissue disease
- HLA-B27 — supportive in suspected axial spondyloarthritis
- Serum uric acid — for suspected gout (though normal during an acute attack)
- Joint fluid analysis with crystal examination — definitive for gout (negatively birefringent monosodium urate crystals) and pseudogout (positively birefringent calcium pyrophosphate)

Imaging

Plain X-ray remains the workhorse for OA staging — Kellgren-Lawrence grades 0 through 4. For RA, X-rays show erosions and joint space narrowing in advanced disease; MRI or ultrasound can detect inflammation and erosions earlier. For axial spondyloarthritis, MRI of the sacroiliac joints detects inflammation years before radiographic changes. CT and MRI are reserved for surgical planning or specific clinical questions.

The ACR Classification Criteria

The American College of Rheumatology publishes classification criteria that guide diagnosis for research and clinical purposes — for RA (2010 ACR/EULAR), for lupus, for PsA (CASPAR), for gout (2015 ACR/EULAR), and for axial spondyloarthritis (ASAS). These criteria are not perfect diagnostic algorithms but they discipline the diagnostic process.

5. THE MEDICATION LANDSCAPE

Arthritis pharmacology has been transformed over the past two decades. For OA, treatment is largely symptomatic — there is still no FDA-approved disease-modifying OA drug. For RA, PsA, lupus, gout, and the spondyloarthropathies, however, the medication revolution has been profound.

5.1 Symptomatic Treatment of Osteoarthritis

NSAIDs (Oral and Topical)

Non-steroidal anti-inflammatory drugs — ibuprofen, naproxen, meloxicam, celecoxib, diclofenac — remain the first-line pharmacologic treatment for OA pain. Topical diclofenac (Voltaren gel, available over the counter) is now the ACR-preferred first option for hand OA and a recommended option for knee OA, with substantially lower systemic risk than oral NSAIDs.

Acetaminophen

Once a first-line OA treatment, acetaminophen has been demoted in recent guidelines because its effect on pain is modest. It remains a reasonable add-on for patients who cannot tolerate NSAIDs.

Duloxetine

An SNRI antidepressant with FDA approval for chronic musculoskeletal pain including OA of the knee. Useful for patients with concurrent depression or central sensitization.

Opioids

ACR guidelines now strongly recommend against the routine use of opioids for OA pain. Tramadol is conditionally allowed but the long-term outcomes do not justify the dependence and overdose risk. The shift away from opioids for OA is one of the most important changes in rheumatology over the past decade.

5.2 Disease-Modifying Antirheumatic Drugs (DMARDs)

For RA, PsA, lupus arthritis, and other inflammatory arthritides, DMARDs are the foundation of treatment. The 'treat-to-target' strategy — aim for low disease activity or remission, adjust therapy if not achieved — has transformed outcomes.

Conventional Synthetic DMARDs (csDMARDs)

- Methotrexate — the anchor drug for RA, dose-escalated typically to 15–25 mg weekly; requires folic acid and labs monitoring
- Hydroxychloroquine (Plaquenil) — used in RA, lupus, and lupus arthritis; requires annual eye exams (retinal toxicity)
- Sulfasalazine — used in RA and spondyloarthritis
- Leflunomide — alternative to methotrexate; long half-life requires cholestyramine washout

5.3 Biologic DMARDs

Biologic therapy has been the most consequential advance in rheumatology since the introduction of methotrexate. The major mechanism classes:

TNF Inhibitors (TNFi)

- Adalimumab (Humira) and now ten FDA-approved biosimilars including Cyltezo, Amjevita, Hadlima, Hyrimoz, Yusimry, Hulio, Idacio, Yuflyma, Abrilada, and Simlandi (the tenth, approved February 2024 — interchangeable)
- Etanercept (Enbrel) and biosimilars (Erelzi, Eticovo)
- Infliximab (Remicade) and biosimilars (Inflectra, Renflexis, Avsola, Ixifi)
- Certolizumab (Cimzia), Golimumab (Simponi/Simponi Aria)

IL-6 Inhibitors

- Tocilizumab (Actemra) and biosimilar (Tofidence)
- Sarilumab (Kevzara)

IL-17 Inhibitors

- Secukinumab (Cosentyx) — PsA, AS, axial spondyloarthritis
- Ixekizumab (Taltz) — PsA, AS
- Bimekizumab (Bimzelx) — first dual IL-17A/F inhibitor, FDA approved September 2024 for PsA, non-radiographic axial spondyloarthritis, and ankylosing spondylitis; expanded November 2024 for hidradenitis suppurativa

