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CDC Guideline Impact

New Opioid Guidelines a Powerful Step in the Right Direction

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A Mitchell Whitepaper

"TACKLING **OPIOID ABUSE** IS AS IMPORTANT AS COMBATING THE THREAT OF TERRORISM."

- President Obama

Speaking to The National Rx Drug Abuse & Heroin Summit, 03.29.16

There were a record number of drug-related deaths in 2014 and 61% were from some kind of opioid.

This startling statistic from the U.S. Centers for Disease Control and Prevention (CDC) was a wake-up call to the nation in conjunction with the White House's announcement of $1.1 billion in funding measures to address prescription opioid abuse including opioid prescriber training and a Prescription Drug Monitoring Program expansion to 49 states.

As part of this plan, the CDC has finally released new guidelines for the prescribing of opioids for chronic pain. These guidelines provide clear recommendations for treating physicians that prior to now have been ambiguous at best.

Opioid medications represent a significant cost to the Property and Casualty (P&C) industry. The direct cost of these drugs as well as the indirect cost associated with poor outcomes due to overuse, misuse, and abuse of opioid medications is significant – roughly estimated at $6 billion annually in the Workers Compensation (WC) market alone.

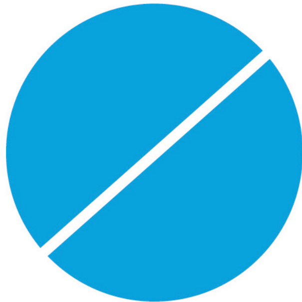
This article will review the history of opioid prescribing in America, provide an overview of the CDC opioid guidelines, and discuss the potential impact that guidelines will have on the P&C Industry.

Injuries and Pain

Most prescription drug expenditure in the P&C industry is associated with the treatment of automobile injuries and injuries occurring at work (workers' compensation (WC)). Due to varying state regulations and policy limits in the auto market, definitive numbers for overall drug costs are difficult to obtain. In the WC market, it is estimated that well over $6 billion is spent on prescription drugs on an annual basis, representing approximately 19% of overall medical cost.

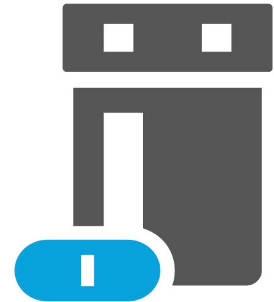
Drugs for the treatment of pain associated with injury are, not surprisingly, the most commonly prescribed (more than 50% of the time). Medications employed to treat pain include Non-Steroidal Anti-inflammatory Drugs (NSAIDS), opioids, and various other drug classes focused on treating neuropathic (nerve related) pain such as antidepressants, anti-psychotics, and anti-epileptic drugs. NSAIDS, such as ibuprofen and naproxen, are effective in treating pain, are not addictive, have the added benefit of reducing inflammation often associated with physical injury, and have been considered the first line choice for pain therapy for some time.

Pharmaceuticals in Workers' Compensation



$6B
Spent in WC on Prescription Drugs

50%
For Pain Management



70%
Of Those Are Opioids

Despite not being first line therapy for the treatment of pain, opioids are commonly prescribed for newly injured individuals. Approximately 70% of pain drugs prescribed are opioids representing almost a third of overall prescriptions. Individuals using opioids over an extended time may experience tolerance, meaning a higher dose is needed to obtain the same level of pain relief. This often leads to escalating doses of opioid over time. Higher doses for extended periods are associated with higher rates of dependence, higher rates of addiction, poor health outcomes, and significantly higher claims costs. An opioid addicted person will experience withdrawal symptoms when the prescribed dose is significantly reduced or stopped by the prescribing physician.

Quiting Is Not Easy

Withdrawal symptoms may be extremely uncomfortable and include:

- Low energy, irritability, anxiety, agitation, insomnia
- Muscle aches and pains
- Abdominal cramping, nausea, vomiting, diarrhea
- Hot and cold sweats, goose bumps
- Runny nose, teary eyes

The intense desire to avoid withdrawal symptoms can lead to drug seeking behavior outside of a patient / prescriber relationship - namely purchasing prescription opioids on the street.

