

The Role of Insurers in Preventing Misuse and Abuse of Controlled Substances



Prescription opioid abuse cost the health care system \$25.0 billion during 2009 (Birnbaum et al., 2011). Drug diversion may cost insurers in excess of \$70 billion yearly, when claims related to office visits, diagnostic tests, emergency department (ED) visits, and the negative consequences of opioid abuse (including liver damage) are included (CAIF, 2007).



■ Introduction

Doctor shopping by patients has become a major contributor to the epidemic of misuse of controlled substances. A study of the Medicare population with opioid prescriptions found that over one-third filled prescriptions from two providers, 14% from three providers, and 12% from at least four providers, and that the provider who wrote the most prescriptions for each patient wrote less than half of all the prescriptions the patient received (Jena et al., 2014). Each doctor shopper may cost insurers as much as \$15,000 annually (O'Toole, 2012).

In a report issued in 2012, the General Accounting Office (GAO) reported that the Medicaid programs in five states—California, Illinois, New York, North Carolina, and Texas—were billed \$63 million for inappropriate purchases of controlled substances (Hendrikson, 2012). GAO also expressed concern that the states generally lack the means to detect problems related to the use of controlled substances. The report suggested that the Centers for Medicare and Medicaid Services provide guidance as to how to detect fraud in the Medicaid system, including inappropriate prescribing practices by providers and the misuse and diversion of controlled substances by recipients (GAO, 2009).

Eighty percent of all workers' compensation injury claims filed over a 3-year period beginning in 2009 resulted in a prescription for potentially addictive opioids (Victor, 2013). Employees with soft-tissue injuries are particularly vulnerable to the abuse of controlled substances that may be prescribed for their pain management. Further, these substances, which are being prescribed for injured workers in steadily increasing amounts (L&I, 2009), may now constitute one-quarter of the drug costs borne by workers' compensation (Lipton, Laws, & Li, 2013). As Dr. Len Paulozzi of the Centers for Disease Control and Prevention said, "There's an awful lot of back injuries in the workers' comp population and subsequent surgery related to back problems, and back pain is one of the

most common indicators now of use of opioids in the United States" (Johnson & Jergler, 2013). However, as a strategy to manage chronic pain related to tissue damage, controlled substances may not be particularly effective. Dr. Paulozzi continued: "Opioids might be good for use in the acute phase, say within six weeks after injury. But if it doesn't improve the situation in the short term, continuation is not really indicated." Worse, using opioids to control pain creates a condition called *hyperalgesia*, which makes patients more sensitive to pain from future injuries and less able to control that pain.

Several studies suggest prescribing strong opioids for injured workers suffering lower back pain decreases activity levels and delays recovery and return to work, and it also increases medical costs and litigation (Swedlow et al., 2008; Webster, Verma, & Gatchel, 2007). In California during 2008, the average cost of a prescription for a Schedule II substance—which represents the apex of the hierarchy of legal controlled substances—was \$280 (Swedlow, Ireland, & Johnson, 2011b). In 2011, the State estimated that giving permission to third-party payers to access the Prescription Monitoring Program database would yield reductions in total benefits paid for 3% of claims related to 2–3 opioid prescriptions, 5% on claims related to 4–7 prescriptions, and 7% on claims related to 8 or more



prescriptions (Swedlow & Ireland, 2013). A more recent study of California's workers' compensation system revealed that 3% of prescribing providers issued over half of all Schedule II prescriptions and accounted for two-thirds of all payments. Nearly half of these prescriptions were for claims related to minor back injuries (Swedlow, Ireland, & Johnson, 2011a).

As Trey Gillespie of the Property Casualty Insurers Association of America said, over time, "prescription medication [has become] a bigger portion of the medical expense. This is especially true if the worker has become dependent or addicted to opioid medication to control pain. Consequently, payers are working hard to reduce the number of workers who become dependent on or addicted to pain medication and to find treatment alternatives to opioid medications to manage pain" (Johnson & Jergler, 2013).

So, what are some states and insurers doing to combat this epidemic?

■ *Patient Review and Restriction Programs*

States and insurers are implementing patient review and restriction programs. These programs, which a number of states have implemented, are sometimes known as Medicaid Lock-In Programs. They use a variety of criteria indicative of overutilization of medical services or the potential for fraud, based on the number of providers and dispensers that patients have visited and the number of prescriptions for controlled substances that they have filled over a given period. Generally excluded are patients with chronic conditions such as cancer and those suffering from terminal illnesses. Eligible patients are restricted to a certain number of providers and dispensers for a fixed period.

Evaluation results for lock-in programs in several states are compelling. For example, Missouri's program yielded annual savings of between \$7 million and \$41 million, and Hawaii's program yielded annual savings of \$2 million. Programs in Louisiana, Oklahoma, and Ohio all reduced prescriptions for narcotics—Ohio's by 41%—and Oklahoma also reduced visits to EDs and to multiple providers and dispensers (CDC, 2012). In Virginia, WellPoint Anthem Blue Cross and Blue Shield estimated that it saved more than \$300,000 by restricting 100 patients to a single pharmacy. It saved over \$40 in medical costs for each prescription dispensed (CAIF, 2007).

MaineCare, which administers the State's Medicaid program, has limited patients to 2 weeks of painkillers a year, although it does permit renewals in intervals of 2 weeks to patients who receive special permission. Patients with chronic pain that lasts more than 8 weeks are required to try such alternative treatments as

cognitive behavioral therapy, pain acceptance therapy, and chiropractic treatment. Exempt from these rules are patients with AIDS or cancer or those in hospice settings. An evaluation of the program revealed that in 2013, relative to the previous year, 17% fewer patients filled prescriptions for opioid pain relievers, and the number of pills dispensed decreased by 27% (Davis, 2014).