IL-23 Inhibitors

- Risankizumab (Skyrizi) — PsA
- Guselkumab (Tremfya) — PsA

Other Mechanisms

- Abatacept (Orencia) — T-cell co-stimulation modulator; RA, PsA, JIA
- Rituximab (Rituxan) — B-cell depleting anti-CD20; RA, vasculitis

5.4 JAK Inhibitors

Janus kinase inhibitors are oral targeted small molecules:

- Tofacitinib (Xeljanz)
- Baricitinib (Olmiant)
- Upadacitinib (Rinvoq)

All JAK inhibitors carry FDA boxed warnings for serious infection, mortality, malignancy, major adverse cardiovascular events (MACE), and thrombosis — based on the ORAL Surveillance trial of tofacitinib in patients 50+ with one cardiovascular risk factor. The FDA limits JAK inhibitor use in

many indications to patients with inadequate response or intolerance to TNF inhibitors. Older patients and those with cardiovascular risk factors are typically not first-line candidates.

5.5 Gout Pharmacology

- Allopurinol — first-line urate-lowering therapy; dose-titrate to serum uric acid <6 mg/dL
- Febuxostat (Uloric) — alternative when allopurinol cannot be tolerated; FDA boxed warning for cardiovascular mortality vs. allopurinol
- Colchicine — for acute flares and as bridging prophylaxis when starting urate-lowering therapy
- Pegloticase (Krystexxa) — IV pegylated uricase for refractory tophaceous gout; intensive monitoring required
- NSAIDs and corticosteroids — for acute gout flare management

5.6 Cost and Access

Biologic and JAK inhibitor pricing has been the central health-policy story of the 2020s. Humira's annual list price approaches \$90,000. The ten approved biosimilars now offer real alternatives at substantially lower cost — from Yusimry at approximately \$639 per script through higher-priced offerings around \$2,655. As of 2025, 96% of Medicare Part D plan formularies cover at least one adalimumab biosimilar.

The Medicare Part D \$2,000 out-of-pocket cap, effective in 2025 under the Inflation Reduction Act, transformed access to biologic and JAK inhibitor therapy for Medicare beneficiaries. A patient who previously faced \$8,000–\$15,000 in annual out-of-pocket biologic costs is now capped at \$2,000 per year. This is one of the most consequential policy changes for older arthritis patients in a generation.

6. PROCEDURES, INJECTIONS, AND JOINT REPLACEMENT

When medications no longer provide sufficient relief, the procedural and surgical toolbox is large and evolving.

6.1 Intra-Articular Injections

Corticosteroid Injections

Triamcinolone, methylprednisolone, and dexamethasone can be injected into knees, hips, shoulders, and other joints. Effective for 6–12 weeks in most patients. Limited to 3–4 injections per joint per year because of concerns about cartilage damage and joint deterioration.

Hyaluronic Acid (HA) Viscosupplementation

Hyaluronic acid preparations (Synvisc, Hyalgan, Euflexxa, Orthovisc, others) are injected to supplement the joint's natural hyaluronic acid. Coverage and efficacy data are mixed, and ACR recommendations are conditional against routine use. However, real-world data show that HA injections can delay total knee arthroplasty by approximately 8.7 months on average — a meaningful interval for patients who need to bridge to surgery or who are not yet surgical candidates.

Platelet-Rich Plasma (PRP)

Autologous PRP injections show benefit for knee OA in some studies, with peak effect at 6–12 months. PRP is not covered by Medicare for OA indications; patients pay \$500–\$2,000 per injection out-of-pocket.

Genicular Nerve Radiofrequency Ablation (RFA)

Emerging as a treatment for KL Grade 3–4 knee OA in patients who are not surgical candidates or who want a bridge before surgery. RFA of the genicular nerves provides pain relief lasting 6–12 months. Increasingly covered by Medicare and commercial insurance.

6.2 Joint Replacement Surgery — The Numbers

Total knee arthroplasty (TKA) and total hip arthroplasty (THA) are among the most performed and most successful surgeries in medicine. The volumes are staggering:

Procedure	Annual Volume (Medicare 2022)	Projection by 2040
Total Knee Arthroplasty (TKA)	1,013,533	~2.79 million annually
Total Hip Arthroplasty (THA)	~500,000+ (all-payer)	Significant growth
Robotic-assisted TKA share	13–16% (2024)	~50% by 2030 (projected)
Outpatient/ASC TKA cost	~\$8,500	Volume expanding rapidly

Procedure	Annual Volume (Medicare 2022)	Projection by 2040
Hospital-based TKA cost	~\$30,000+	Slower growth

Mean age at TKA is approximately 67.6 years; 58.6% of TKA patients are women. The shift to outpatient and ambulatory surgical center (ASC) procedures has been dramatic, driven by both cost pressure and improved perioperative protocols. About 92% of THA patients now discharge directly home from the hospital — a huge improvement over the SNF-routine practice of 15 years ago.

