Minimizing Rx Opioid Fraud and Abuse While Maintaining Appropriate Access for Patients In Need

Best Practices for Rx Payers

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THCI Program
on
Opioid Risk Management

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Background: *Prescription for Peril*

- **"White Paper" commissioned by Coalition Against Insurance Fraud, Washington, DC**
- **Overview of**
  - **Forms of diversion & its estimated scope**
  - **Underlying/driving forces**
  - **Detection, investigation, referral activity**
  - **Prosecutorial, judicial, licensing activity**
- ***Impact on & implications for third-party Rx payers***
- **Recommendations for payers & potential broader solutions**

How/When?

- Interviews
  - SIU personnel (insurer/PBM)
  - Other insurer personnel
  - Industry & law enforcement diversion experts
- Literature/Data Review
  - National Survey on Drug Use & Health
  - 2005 Study of Controlled Substance Diversion & Abuse—National Center for Addiction & Substance Abuse at Columbia University
  - Other studies, published reports
- Case Reviews
- November, 2006 - July, 2007
- Published December, 2007

Why?

- **Diversion's impact on Rx payers a largely overlooked topic**
- **Significant cost implications for industry**
  - **Rx = 10% of total health care spending ($230 billion in 2007)**
  - **Rx = 10% - 12% workers' comp spending ($3 billion/yr)**
    - **Breakthrough pain meds predominate**
  - **Reinsurer: "Seeing non-catastrophic work comp claims spiking like catastrophic, largely due to Rx costs"**
- **Significant patient-safety/potential liability implications for industry**

Not A New Problem

- First observed in Civil War re: morphine theft/abuse
- 1987: Establishment of National Association of Drug Diversion Investigators (NADDI)
- 1990: Cincinnati P.D. establishes Drug Diversion Squad—500 Cases/Yr by 1993
- 1992: GAO study cites drug diversion as “prevalent type of Medicaid fraud”
- 1992: FBI “Operation Goldpill”—3 years, 50 cities, 200 pharmacists & other perpetrators