■ *Prescription Drug Monitoring Programs (PDMPs)*

States and insurers also use PDMPs. PDMPs are state-level electronic databases that are depositories for data pertaining to all prescriptions for controlled substances filled by the state's pharmacies other than those affiliated with hospitals. Networks would be well-advised to require that participating prescribers and dispensers check each patient's controlled substance prescription history before providing these substances and that they enter all covered controlled substance scripts in the PDMP database.

PDMPs that include data pertaining to the patient's means of payment can be used to determine if Medicaid patients are circumventing program restrictions by using cash to purchase controlled substances. Unfortunately, as of 2012, only slightly over half the states were sharing their PDMP databases with either their Medicaid or Medicare programs, and only Michigan allowed private insurers access to it (PDMP, 2014). Using its PDMP database, Washington State's Medicaid program discovered that in the first 6 months of 2012, more than 200 patients had paid cash for dispensed controlled substances on the same day, and 500 patients had filled two or more opioid prescriptions for use during the same time period. The program also discovered that Medicaid patients were paying cash for prescriptions for controlled substances in 435 of its pharmacies, which indicated that they were out of compliance with their contracts (Best, 2012).

■ *What Employers Can Do*

The Workers' Compensation Research Institute estimates that nearly 80% of injured workers fill at least one prescription for an opioid analgesic and suggests that employers have a vital role to play in reducing unnecessary prescriptions for controlled substances. Employers can fulfill this role by reviewing closely the clinical programs of their pharmacy benefits managers and insurers. These programs are urged to routinely monitor the prescribing behavior of all providers who have written opioid prescriptions paid for by the insurer. They also should monitor each worker's prescription history and its consistency with the worker's injury nature and severity, related health problems, and overall health status. Insurers and pharmacy benefits managers can also examine the strength and duration of any controlled substances provided and then can note workers who refill prescriptions early or have temporally redundant (or overlapping) prescriptions (Victor, 2013). In addition, patients on high-dose opioids sometimes have their opioid levels monitored by means of lab tests that assure they are not selling or otherwise diverting the pills, taking a higher dose than prescribed, or mixing drugs in dangerous ways. Among 422,005 patient test reports from 2013, Quest Diagnostics found that 22% were taking different drugs than prescribed, 35% were taking additional drugs, and perhaps because they no longer needed them, 43% were no longer taking their prescribed opioids (Quest Diagnostics, 2014). Workers' compensation programs may also consider following the example of Texas. The State has the only program with a closed formulary that prohibits the prescription of specified drugs without prior authorization. In the 6 months after the system was implemented in 2011, the percentage of claims receiving prescriptions for prior-authorization drugs declined by 75% (from 19.4% to 4.8% of all claimants), the average number of scripts per claim that involved these drugs declined by 23% (from 2.04 to 1.58), and total pharmacy payments for all drugs declined by 26% (from \$5.33 million to \$3.96 million) (Quest Diagnostics, 2014).



■ *What Some Private Insurers Are Doing*

Aetna's Pharmacy Management Program is a four-pronged effort to prevent the misuse and abuse of controlled substances. First, the program can limit coverage of any particular drug and can verify that the covered member needs the drug before approving it. The program also proactively notifies the pharmacist if the drug is prescribed at a level that may be inappropriate. Second, the program reviews each member's prescription history before filling a new prescription. Third, members who are suspected of misusing controlled substances may be referred to a pain specialist or to Aetna's Behavioral Health or Case Management services, or they may be encouraged to enroll in a pain management program. Finally, the program may respond to members who decline offers of assistance by restricting them to a single provider or by reducing coverage for refills. Following the inception of this program, opioid use among the carrier's 4 million members declined 15% over the course of 2 years (Aetna, 2013).

Blue Cross Blue Shield of Massachusetts implemented a similar program. Members covered by the carrier are limited to two successive, 15-day prescriptions for opioid analgesics and require authorization before they may fill prescriptions for more than 30 days of analgesics within any 2-month period. Members seeking authorization must undergo a risk assessment for addiction and develop a treatment plan with their provider. Members with cancer or terminal illnesses are excluded from the program. Following the implementation of this program, the insurer reduced prescriptions for opioid analgesics by 6 million pills over an 18-month period (MacQuarrie, 2014).

Prime Therapeutics, a pharmacy consulting program, identified patients of concern based on a score developed from their use of controlled substances and doses of opioid analgesics in excess of 120 morphine milligram equivalents per day. Following implementation of the program, claims related to controlled substances decreased by one-third, and claims related to opioids decreased by 40%. The number of providers and dispensers used by this population both decreased by 30%. Savings over a 3-month period averaged \$220 per member (Prime Therapeutics, 2014).

In conclusion, the costs to society and to insurers due to the misuse, abuse, and diversion of controlled substances are very high. Fortunately, insurers have many tools available to address this burgeoning public health epidemic. This includes developing and implementing patient review and restriction programs that limit patients who were getting opioids from multiple providers and dispensers to a single medical home. Insurers can—and should—also promote the use by

both providers and dispensers of the States' prescription drug monitoring programs to examine their patients' histories of filled prescriptions and how these patients paid for the prescriptions. Insurers also can sponsor clinical reviews of patients with extended histories of prescriptions for controlled substances to assess whether these histories are commensurate with the patients' diagnoses. These strategies constitute both good patient care and good business.



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