6.3 Revision Arthroplasty

Joint replacements wear out, loosen, get infected, and sometimes fail mechanically. Revision TKA and revision THA are substantially more complex than primary surgery, carry higher complication rates, and require longer recovery. Medicare cost for revision TKA averages \$34,000–\$36,000. Patients with multiple revisions accumulate functional limitations and are frequently among the more challenging LTC underwriting cases.

6.4 Reverse Shoulder Arthroplasty

Reverse total shoulder arthroplasty has transformed the management of rotator cuff arthropathy — the condition in which a chronic rotator cuff tear leads to glenohumeral arthritis. The 'reverse' geometry allows the deltoid muscle to do the work of the missing rotator cuff. This is now one of the fastest-growing arthroplasty procedures in the United States and a significant improvement in function for older patients with previously untreatable shoulder pain and disability.

7. THE 2026 PIPELINE

Arthritis therapeutics in 2026 sits at a particularly interesting moment. The biologic and JAK inhibitor era has matured; biosimilars are reshaping access; and several genuinely novel approaches are in late-stage trials.

7.1 Disease-Modifying Osteoarthritis Drugs (DMOADs)

There is still no FDA-approved disease-modifying drug for OA. Several candidates are in or have completed late-stage trials:

- Sprifermin (recombinant human FGF-18) — Phase 3 trials showed modest cartilage thickness preservation but unclear symptomatic benefit
- Lorecivivint (Biosplice) — small-molecule Wnt pathway modulator; Phase 3 results have been mixed
- TPX-100 — Phase 2 cartilage matrix-modulating peptide
- LNA043 (Novartis) — angiopoietin-like 3 derivative for cartilage regeneration

None of these have produced the clinical home run patients and clinicians want. The expectation that a true DMOAD will be approved in the next two to three years remains uncertain.

7.2 CAR-T for Refractory Autoimmune Disease

The most exciting paradigm shift in rheumatology in 2026: CD19-directed CAR-T cell therapy for refractory severe lupus, RA, and other systemic autoimmune diseases. Case series from Germany have demonstrated drug-free remission lasting beyond two years in patients who had failed every available therapy. This is not yet FDA-approved for rheumatic disease, but it represents a genuine 'immune reset' approach that could transform the most severe autoimmune cases. Multiple Phase 1/2 trials are now enrolling in the United States and Europe. Source: NEJM and Nature Medicine case series, 2023–2024.

7.3 TYK2 Inhibitors

Deucravacitinib (Sotyktu) is an oral allosteric tyrosine kinase 2 (TYK2) inhibitor — already approved for psoriasis and now in Phase 3 trials for psoriatic arthritis and lupus. TYK2 inhibition appears to have a more favorable safety profile than pan-JAK inhibitors, potentially offering oral targeted therapy without the boxed warning concerns of Xeljanz, Rinvoq, and Olumiant.

7.4 Anti-NGF Therapies — A Cautionary Tale

Tanezumab, an anti-nerve-growth-factor monoclonal antibody, showed strong analgesic effects in OA Phase 3 trials but was associated with rapidly progressive OA in some patients — leading to FDA non-

approval in 2021. The cautionary tale: pain relief without joint protection may actually accelerate damage. This shaped current thinking about the limits of analgesic-only OA strategies.

7.5 Stem Cell Therapy: Legitimate vs. Unregulated

NIH-funded clinical trials of mesenchymal stem cell therapy for OA are ongoing and following rigorous protocols. These should not be confused with the largely unregulated \$5,000–\$30,000 stem cell injections offered at hundreds of U.S. clinics. The FDA has issued multiple warnings about unapproved stem cell products marketed for arthritis. Until a regulated, FDA-approved stem cell product exists, patients spending out-of-pocket on these procedures have no evidence-based basis to expect benefit.