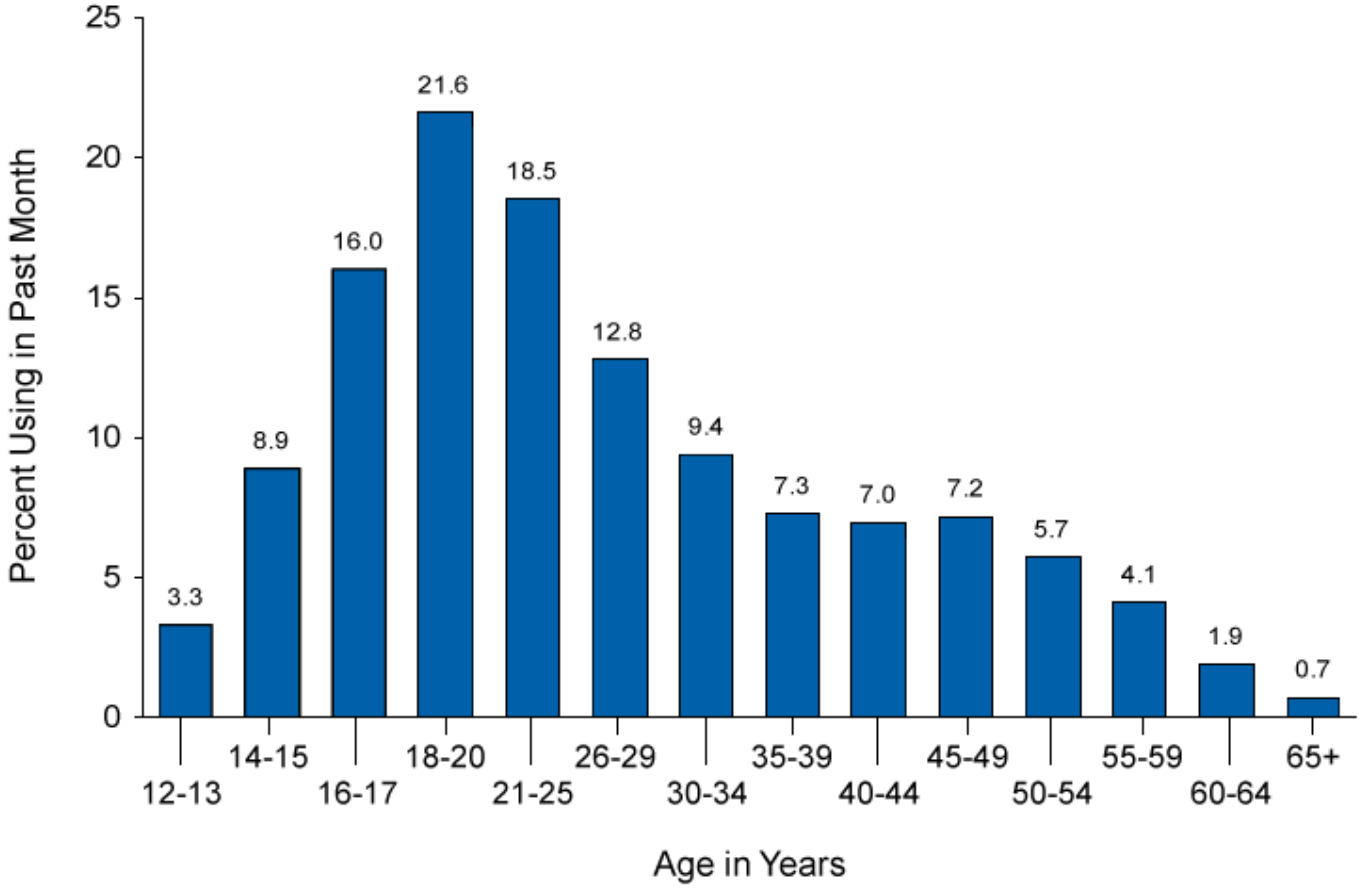
A New Drug-Payment Equation

- **Rx Costs, 1990:** **$40.3 Billion**
  - **Government:** **18%**
  - **Private Insurance:** **26%**
  - **Consumers:** **56%**
- **Rx Costs, 2005:** **$200.7 Billion**
  - **Consumers:** **25%**
  - **Government:** **28%**
  - **Private Insurance:** **47%**

U.S. Controlled-Substance Consumption 1992 - 2002

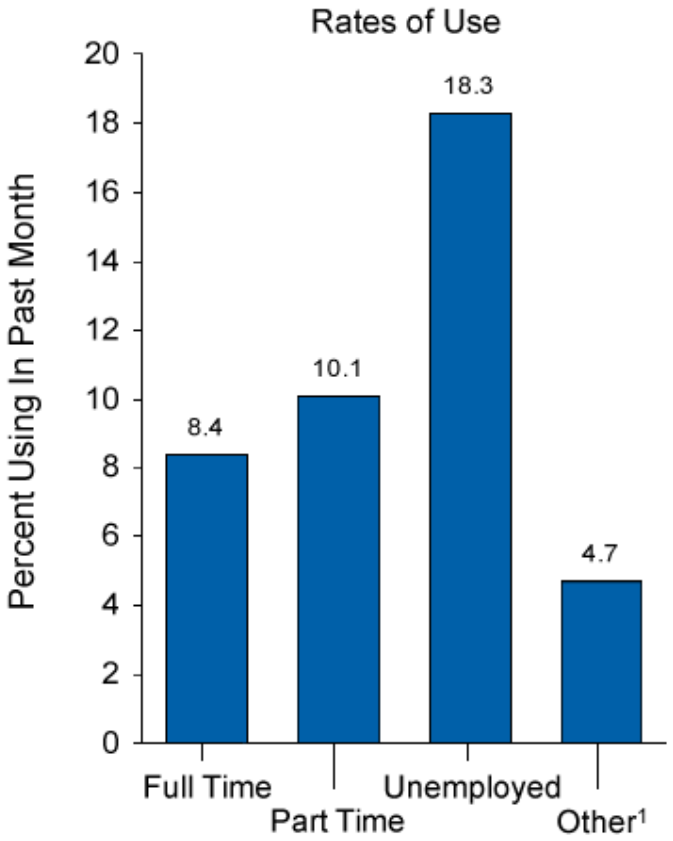
- **U.S. Population: + 13%**
- **Non-Controlled Drugs: + 57%**
- **Controlled Drugs: + 154%**
  - **Opioids: + 222%**
    - **Hydrocodone: + 376%**
    - **Oxycodone: + 380%**
  - **Benzodiazepines: + 49%**
  - **Stimulants: + 369%**

