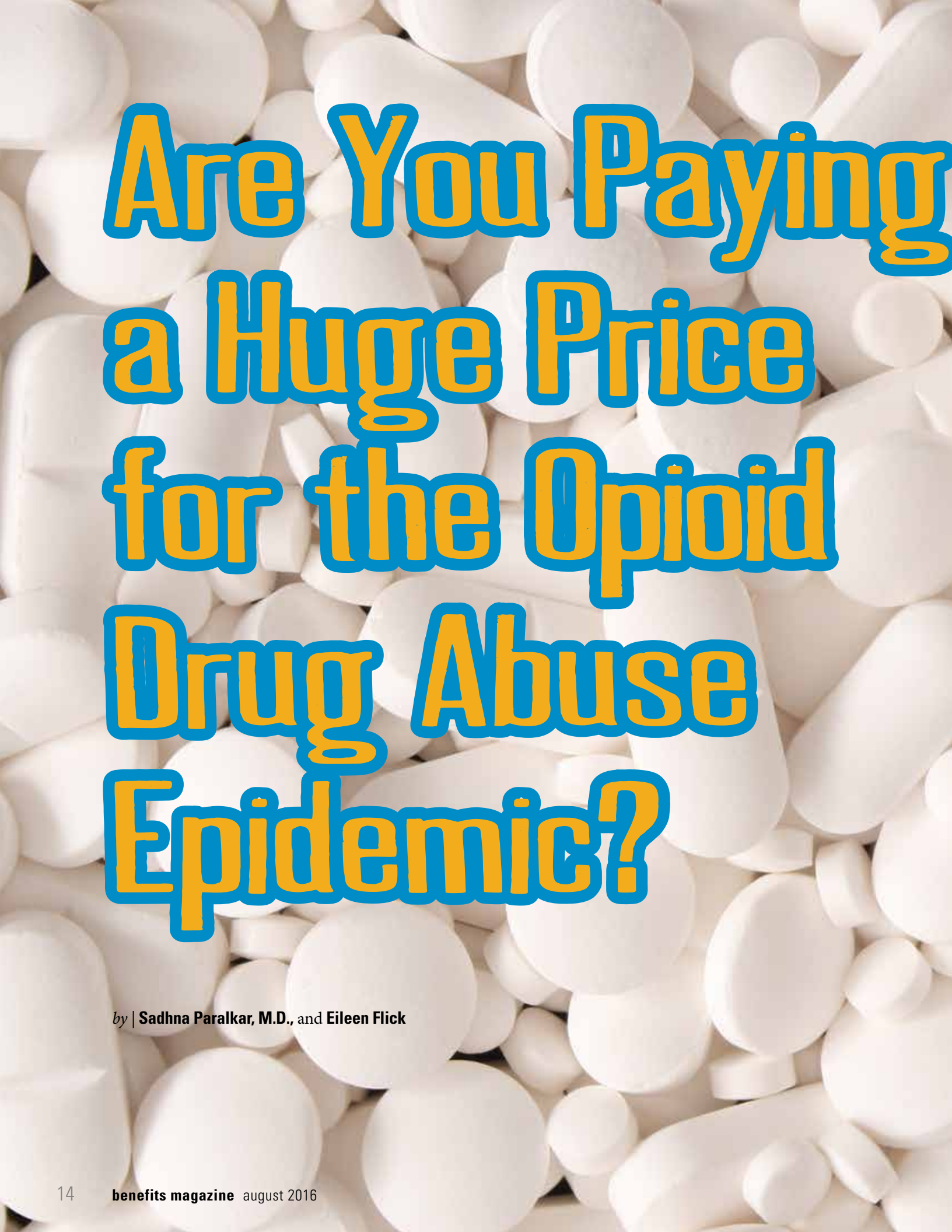

Are You Paying a Huge Price for the Opioid Drug Abuse Epidemic?

by | **Sadhna Paralkar, M.D.,** and **Eileen Flick**

Millions of health plan participants are addicted to or misusing opioid painkillers, leading to suffering, deaths and huge costs. Plan sponsors can take steps to try to protect themselves and participants.