7.6 Newer Biologics and Biosimilars

Continued biosimilar approvals through 2025 and 2026 are expected for additional brand biologics, further pressuring prices. Specific next-generation IL-17 and IL-23 inhibitors, combination biologics, and longer-interval administrations are in late-stage development. The 'biologic vs. biosimilar' debate has largely resolved in favor of biosimilars for most clinical situations, with growing evidence that switching is safe.

8. THE COSTS OF ADVANCED ARTHRITIS

Arthritis is a costly disease — and the cost is concentrated in long-term care, not in surgery or medications.

8.1 Aggregate U.S. Economic Burden

\$303.5B Total annual U.S. economic burden of arthritis

\$140B Direct medical costs

\$164B Lost productivity and earnings

These figures are based on 2013 data and almost certainly understate current costs — the actual 2026 figure is meaningfully higher. Source: CDC, NACDD Arthritis Factsheet 2025.

8.2 Joint Replacement Costs

Procedure / Setting	Approximate Cost
Primary TKA — hospital	\$20,000–\$40,000
Primary TKA — ambulatory surgical center	~\$8,500
Primary THA — hospital	\$32,000–\$45,000
Revision TKA — Medicare average	\$34,000–\$36,000
Reverse total shoulder arthroplasty	\$25,000–\$35,000
Periprosthetic joint infection treatment	\$100,000+ (2-stage revision)

8.3 Biologic Therapy Costs

The biologic medication picture has been transformed by biosimilars and the Medicare Part D \$2,000 OOP cap:

- Humira (originator) — approximately \$90,000/year list price
- Adalimumab biosimilars — range from approximately \$639 per script (Yusimry) to \$2,655 per script depending on product and channel
- Enbrel, Remicade, Cosentyx, Skyrizi — all priced in the \$35,000–\$75,000 annual range without insurance
- Medicare Part D 2025: \$2,000 annual out-of-pocket cap for the patient
- Patient assistance programs and copay cards can further reduce out-of-pocket costs for commercially insured patients

8.4 Long-Term Care Costs — The Real Number

The cost of LTC is the cost arthritis families actually feel:

Care Setting (2025 National Median)	Annual Cost	YoY Change
Skilled nursing facility — private room	\$129,575	+1%
Skilled nursing facility — semi-private	\$114,975	—
Assisted living facility	\$74,400	+5%
Home health aide (44 hr/week)	\$80,080	+3%
Adult day health care	\$24,700	—

Source: CareScout (formerly Genworth) 2025 Cost of Care Survey, carescout.com.

Florida-specific 2025 figures show somewhat lower nursing home costs (SNF private \$91,250, rank 48) but assisted living at \$67,200 and home health aide at \$68,640. The combination of a heavy arthritis burden, a large elderly population, and meaningful LTC cost makes Florida a state where the planning conversation matters more than the national average suggests.

9. THE LTC PATHWAY FROM ARTHRITIS

Arthritis is the most LTC-relevant chronic condition you can have without it being recognized as such. Almost 1 in every 4 new cases of ADL disability is attributable to arthritis. In patients with ADL dependence who have arthritis, the arthritis contributes to that dependence in approximately 75% of cases.

9.1 ADL Impact by Joint Pattern

Joint / Type	Affected ADLs and IADLs
Knee OA, bilateral	Walking, stairs, transfers, bathing, toileting
Hip OA	Putting on socks/shoes, low transfers, bathing, sitting on toilet
Hand / wrist OA	Buttons, zippers, meal prep, medication management, hygiene
Shoulder OA	Overhead dressing, reaching behind back, hair care
Cervical spine RA	Head movement for driving; positioning risk
Lumbar stenosis	Sustained standing or walking more than minutes

9.2 The Falls Cascade

As described in Section 3.7 and in our companion Falls and Fractures white paper, arthritis patients have 11–17x higher risk of gait and balance deficits. A fall in an arthritis patient triggers a predictable cascade: injury → hospitalization → deconditioning → SNF or home health → fear of falling → further deconditioning → repeat falls → loss of independent ambulation → full ADL dependency.

9.3 Post-Joint-Replacement Rehabilitation

Joint replacement surgery is, in clinical terms, a planned LTC utilization event. The successful uncomplicated case still generates weeks of home health, months of outpatient PT, and a transient functional decline that requires family support. The complicated case — bilateral surgery, revision, PJI, patient without home caregiver — drives substantial SNF utilization.

9.4 The Osteosarcopenia Triple Hit

OA + sarcopenia + osteoporosis is the dependency formula that LTC planners need to recognize. Each condition worsens the others. The endpoint is the fragile older adult one fall away from a hip fracture, with 20% one-year mortality and >50% loss of pre-fracture function.