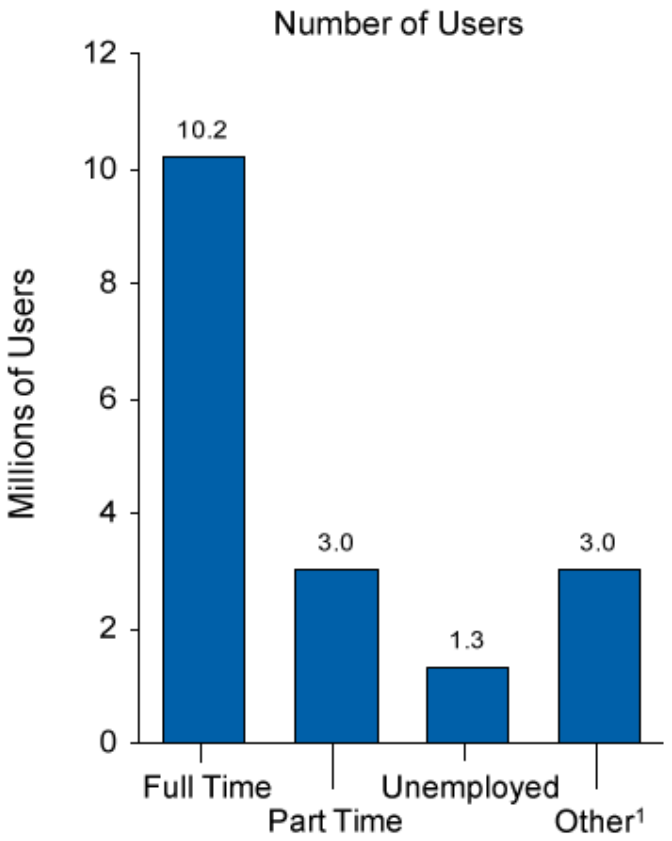
Past Month Illicit Drug Use among Persons Aged 12 or Older, by Age: 2007



SOURCE: SAMHSA, NSDUH 2007

Past Month Illicit Drug Use among Persons Aged 18 or Older, by Employment Status: 2007





SOURCE: SAMHSA, NSDUH 2007

Potential Diversion/Fraud and Abuse Perpetrators. . .

- **Patients—i.e., drug-seekers/“doctor shoppers”**
- **Bogus patients—i.e., prescription buyers**
- **Prescribers (MD/DOs, dentists, nurse practitioners, veterinarians) and prescriber employees**
- **Dispensers and dispenser employees (pharmacists, pharmacy technicians)**
- **Street dealers/patient recruiters**
- **Pharmaceutical wholesalers**
- **Large-scale pharmaceutical thieves**
- ***Various combinations of the above***

The Dire Consequences

- **2002: Fatal pain-med poisonings surpass cocaine & heroin deaths**
- **2004: At 19,838 fatalities, accidental drug overdose becomes #2 cause of unintentional-injury death in U.S.**
  - **Up 78% between 1999 and 2004: Sedatives, Vicodin, Oxycontin cited as principal factors**
  - **Up more than 100% in 23 states (e.g., WV: 550%)**
- **2005: 43% of drug-abuse E.R. visits—600,000—involve pharmaceuticals**
- **2003: Acetaminophen poisoning becomes #1 cause of acute liver failure in U.S.**
- **2005: Annual U.S. liver transplants up 20% since 2001. First-year costs: $393,000**