benefits
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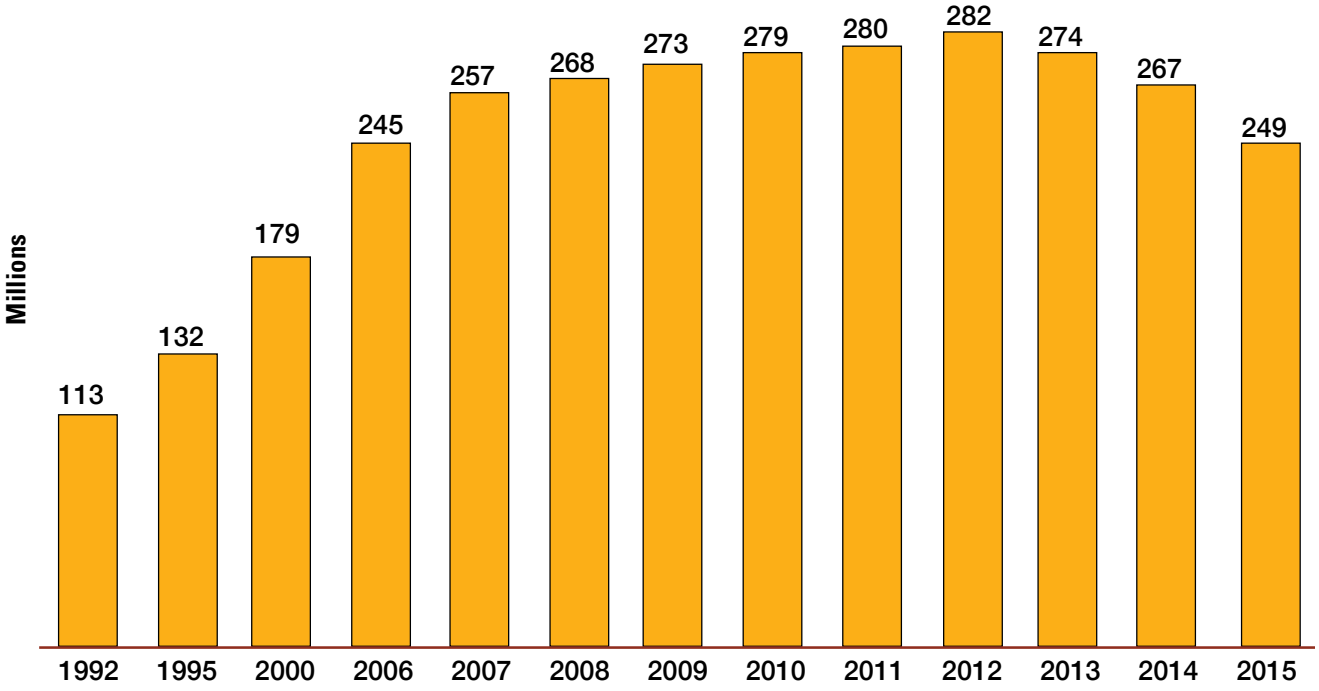
FIGURE

Number of Opioid Prescriptions Dispensed by U.S. Retail Pharmacies



Source: IMS Health.

The United States is struggling with an opioid drug abuse epidemic, and one often-overlooked impact is the huge additional—and often undetected—costs incurred by health plan sponsors. Inappropriately prescribed opioids, or opioids obtained through fraudulent practices, can cost plans tens of thousands of dollars. Plans also incur costs for emergency room visits and hospitalizations due to overdoses.

Making matters worse, a new generation of broadly marketed substance abuse treatment centers is taking advantage of opioid addiction by charging outrageous fees, a percentage of which plans generally must cover.

Plan sponsors need to take steps to protect themselves from what has become a widespread and insidiously expensive public health problem. They should actively identify potential prescription drug misuse and develop solutions to minimize fraud and abuse. *Data analytics,* a process used to discover trends and patterns in claims data, can be used to help develop and support health plan strategies and improve the likelihood that any actions taken will have the intended impact.

What's Going On?

More than 2.1 million Americans are addicted to OxyContin®, Vicodin®, Demerol® and other similar drugs (see Table I for a list) without a prescription, according to the *National Survey on Drug Use and Health.* Another 2.5 million or more are pain patients who may be suffering from an opioid use disorder but have legitimate prescriptions for the drugs.[1] Deaths from opioid analgesics far exceed deaths from any other drug or drug class, licit or illicit.

The problem often starts when a doctor prescribes an opioid for a patient with a toothache, an athletic injury or pain from surgery. Such prescriptions have become extremely common. Opioids are widely accepted by the public, and patients seeking pain relief have come to expect them. As a result, doctors prescribed approximately 249 million opioids in the United States in 2015, up from approximately 113 million in 1992[2] (see the figure), although the number of opioid prescriptions has begun to fall in recent years.[3] The U.S. is the world's largest opioid consumer, accounting for almost 100% of hydrocodone and 81% of oxycodone use.[4]

Oddly enough, systematic reviews

and multiple studies have concluded that the effectiveness of prolonged opioid treatment for chronic noncancer pain is unknown,[5, 6] but opioids do generate a sense of euphoria that can be extremely addictive. This leads some patients to continue to crave opioids and go to great lengths to procure them even long after any pain has passed. Many doctors are unaware that their patients have become addicted to the pain relievers. Some opioid addicts "doctor shop," obtaining prescriptions from several different doctors at the same time.