10. CAREGIVER BURDEN

Informal caregivers of arthritis patients provide substantial hands-on assistance — and the burden is heavier than is often appreciated.

10.1 Time and Physical Demands

27.4 hours/week Average caregiving time for RA patients (Wiley study)

- More than 80% of caregivers increased time on household activities after the patient's arthritis progressed
- Nearly half of caregivers increased time on personal care (bathing, dressing, transfers)
- 43.5% of caregivers incurred additional financial costs from caregiving
- Caregivers of RA patients spend approximately 7 more hours per week on household tasks than caregivers of stroke survivors (PMC 2025 systematic review)

10.2 Medication and Infusion Coordination

Biologic DMARD management creates specific caregiver workloads:

- Subcutaneous injection technique — caregivers learn to administer or assist when patient hand deformity prevents self-injection
- Infusion therapy — bi-weekly to monthly trips to infusion centers; 78% of patients bring a caregiver; average 2.3 hours per visit plus 44 minutes of travel
- Monitoring labs (CBC, LFTs) and recognizing infection warning signs
- Insurance navigation for \$80,000+/year medications and prior authorizations

10.3 Transportation

Advanced arthritis often means the patient cannot drive safely (shoulder, neck, hip limitations, pain). Caregivers shoulder transportation to multiple PT sessions per week, rheumatologist and orthopaedist visits, and — for rural patients — long trips to infusion centers.

10.4 Emotional Burden and Depression

Chronic pain caregiving is emotionally exhausting. Depression prevalence among older adults with arthritis runs 55% (minor depression), 62.9% (moderate), and 67.8% (severe) — substantially higher than age-matched controls without arthritis. Caregivers themselves are at elevated risk of depression, burnout, and their own health decline.

11. LTC INSURANCE UNDERWRITING REALITY

Long-term care insurance underwriting for arthritis is highly type-, severity-, and treatment-dependent. The same patient described as 'has arthritis' might be standard-issue insurable or definitively declined, depending on the underlying picture.

11.1 The Key Underwriting Questions

- When was arthritis diagnosed?
- Which type — OA, RA, gout, PsA, lupus, axial spondyloarthritis?
- Which joints are affected and to what severity?
- Any ADL or IADL limitations currently documented?
- Joint deformities visible or documented on imaging?
- Current medications — especially Prednisone dose, methotrexate dose, biologic, JAK inhibitor, or narcotic?
- Joint replacement history — completed, planned, or 'recommended'?
- Recent imaging findings (KL grade for OA, erosions for RA)?
- Injection history (corticosteroid, HA, PRP)?

11.2 Decision Framework by Scenario

Clinical Picture	Likely Outcome
Mild OA, NSAID only, no ADL limitation, stable imaging	Standard or better
Moderate OA, HA or steroid injections, no ADL limit	Individual consideration; 90-day stability often required
Moderate OA with planned/recommended joint replacement	Typically declined until surgery + 3–6 months stable
Bone-on-bone OA (KL Grade 4)	Typically declined
Severe OA with joint deformity or ADL limit	Declined
RA in remission, low-dose methotrexate, no ADL limit	Individual consideration; may be standard
RA on biologic, controlled, no ADL limit	Individual consideration; carrier-dependent
RA with severe joint disease or ADL limit	Declined
Daily narcotic use or Prednisone >10 mg/day	Declined

Clinical Picture	Likely Outcome
Post-joint replacement, stable 3–6 months	May be reconsidered
Multiple joint replacements + comorbidities	Rated or declined

Key rule: ADL limitation already documented in the medical record = typically declined for traditional LTCI. The planning window is BEFORE the ADL limitation appears in the chart. Once the rheumatologist or orthopaedist writes 'unable to ambulate without assistance' or 'requires help with bathing,' the window has closed for traditional LTCI.

11.3 Hybrid and Alternative Options

For borderline arthritis profiles or for clients past the traditional LTCI window:

- Hybrid life/LTC policies — often more flexible underwriting than standalone LTCI
- Annuity-linked LTC riders — some accept lower health standards
- Accelerated death benefit riders in life insurance — may cover some LTC costs
- Critical illness insurance — does not cover arthritis directly but may cover falls-related hospitalizations

11.4 The 'Still Active' Planning Window

The single most important message for arthritis patients considering LTC planning: do not wait until you 'really need it.' Arthritis is progressive. The decade between first symptoms (ages 50–60) and significant ADL limitation (ages 65–75) is the planning window.