“Triple-Threat” Payer Impact

- **Cost of unnecessary, excessive or bogus prescriptions**
- **Cost of related medical claims—legitimate or falsified**
  - **Physician office visits & other treatments**
  - **Diagnostic tests (imaging, nerve conduction)**
  - **Emergency room/urgent care clinic exams/treatments**
  - **Conditions caused by Rx abuse—e.g., liver damage/failure**
  - **Treatment of affected family members**
- **Incalculable potential-liability cost**
  - **Dangerous prescribers/prescription sellers**
  - **Insured’s injury or death**
  - **Insured’s injury of others**

Wellpoint/Anthem (VA)

- **100 members with multiple narcotic Rx scripts from 5 or more sources in 90-day period:**
  - **Prescribers: 689**
  - **Pharmacies: 608**
  - **Narcotic Scripts: 1,217**
  - **Paid Narcotic Rx claims: $20,233**

- **Medical claims for same 100 members, same 90-day period:**
  - **Office visits: 4,131**
  - **Outpatient Facility Visits: 958**
  - **Total Medical Claim $: $832,172**

- **Average medical-to-Rx $: $41 to $1**

- **Full-year 100-member savings following intervention & pharmacy restriction: $333,418**

Analysis Group, Inc.

- **"Direct Costs of Opioid Abuse In An Insured Population"**
  - —*J Managed Care Pharmacy*, Jul/Aug 2005
  - —1998 - 2002 claim data from 2-million member database
  - —Aged 12 - 64, continuous enrollment 12 months of study
  - —At least 1 non-heroin opioid-related ICD-9 code in claim history

- **Diagnosed opioid abusers' "total health costs 8 times those of non-abusers'"**

	Non-Abusers	Abusers
—Drug	$386	$2,034
—Inpatient	$318	$7,659
—Physician/OP	$928	$5,398
—Other (E.R. +)	$198	$793
TOTAL	$1,830	$15,884
Excess Annual Cost (2003 $)		$14,054
2007 $		$16,485

Sobering Scenarios

- **“Fully Loaded”—1.9% insured opioid abusers @ avg. excess cost:**
  - **4.85 million x $16,485 = $79.9 billion/yr**
- **“Moderate”—1.9% insured opioid abusers @ avg. excess cost, less in-patient $:**
  - **4.85 million x $8,572 = $41.6 billion/yr**
- **Most Conservative—1% insured opioid abusers at reduced avg. excess cost:**
  - **2.6 million x $8,572 = $22.3 billion/yr**

Sobering Scenarios: Plan-Level

- **"Most Conservative" excess-cost math applied to plan sizes:**
  - **10 million lives @ 1% abusers**
    - **100,000 members x $8,572 = $857,000,000/yr**
  - **1 million lives @ 1% abusers:**
    - **10,000 members x $8,572 = $85,700,000/yr**
  - **500,000 lives @ 1% abusers:**
    - **5,000 members x $8,572 = $42,900,000/yr**
  - **250,000 lives @ 1% abusers:**
    - **2,500 members x $8,572 = $21,400,000/yr**

The Wild Card: Potential Payer Liability

- **Payers that fail to take an active approach to doctor-shopping and other aspects of diversion face significant potential liability related to prescription-drug addiction and overdose deaths:**

  "The data was right under the prescription payer's nose; had it only taken the trouble to look at what it was paying for, it could have prevented this addiction . . . liver failure . . . overdose death . . . fatal accident"

- **Precedent for "should have known" suit against pharmacy**
  - **FL court decision affirms pharmacy's "duty to warn"**
- **Credentialing & network issues also come into play**
- **Awareness of risk is integral aspect of some companies' active approaches**
- **Passive approach insufficient/risky in face of "national epidemic" & widespread mortality**