Another issue is *opioid diversion*, where a legally prescribed opioid is transferred or sold illicitly to someone other than the patient for whom it was initially prescribed.

What Are the Financial Implications for Health Plans?

Several Segal Consulting clients have observed higher health plan costs for prescription opioids. Because most opioids are low-cost generics, the high costs typically are driven by high-volume dispensing, which is also often an indication of potential abuse.

One sample study employed data analytics to review individual physicians who had prescribed a greater-than-500-day supply of opioids to individual participants. It found these physicians had cost a plan more than $600,000 over 12 months (see Table II). One doctor had prescribed one patient a 1,576-day supply of opioids, which cost more than $85,000.

Other costs arise when opioid-addicted participants become ill (e.g., severe dependence, drug overdose, severe side effects) as a result of the abuse. Beyond this, some may require emergency treatment for overdoses.

Also driving costs are regulations under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). MHPAEA requires group health plans and health insurance issuers to ensure that the financial requirements (e.g., copayments and deductibles) and treatment limitations (e.g., visit limits) applicable to mental health or substance use disorder (SUD) benefits (e.g., treatment for opioid addiction) are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

As a result of this expanded access, new substance abuse treatment centers have entered the marketplace to take advantage of the increased volume of treatment and potential revenue opportunities. Many of these centers have mass-marketed themselves using television and other media to encourage patients to travel out of state for treatment. Not only are these centers very expensive (e.g., demanding comprehensive drug testing at a rate of $5,000 or more daily for many consecutive days), they impede family involvement in recovery, a vital element of successful treatment protocol. Moreover, the cost differential for treatment at in-network and out-of-network/out-of-state recovery centers can be astounding (see Table III).

TABLE I

Opioid Pain Relievers

Generic Name	Brand Name(s)
Codeine	Various brands
Fentanyl	Duragesic®, Actiq®
Hydrocodone	Norco®, Vicodin®, Lortab®, Lorcet®
Hydromorphone	Dilaudid®, Exalgo®
Methadone	Dolophine®
Meperidine	Demerol®
Morphine	Astramorph™, Avinza®, Duramorph®, Roxanol™
Oxycodone	OxyContin®, Percocet®, Percodan®
Oxymorphone	Opana®

TABLE II

Sample Study of Large Opioid Prescriptions

Prescribers	Unique Patients	Average Day Supply of Opioids Prescribed	Total Plan Paid for Opioids
Prescriber #1	1	1,576	$85,298
Prescriber #2	1	1,480	$20,132
Prescriber #3	1	1,203	$8,176
Prescriber #4	1	1,173	$6,256
Prescriber #5	1	1,143	$2,581
Prescriber #6	1	1,053	$11,748
Prescriber #7	1	986	$2,962
Prescriber #8	1	878	$1,838
Prescriber #9	1	839	$4,711
Prescriber #10	1	808	$1,573
Grand Total (65):	100	712	$612,564

Note: The first ten prescribers listed represent physicians who had the ten largest average day supplies of opioids prescribed. The grand total includes results for 65 prescribers.

Source: Segal Consulting.

TABLE III

Sample Plan Sponsor Recovery Center Cost Differential

Provider	Average Paid
In-Network	$13,500
Out-of-Network/Out-of-State	California: $108,500 Florida: $42,000

Source: Segal Consulting.

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Pharmacy Benefits: Plan Design and Management
F. Randy Vogenberg. International Foundation. 2011.
Visit *www.ifebp.org/books.asp?6962* for more details.

Congress also has recognized the national epidemic of prescription opioid abuse. In March 2016, the Senate passed legislation that would authorize grants for states to address the prescription opioid epidemic.[7] In addition, the legislation would require the Department of Health and Human Services (HHS) to convene an interagency task force to develop best practices for pain management and prescribing pain medication. The House passed similar legislation in May.[8] As of mid-June, the legislation was being considered by a conference committee charged with working out the differences between the Senate and House versions.

How Can a Plan Sponsor Take Action?

To protect themselves, plan sponsors need a strong preferred provider organization network for behavioral health services to properly treat opioid addiction and thoughtful utilization management controls that can ferret out fraud or abuse. The first step to uncovering fraud or abuse is to review the pharmacy benefit manager (PBM) clinical programs targeting this drug class.

Special care also needs to be taken in designing programs to treat opioid addiction, including the appropriateness of antiaddiction prescription drugs used for opioid addiction (e.g., naltrexone, buprenorphine). These drugs should be prescribed by physicians with special training and should be closely monitored for medical necessity, treatment adherence and appropriate dosage and delivery.