Opioid Prescribing - Déjà vu…Again

Before the mid 1980's, physicians were reluctant to prescribe opioids, especially for chronic pain. The prevailing thought was that opioids often lead to addiction and turn patients into drug seeking addicts. There began to be a shift in the perception of opioids throughout the end of the 1980's as a viable solution for the treatment of long-term, chronic pain.

Although several factors contributed to the rising support of opioid use, many researchers point to Russell Portenoy as one of the driving forces in legitimizing opioid use for chronic pain. In 1986, Portenoy was co-author of "Chronic Use of Opioid Analgesics in Non-malignant Pain: Report of 38 Cases," published in the peer reviewed journal Pain. Portenoy advocated for opioid use and attempted to minimize concerns of the medical community by stating that less than 1% of patients prescribed opioids for chronic pain become addicted.

Pharmaceutical companies such as Purdue Pharma (manufacturer of OxyContin®), Endo (manufacturer of Percocet®), Cephalon (manufacturer of Actiq®) provided millions of dollars in grant funding to Portenoy's programs. In a Wall Street Journal interview in 2012, Portenoy conceded that no studies support the effectiveness of opioids in the treatment of chronic, non-cancer related pain and that the risk of addiction was actually greater than he had previously stated.

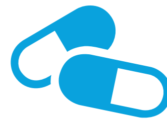
Pharmaceutical companies are also played a role in legitimizing opioid use for chronic pain. Advertising by drug manufacturers helped to convince physicians that chronic opioid therapy posed little risk for their patients. In 2007, Purdue Pharma pled guilty to misleading prescribers, the public and federal regulators about the abuse potential and addiction risk of its blockbuster long-acting opioid, OxyContin. Purdue Pharma was fined $600 Million dollars. In addition, three former executives also plead guilty to the charges with fines totaling $34.5 million dollars.

By the time the true risk of abuse and addition was realized, the liberal prescribing of opioids in American had reached epic levels.

The Scale of the Epidemic

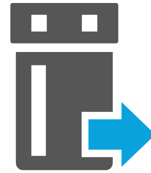
From 1999 to 2008, overdose death rates, sales and substance use disorder and treatment admissions related to prescription pain relievers all increased in parallel.

The overdose death rate in 2008 was nearly four times the 1999 rate; sales of prescription pain relievers in 2010 were four times those in 1999; and the substance use disorder treatment admission rate in 2009 was six times the 1999 rate.[2]



Doubled

Opioid Prescribing Rates for Adolescents & Young Adults 1994-2007[1]

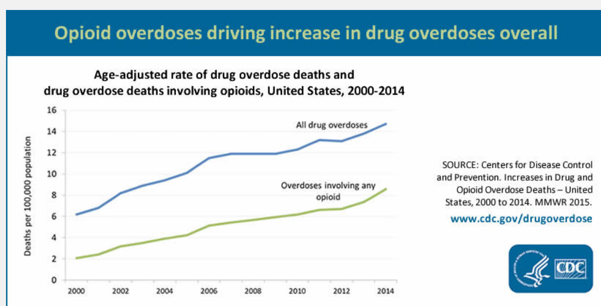


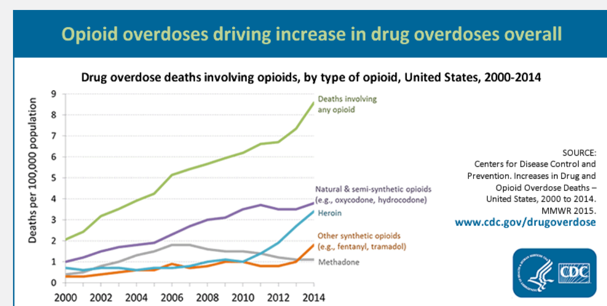
259 Million

Prescriptions Written for Opioids in 2012 = 1 Bottle Per US Adult [3]

CDC Data Shows Dramatic Trends

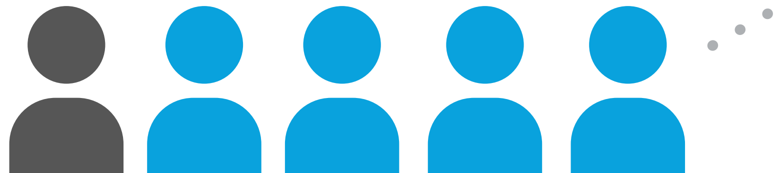
An escalating street price of prescription drugs on the black market combined with a relatively cheaper heroin price has ignited a nationwide heroin epidemic.





