



Prescription Opioid Abuse: Challenges and Opportunities for Payers
Tufts Health Care Institute (THCI) Program on Opioid Risk Management
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EXECUTIVE SUMMARY

Prescription opioid abuse and addiction are taking a rapidly growing toll on individuals, institutions and businesses in the United States. It has been estimated that nearly 2.5 million individuals initiate the nonmedical use of prescription opioids each year, and incidence of prescription opioid abuse now exceeds that of many conventional street drugs, including cocaine and heroin. Overdose deaths from prescription drugs have exceeded those from street drugs since 2004, and in 2005, nearly 600,000 of 1.4 million emergency room visits involved prescription drugs, largely pain medications.

Much of the cost of prescription opioid abuse and its health consequences is paid for by private and public health insurers. Drug abusers, or those who sell prescription drugs illegally on the black market, obtain opioids by diverting prescriptions that have been paid for by insurance companies or by government programs. In addition to the costs of the drugs themselves, individuals who abuse prescription opioids incur much higher medical costs than non-abusers due to the serious health consequences of opioid addiction. Overall, the medical and prescription costs associated with opioid abuse have been estimated to create losses of over \$72.5 billion a year for private and public health care payers. An additional, currently incalculable risk of loss arises from the potentially high liability claims that may be made because insurers have failed to identify prescription opioid abusers before they seriously harm themselves or others.

A Tufts Health Care Institute (THCI) Program on Opioid Risk Management summit meeting was convened in June 2010 to bring together private insurance company and government health plan representatives, public health experts and officials, pain management specialists, and other stakeholders to present their perspectives and their research, to raise awareness of the complex issues involved, and to consider potential solutions that health care payers might implement to combat this difficult and costly problem.

Defining the Scope of the Problem

Prescription drug costs represent about 10% of US health care spending, and the share of that cost that is borne by health care payers has increased significantly in recent years. In 1990, prescription drug costs were about \$40 billion, 56% of which was paid directly by consumers and only 26% of which was paid by private insurers. In 2005, this total had risen to \$201 billion a year, only 25% was paid by consumers, and 47% was paid by private insurers. During the same period, the government share of prescription drug costs rose from 18 to 28%.

Prescriptions for controlled substances, including opioids, represent a significant proportion of these rising costs. Total opioid prescriptions rose over 200% between 1992 and 2002, with the frequently abused medications hydrocodone and oxycodone posting nearly 400% increases. Opioid prescriptions can be misused or diverted by a wide range of methods. Patients may seek prescription opioids for pain symptoms that are real, exaggerated, or nonexistent, visiting

multiple physicians and filling the prescriptions at multiple pharmacies, a practice known as “doctor shopping.” These prescriptions may then be misused by the patients themselves, diverted to family members or friends, or sold on the black market. Physicians, pharmacists and clinics may also perpetrate fraud, selling prescriptions or the drugs themselves to patients, then billing the costs to private health insurers or the government. Such fraudulent activities can be quite costly. A recent review of prescription data at MassHealth, the state agency that oversees comprehensive health coverage in Massachusetts, found that the top 50 MassHealth members identified as doctor shoppers accounted for 9% of total pharmacy costs in 2009, for a total of nearly \$400,000 in that year alone.

In addition to the direct costs to health insurers, prescription opioid abuse has a large, somewhat hidden impact on a wide range of other types of insurers, on state and local governments, and on the banking industry. Automobile, property, and workers compensation insurers face increased costs for the accident, property damage, and workers compensation claims created by individuals driving while impaired or otherwise engaging in risky behavior, and through fraudulent claims designed to finance the purchase of illegal prescriptions. Law enforcement agencies, court systems, and emergency services providers face direct costs related to reports of fraud, theft, or illegal actions by the drug user, as well as responses to injury, fire and rescue calls. Prescription drug abusers create additional costs for state and local governments through their impact on court systems, departments of correction, drug prevention and rehabilitation programs, domestic violence shelters, rape crisis centers, and other public services. Many abusers are unable to work, increasing costs for state income assistance and support services for dependents. Banks are affected by the costs of home foreclosures, bankruptcy cases, and fraud, particularly identity theft, which is often perpetrated to support illegal drug use.

The growing epidemic has an effect on patients with a legitimate need for chronic pain medication and their physicians as well. In 1999, the Veterans Health Administration recognized pain as the “fifth vital sign,” to be added to such basic measures of medical condition as blood pressure and body temperature, as a result of the increasing recognition that pain is significantly undertreated in the US. At the same time, growing awareness of prescription opioid abuse has led to increased attention from law enforcement and medical regulatory bodies. Individual practitioners, many of whom received little or no training in pain management in medical school, have become reluctant to take on the potential liabilities of prescribing opioids for their patients. It is possible that this chilling effect prevents many patients with legitimate pain control needs from obtaining the prescription opioids that would help them.