Of course, in developing protocols for utilization management controls with respect to treatment for addiction, plan sponsors need to comply with MHPAEA. Plan sponsors should develop a set of neutral, objective criteria to determine which classes of drugs should be subject to utilization management controls and which controls should apply to them. The same utilization management controls must apply on the medical side to any drugs that meet the established criteria.

General strategies for managing potential opioid abuse include plan design, vendor management and care management programs. Plan sponsors should consider the following eight solutions:

1. Institute an enhanced fraud and abuse program that uses data analytics to identify and manage fraudulent drug use. Clues to look for include unusually large daily dosages of opioids per patient, multiple providers combined with excessive doses and duplicate claims from multiple pharmacies.
2. Require prior authorization for opioid prescriptions of more than 15 days for all outpatient pain management prescriptions.
3. Monitor hospital discharges and conduct patient oversight to look for prior drug abuse events (e.g., overdoses or substance abuse treatment). Capturing all prior events will help plan sponsors evaluate the appropriateness of newly prescribed medications and avoid relapses.
4. Develop plan strategies to cover abuse-deterrent opioids[9] (e.g., require written permission from the provider before an abuse-deterrent prescription can be switched to a non-abuse-deterrent prescription).
5. Work with the PBM to establish a fraud tip hotline. In most cases, the PBM will monitor the hotline each day. Tips are triaged, investigated and referred to plan sponsors as appropriate.
6. Offer alternative treatment for pain management (e.g., osteopathic manipulative treatment).
7. Train and educate prescribing physicians. This should include instituting multidisciplinary condition man-

agement programs that address comorbid conditions (e.g., SUDs and mental health issues).

8. Communicate and educate participants about the addiction aspects of opioids.

It is also important to pay attention to a participant's psychosocial health[10] needs (e.g., depression that results from the inability to manage pain). Ignoring these needs can lead to increased medical visits, hospitalizations and long-term chronic disease.

Key Takeaways

Although the opioid drug abuse epidemic is serious, it is far from hopeless. There are concrete and practical steps plan sponsors can take to identify fraud and abuse and help participants get the treatment they need for a reasonable cost. By using the strategies outlined in this article, plan sponsors can reduce the incidence of opioid drug abuse, ensure participants get better care and ultimately manage the plan's overall costs.

Endnotes

1. G. C. Alexander, S. Frattaroli and A. C. Gielen, editors. *The Prescription Opioid Epidemic: An Evidence-Based Approach.* Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland: 2015.
2. IMS Health.
3. Abby Goodnough and Sabrina Tavernise, "Opioid Prescriptions Drop for the First Time in Two Decades," *The New York Times,* May 20, 2016; available at www.nytimes.com/2016/05/21/health/opioid-prescriptions-drop-for-first-time-in-two-decades.html?_r=0.
4. *International Narcotics Control Board Report 2008.* United Nations Publications. 2009. p. 20.
5. Assessment of Analgesic Treatment of Chronic Pain: A Scientific Workshop. Linked to April 24, 2014; available at www.fda.gov/downloads/Drugs/NewsEvents/UCM308363.pdf.
6. ER/LA Opioid Analgesic Class Labeling Changes and Postmarket Requirements, Letter to ER/LA opioid application holders. Linked to April 24, 2014; available at www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM367697.pdf.
7. The Comprehensive Addiction and Recovery Act (CARA) of 2016 (S. 524) passed the Senate by a vote of 94-1.
8. The House of Representatives passed similar legislation by a vote of 400-5 on May 13, 2016.
9. Abuse-deterrent properties meaningfully discourage abuse, even if they do not prevent it. For example, because opioids can be abused in a number of ways—swallowed whole; crushed and swallowed; crushed and snorted; crushed and smoked; or crushed, dissolved and injected—abuse-deterrent properties may make them difficult to snort or inject.
10. Psychosocial health includes mental, emotional, social and spiritual well-being.

takeaways

- Deaths from opioid analgesics far exceed deaths from any other drug or drug class.
- Doctors prescribed about 249 million opioids in the U.S. in 2015.
- It's not known how long opioids remain effective against pain from causes other than cancer, but opioid addiction often results.
- Opioids, which generally are a low-cost drug, can be very expensive to plan sponsors because of high-volume dispensing.
- New substance abuse treatment centers have entered the marketplace to take advantage of the increased volume of treatment and potential revenue.
- Plan sponsors need a strong preferred provider organization network for behavioral health services to properly treat addiction and utilization management controls that can find fraud or abuse.

bios

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