During this window, most people with OA or well-controlled RA are still insurable at standard or near-standard rates. Once any of the following occur, the window typically closes:

- Joint replacement is 'recommended' by a physician
- Daily narcotic use begins
- ADL limitations appear in the medical record
- Multiple joint deformities are documented
- Prednisone is taken at >10 mg/day chronically

The cost of LTC coverage at 55 — before these thresholds — is dramatically lower than at 65, and availability is far higher.

12. NEXT STEPS AND KEY MESSAGES

12.1 For Individuals and Families

Message 1: Early aggressive treatment in RA changes the long-term trajectory.

RA treated aggressively at diagnosis — treat-to-target with DMARDs and biologics — produces dramatically better functional outcomes over 10–20 years. The 'window of opportunity' is the first 3–12 months. Early treatment prevents the joint destruction that creates ADL dependency. Rheumatology referral at the first signs of inflammatory arthritis — swelling, prolonged morning stiffness, symmetric joint involvement — should not wait.

Message 2: OA prevention starts with weight management and physical activity.

Each pound lost removes about 4 pounds of pressure from the knee joint. Even modest weight loss (5–10% of body weight) significantly reduces OA progression and pain. Exercise — particularly strengthening and aerobic — is the most evidence-based non-surgical OA treatment. The 'bone-on-bone' OA patient who was never told to lose weight a decade earlier is a preventable LTC story.

Message 3: Joint replacement timing matters.

Waiting too long for joint replacement — end-stage disease with severe deconditioning, advanced age, multiple comorbidities — dramatically increases rehab needs and complications. Replacing too early in a 45-year-old may mean revision surgery before age 70. The sweet spot is moderate-to-severe disease with significant functional limitation but reasonable conditioning. From an LTC planning perspective: apply for coverage before surgery is on the table.

Message 4: LTC planning before mobility limitations document the insurability problem.

The planning conversation belongs at first diagnosis of OA or RA — in the 50s and functional — not in the 70s with documented ADL limitations. The financial cost of one SNF year (\$129,575 nationally in 2025) exceeds many years of LTC premium. The human cost of unplanned dependency falls on a spouse or adult children.

Message 5: Don't underestimate 'just arthritis.'

Arthritis is not gracefully getting old. It is the #1 cause of disability in the United States. It creates the falls that cause hip fractures. It drives the need for home aides, assisted living, and skilled nursing. It imposes \$303.5 billion in annual economic cost. For LTC planners: every client over 50 needs an arthritis conversation.

Message 6: Sarcopenia plus arthritis is compound interest on disability.

Chronic arthritis leads to pain → inactivity → muscle loss (sarcopenia) → weaker joints → greater pain → more inactivity. Resistance exercise and adequate protein intake are protective. This is not optional wellness advice — it is dependency prevention.

12.2 For LTC Planning Advisors

- Screen every client over 50 for arthritis type, severity, medications, recent imaging, and joint replacement history before submitting applications
- Pre-screen with carriers before a full application when RA, biologic use, or joint replacement is in the history
- Educate clients about the 3–6 month post-surgery stability window — surgery is not automatically disqualifying if recovery is complete and full function restored
- Use functional assessment language with clients: 'Can you button your shirt? Get in and out of the bathtub? Climb a full flight of stairs without stopping?' These questions reveal insurable windows
- Florida and Southeast agents: your market carries higher arthritis burden, higher pain severity, and higher physical inactivity rates — start the conversation earlier
- The biologic patient: A client on Humira or Rinvoq with controlled RA and no ADL limitations may be insurable at individual company consideration. Do not auto-decline. Pre-screen with the specific carrier

12.3 Key Resources

- Arthritis Foundation — arthritis.org — patient education, programs, advocacy
- American College of Rheumatology — rheumatology.org — clinical guidelines, ACR criteria
- CreakyJoints / Global Healthy Living Foundation — creakyjoints.org — patient community, ArthritisPower registry
- Spondylitis Association of America — spondylitis.org — AS, PsA, axSpA resources
- Lupus Foundation of America — lupus.org — SLE and lupus arthritis resources
- CDC Arthritis Program — cdc.gov/arthritis — prevalence data, evidence-based programs
- NIH/NIAMS — niams.nih.gov — research and patient education
- ClinicalTrials.gov — current enrolling trials for DMOADs, CAR-T, novel biologics
- CareScout Cost of Care — carescout.com/cost-of-care — national and state LTC cost data

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