Risk Management Solutions for Payers

Health care payers, both private and public, can put into place a wide range of procedures and policies that will help to lower the financial risks associated with prescription opioid abuse. They can establish and maintain internal procedures, such as claims reviews, claims matching, and formulary controls, that are likely to identify prescription opioid abusers and reduce inappropriate prescribing. They can also establish external policies that promote and support appropriate prescribing behavior by physicians and other health care providers. The overarching goal of these strategies should be to minimize prescription opioid abuse while at the same time ensuring that patients with pain are able to obtain an appropriate level of access to these medications.

Internal Strategies for Risk Management

Pharmacy and prescriber controls. A number of payers have already implemented processes that can help to limit the misuse of prescription opioids. Formulary controls that limit reimbursement can help ensure that higher risk opioids are not prescribed, or that they limited only to patients with the appropriate diagnoses. Claims review procedures can be designed to question potentially inappropriate prescriptions, and to flag prescriptions that are coming from primary care providers as opposed to specialists. Individuals who are suspected of “doctor shopping” can be locked in to the use of a single pharmacy and/or single prescriber to minimize the possibility of filling inappropriate or fraudulent prescriptions.

Surveillance of claims data. Prescription claims data can be reviewed for the overuse of prescription opioids. MassHealth, for example, reviews prescriptions for controlled substances to identify cases of inappropriate prescribing, including a review of clinical outcomes and whether the medications used were medically appropriate. A few forward-looking companies have instituted procedures for matching prescription, medical, behavioral and substance abuse claims that can identify patterns or “red flags” suggestive of abuse or fraud. At Wellpoint, a private health benefits company, a comprehensive internal mechanism has been developed that proactively identifies members suspected of inappropriate use of pharmacy or medical benefits. Once identified, each case is carefully researched, the member and the health care provider involved are contacted, and interventions can range from provider and patient education, to substance abuse treatment, to the involvement of law enforcement if necessary.

Claims matching can be difficult to institute because many of the claims databases do not interface with one another, particularly at companies that use an external pharmacy benefits management company. It is important that payers develop procedures for handling potential fraud cases that are effective but still allow for individualized consideration of each case, including clinical oversight to ensure that patients and providers are not being singled out or penalized for appropriate medical uses of opioids.

Cooperation and data sharing with other types of insurance providers. Automobile, property, and workers compensation insurers have a wealth of data on individuals who have incurred damage and liability claims, some of whom are likely to be prescription opioid abusers. These companies have common databases that can share this data, but currently such databases are not easily linked to databases of medical claims or prescriptions. Future industry standards could be developed that would allow these databases to be integrated, allowing faster identification of misuse and fraud, reducing costs, and benefiting all companies involved.

Risk Management Strategies for Health Care Providers

Clinical research on prescription opioid abuse has shown that there are a number of strategies that clinicians can use to limit the risks associated with prescribing these medications. This research has led to guidelines, such as those released by the American Pain Society and the American Academy of Pain Medicine, that suggest a set of universal precautions. Payers can limit their own risk by promoting and supporting the use of these precautions among health care providers in their systems. These precautions include careful screening and risk stratification of patients; effective patient education and counseling that maximizes patient involvement in treatment decision making; individualized treatment that is periodically reassessed, including the use of urine testing, pill counts, or other measures if deemed necessary; and careful documentation of the pain management process.

Patient screening. Surveys of physician attitudes about prescription opioids have found that, while they recognize the effectiveness of these medications, many practitioners are highly

concerned about creating addiction in their patients. However, meta-analyses suggest that only a small percentage of patients become addicted (around 3%), and this percentage may be reducible by screening patients for a previous or current history of drug abuse before writing an opioid prescription. A wide range of other risk factors have been identified, including age and gender, family history, presence of a major psychiatric disorder, a history of aberrant behaviors, and others. Payers can promote patient screening by encouraging practitioners to use some of the many screening tools that are available for this purpose, and reimbursing for the time involved.

Use of Prescription Monitoring Programs (PMPs). At least 40 states now have PMPs, covering 87% of the US population. PMPs collect data from pharmacies on controlled substances prescriptions, including information on who has been prescribed what substance and by whom. This data can be provided to prescribers, pharmacists, law enforcement officials, professional licensing boards, public health researchers, and others in order to identify individuals engaged in prescription drug diversion and to perform research in this area. PMPs have been shown to reduce prescription drug diversion; for example, when New York State started its PMP in 1978, about 12% of all schedule II prescriptions were forged or counterfeit. This percentage was reduced to less than 1% within 5 years. Payers can promote the use of this important resource by strongly encouraging, facilitating through technology, or even requiring prescribers to check the PMP before prescribing controlled substances. In the future, they could also make it easier for time-challenged physicians to use this data by linking the PMP to their electronic prescribing tools, or to pharmacy computers at the time of dispensing. Payers themselves can also use the data generated by PMPs to investigate whether clinicians' prescribing patterns fit within the standard of care in a given community, and to identify geographic areas where doctor shopping and adverse outcomes are higher than average and warrant closer surveillance.

