

**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**

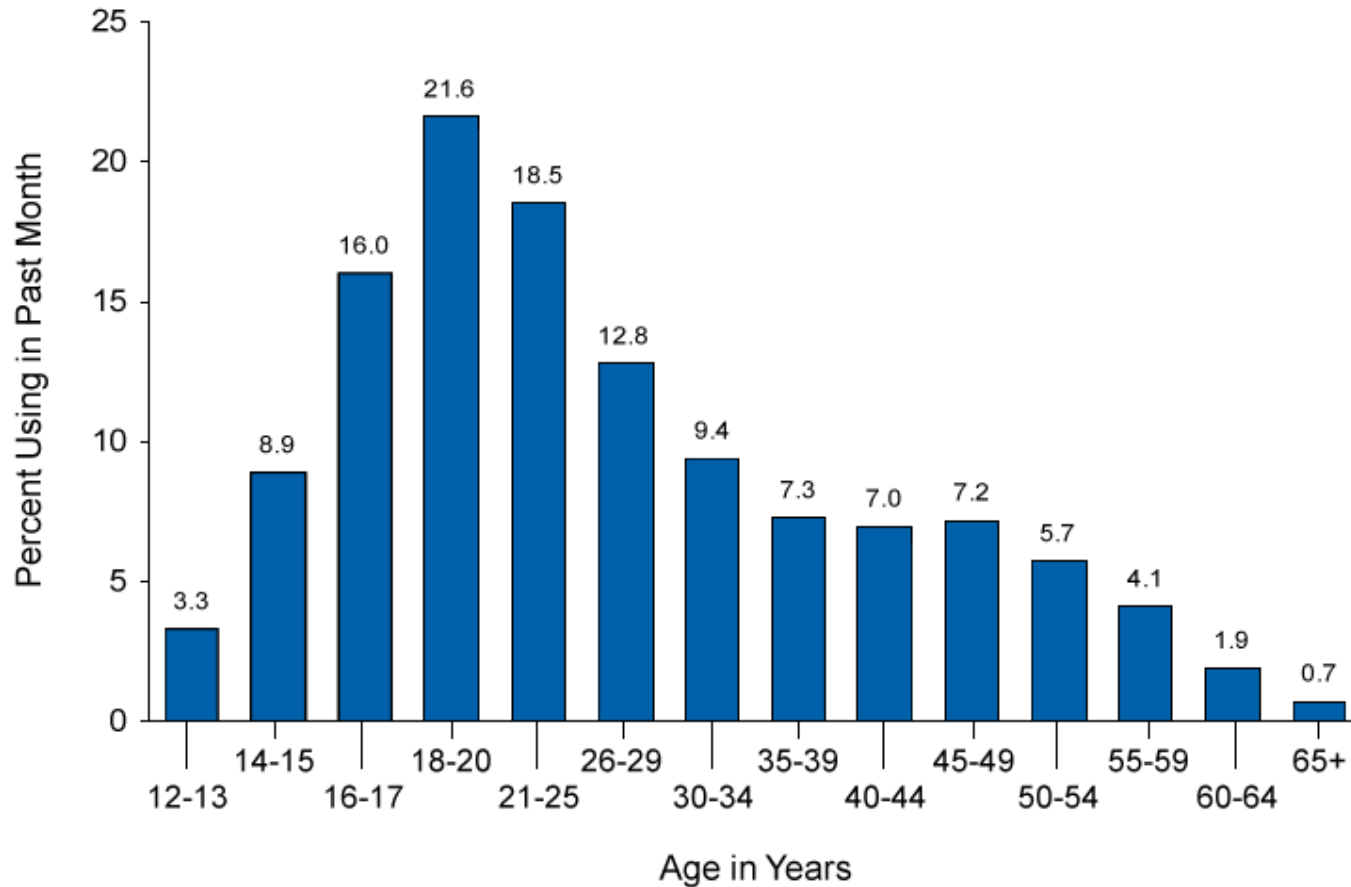
# A New Drug-Payment Equation

- **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

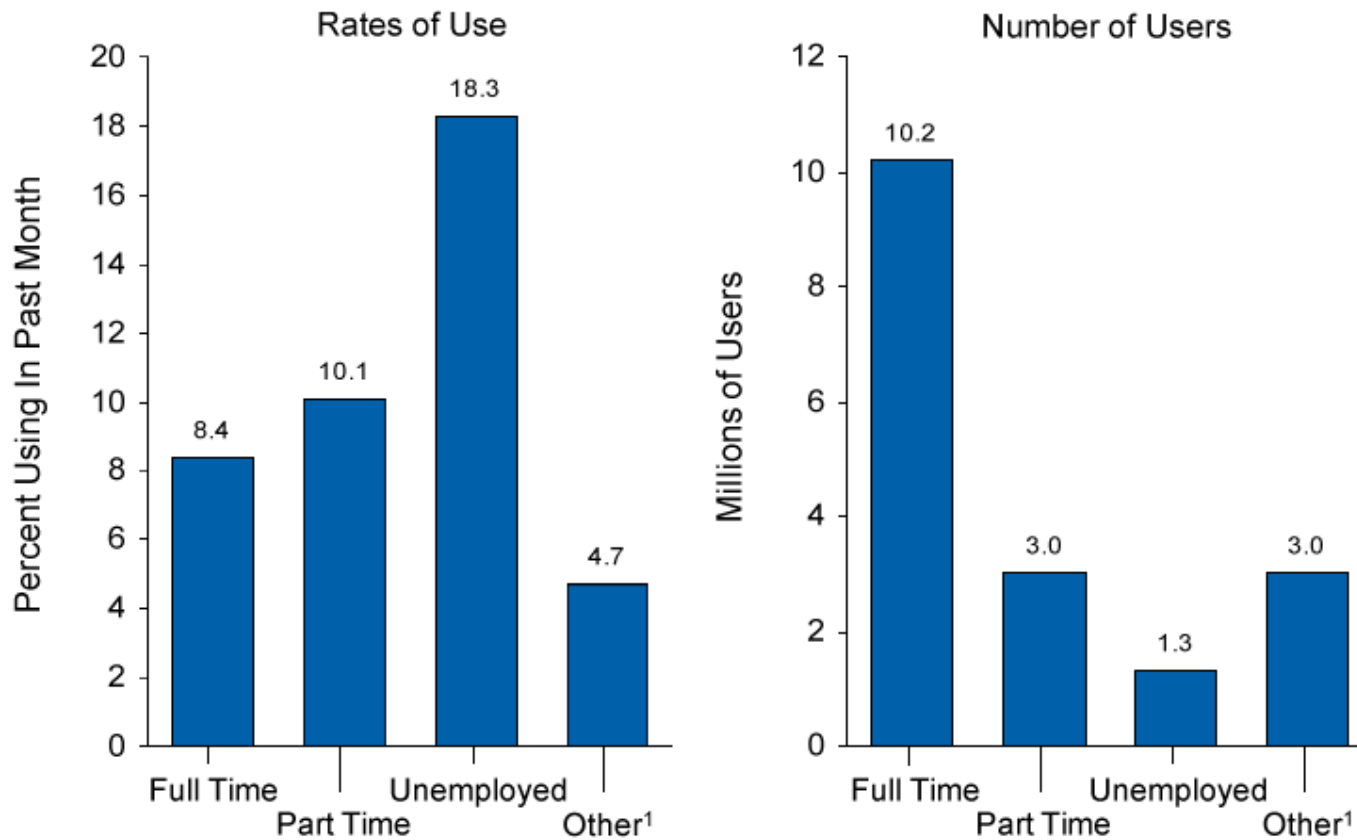
- **U.S. Population:** + 13%
- **Non-Controlled Drugs:** + 57%
- **Controlled Drugs:** + 154%
  - **Opioids:** + 222%
    - **Hydrocodone:** + 376%
    - **Oxycodone:** + 380%
  - **Benzodiazepines:** + 49%
  - **Stimulants:** + 369%

# 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”

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

# 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.