⅘ New Heroin Users Started with Opioids

Heroin is cheaper and easier to get



- As a consequence, the rate of heroin overdose deaths nearly quadrupled from 2000 to 2013.
- During this 14-year period, the rate of heroin overdose showed an average increase of 6% per year from 2000 to 2010, followed by a larger average increase of 37% per year from 2010 to 2013.[4]
- 94% of respondents in a 2014 survey of people in treatment for opioid addiction said they chose to use heroin because prescription opioids were “far more expensive and harder to obtain.”[5]

CDC Guidelines for Prescribing Opioids for Chronic Pain

It was therefore in March of 2016, the CDC published guidelines for prescribing opioids for chronic pain. The guidelines apply to adult patients with chronic pain (longer than 3 months) and do not apply to patients receiving cancer treatment, palliative care, or end-of-life care. A high level summary of the main components of the guidelines include:

Summary of Guidelines
Opioids are not first-line or routine therapy for chronic pain
Establish and measure goals for pain and function
Discuss benefits and risks and availability of non-opioid therapies with patient
Use immediate-release opioids when starting (not OxyContin, MS Contin, or fentanyl patches)
Start low and go slow. Carefully assess risks when prescribing over 50 morphine milligram equivalents/day and avoid dosing over 90 morphine milligram equivalents/day.
When opioids are needed for acute pain, prescribe no more than needed. Do not exceed a 3 days or less, rarely greater than 7 days is needed.
Do not prescribe ER/LA (OxyContin, MS Contin, or fentanyl patches) opioids for acute pain
Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed
Evaluate risk factors for opioid-related harms
Check PDMP (Prescription Drug Monitoring Programs) for high dosages and prescriptions from other providers
Use urine drug testing to identify prescribed substances and undisclosed use
Avoid concurrent benzodiazepine and opioid prescribing
Arrange treatment for opioid use disorder if needed

Potential Impact of Guidelines on WC and Auto Casualty Markets

With prescription drug costs comprising approximately 19% of total medical costs in WC, it is worth insurers looking at drugs from both a health and a financial perspective. Most of the drug cost in WC and auto casualty is driven by opioid prescribing for the treatment of chronic pain. Frequently, pain medications for these claimants can run thousands of dollars per month.

Much of the dangerous chronic opioid use in chronic pain is avoidable early in the claim, during the acute phase shortly after injury. By supporting physicians to follow guidelines that are better for the patient such a 3-day acute prescriptions or choosing a non-addictive option can help the patient enjoy a healthier recovery and benefit the overall claim.

The CDC guidelines are appropriately focused to address the high risk use of opioid therapy. Pharmacy Benefits Managers (PBMs) in the P&C industry have known for years that higher doses of opioids, early use of long-acting opioids, and lack of effective monitoring with tools such as urine drug monitoring, are risks that correlate with high future drug spend.

Examples of CDC Literature

Summary

These Guidelines are a welcome addition and are an excellent opportunity to look at your current programs and policies. A good first step in managing opioids is to have a robust and connected system that gives you visibility, formulary control and early intervention opportunities as soon as possible.

Systems should be in place to flag/alert claims handlers immediately for prior authorization control, support step therapy, and let them to appropriately manage the claim with access to prescription data. Some systems are also utilizing risk scoring reports and predictive modeling to identify patterns of behavior such as 'doctor-shopping' that are warning signs of unhealthy behavior.

Finally, if claims are identified that require intervention, policies and programs should be implemented that should include multidisciplinary groups and abuse prevention strategies and plans. A triage and support team can have a positive impact on the overall claim cost but more importantly on the life of your claimant. Our industry is on the front lines of the opioid abuse epidemic. However, with thoughtful guidelines from leaders and continued implementation of best practices, we can truly empower better outcomes for all.

For more information on Mitchell **ScriptAdvisor**,
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