Patient education and communication. Current guidelines recommend multiple practices intended to engage the patient who is receiving opioids in the risk management process. These include patient counseling, informed consent, and treatment agreements that outline patient expectations and responsibilities with regard to opioid therapy. Poor patient knowledge and lack of communication between patient and clinicians have been recognized as barriers to effective prescription opioid utilization. Patient education in the setting of a busy physician practice is time-consuming, and is not likely to occur unless time-efficient and effective approaches are developed and implemented; supportive reimbursement payer policies would also have a facilitating role.

Urine drug monitoring (UDM). Many organizations recommend UDM in their guidelines for prescription opioid management in patients with chronic pain, because it is thought to provide an objective indicator of drug abuse or drug diversion that complements patient self-report, physician assessment, and behavioral monitoring. It has been estimated that clinical methods alone (without laboratory corroboration) miss about half of patients who are misusing opioids. A review of studies using UDM in 2007-2009 showed that at least 11% of patients with chronic pain were misusing opioids, and at least 12% were not adhering to a prescribed medication. At the same time, however, no high quality studies have examined whether UDM has an impact on opioid abuse, addiction and/or overdoses. A recent meta-analysis found only 8 fair to poor quality studies of UDM that examined these outcomes, and these studies showed only a modest 7-23% reduction in misuse with testing. Payers can set the standards for UDM use by means of their reimbursement policies, but at this time it is difficult to know what these standards should be. Questions such as who to test (all patients or only high risk?), how often to test, and what types of tests to use remain unanswered. It is also likely that effective use of UDM will need to

be tailored to specific patients and circumstances so that payers will need to be flexible in their policies. It remains to be seen how this important tool will be used most effectively.

Effective methods for treating prescription opioid abuse. Although clinical evidence is still limited, there are a number of studies that have begun to identify best practices for treating opioid addiction once it occurs. The National Drug Abuse Treatment Clinical Trials Network recently completed a very large trial, the Prescription Opioid Addiction Treatment Study, that provides important evidence regarding the length of pharmacotherapy, effects of intensive counseling, and role of chronic pain in modulating the effectiveness of treatment for prescription opioid addiction. The trial found that relapse was almost universal after withdrawal of maintenance opioid treatment regardless of the length of pharmacotherapy, that intensive counseling did not add to treatment effectiveness, and that patients with chronic pain did not experience worse outcomes from addiction treatment than those without chronic pain.

Considerable research has also been devoted to **SBIRT, or Screening, Brief Intervention, and Referral to Treatment**, a comprehensive, integrated, public health approach to identifying those who have or are at risk for substance abuse disorders and providing early intervention. SBIRT is designed to be implemented in primary care centers, hospital emergency rooms, trauma centers, and other community settings where substance abusers often first interact with the health care system. Patients are screened for substance abuse problems, then provided with a brief intervention or treatment (for low to moderate risk cases) or referred to specialists (for high risk cases). Use of SBIRT is associated with reduced substance abuse, fewer emergency room visits, and fewer hospital days, and several large studies have suggested that it is cost-effective for payers. Payers can support the use of SBIRT by aligning their reimbursement and training policies with the services required to follow this method.

It is critical that payers remain aware of ongoing clinical research into best practices for pain management and opioid abuse treatment, and incorporate these findings into their policies. In addition to setting reimbursement policies, payers can promote evidence-based best practices by establishing quality of care measures for their participating physicians, eventually perhaps leading to pay-for-performance initiatives in these areas.

Coordinated care. It has been suggested that patients with chronic pain, like other chronic conditions, would benefit from care that conforms to the American Academy of Family Physicians' Patient Centered Medical Home Model. This model emphasizes systematic, patient-centered, coordinated care that is facilitated by a partnership between individual patients, their primary care providers, and the patient's family as appropriate. Payers can encourage this type of care by providing information technology support and by participating in health information exchanges that promoted carefully coordinated care that is more effective, as well as reducing costs by reducing or eliminating duplicated tests and treatments.

Physician education. Physicians must receive appropriate education if they are to implement risk management strategies, universal precautions, and effective opioid abuse treatment in their practices, particularly since so little is taught about pain in medical school or post-graduate training. Perhaps due to the complex, longitudinal nature of pain management, short one-time educational interventions, such as continuing medical education lectures or seminars, do little to improve clinical practice in this area. Instead, considerable data has accumulated within the Veterans Administration and in other clinical settings to show that intensive, one-on-one, longitudinal programs that teach physicians how to prescribe opioids safely and then continue support practice improvements over the long term can be highly successful at changing physician behavior in this area. Payers who continue to be aware of the literature in this area

and invest in the training for their physicians are likely to reap the benefits of reduced costs and improved member health.

Conclusion

Many payers in the health care industry lack awareness of the huge toll taken by prescription opioid abuse and diversion, both on the health of their members and on their bottom lines. Although much further research remains to be done, strategies have been identified that companies and government agencies can use *now* to manage the risks involved. It is critically important that payers stay abreast of new developments in this field and implement risk management strategies on an ongoing basis if they are to stem the growing tide of financial losses associated with this serious societal problem.