Key Observations Re: Rx Payers

- **Question not so much "What are payers finding when they look?" as it is "To what extent *are* payers looking?"**
  - **Most outsource Rx benefit/processing to PBMs**
  - **Perception by many that few PBMs engage in true fraud-detection activity (e.g., vs. routine audits)**
  - **Issue not addressed in many PBM relationships**
  - **Even some insurers with captive PBMs don't focus on Rx**

Key Observations

- **High $ provider cases abound, but doctor shopping is most common—and costly—form of diversion**
  - **Aetna: 48% of member-fraud investigations involve Rx**
  - **Low-$$$ cases??**
    - **NADDI: 5 - 10 prescribers, $10,000 - $15,000/yr Rx & medical**
    - **MEDCO, 2005: "High-utilization" members' Rx costs 7x norm**
  - ***— Sole focus on Rx costs overlooks the far-greater impact***

Key Observations

- **Matching Rx data to medical claim data is essential but is the industry exception, not the rule**
  - **Some insurers do it only with difficulty—technical and procedural**
  - **Some don't do at all**
  - **Some have exemplary capability**
  - **Medicare Part D matching requirements might spur more private-sector activity**

- **Many insurers face obstacles—real or perceived—to implementing effective intervention/pharmacy restriction programs**

- **Insurers paying for widespread off-label uses—Actiq, Neurontin, etc.**

- **Opportunities for increased point-of-sale controls**

Key Observations

- **Significant lack of insurer awareness of/involvement in National Assn. of Drug Diversion Investigators**
  - **Few insurance participants in annual training conference**
  - **Outstanding education source & state/local law enforcement network dedicated to diversion cases**
  - **Highly aware of insurance aspects & impact**

- **Tendency among insurers to treat doctor-shopper/diversion cases solely as low-$ insurance-fraud matters vs. federal and/or state drug violations**
  - **State/local diversion resources overlooked?**
  - **County D.A.s often receptive to doctor-shopper/other diversion cases**

Key Observations

- **Need for greater awareness of insurance impact and appropriate industry involvement in national efforts to deal with Rx diversion and abuse**
  - **Only mention of insurers & MCOs in landmark CASA study is recommendation for providers reimbursements re: screening & referring**
  - **No payer presence in ONDCP campaign**
  - **Some perceive industry as uninterested; many would welcome greater involvement**
- **State prescription monitoring databases—if implemented effectively—have significant potential for curbing diversion activity at the prescriber end and via law enforcement investigations**
  - **24 states operational**
  - **8 states enacted**
  - **9 states legislation pending**

Broad Best Practices for Rx Payers

- **Pay more attention**
  - **Increase awareness of true impact and potential exposure, including at senior management levels**
  - **Avail selves of PBM tools/intervention programs (best case)**
  - **Force the issue in PBM relationship (worst case)**
  - **Educate and enlist support of self-insured group customers**
  - **Enlist expert pain-management counsel to assist in striking and maintaining appropriate balance**
  - **Better understand options for appropriate action—addiction assistance vs. law enforcement referral**
- **Become more involved**
  - **NADDI—national and regional/state levels**
  - **Support effective Prescription Monitoring Programs**
- **Address obstacles—real or perceived—to implementing effective intervention measures—e.g., pharmacy restriction**
  - **Policy/contract terms**
  - **Communication with prescribers**
- **Review and consider narrowing off-label coverage policies**

Operational Best Practices for Rx Payers

- Review and improve up-front controls
  - Prior Authorizations
  - Quantity Limits
  - Encourage, if not require, network prescribers to query PMPs
- Review and improve point-of-sale controls
  - Date of Birth queries
  - Photo Identification?
- Address technical obstacles to matching Rx and medical-claim data
- Don’t overlook “sleeper” drugs
  - Promethazine w/Codeine
  - Methadone
  - Buprenorphine (Subutex)
- Develop and implement pharmacy restriction programs
  - Learn from Medicaid—Colorado, New York, etc.