



# Opioids Wreak Havoc on Workers' Compensation Costs

August 2012 • Lockton Companies

## I OVERVIEW

Prescription drug abuse is the nation's fastest-growing drug issue, an epidemic affecting all of society and workers' compensation in particular. **Prescription opioids are presently the number one workers' compensation problem in terms of controlling the ultimate cost of indemnity losses.** There has never been a more damaging impact on the cost of workers' compensation claims from a single issue than the abuse of opioid prescriptions for the management of chronic pain. Nationally, an estimated 55 to 86 percent of all claimants are receiving opioids for chronic pain relief. However, the overwhelming consensus of evidence-based medicine does not support its long-term treatment protocol outside of very specific cases, most of which involve end-stage cancer treatment.

The aggressive prescribing of opioids to treat chronic pain is a relatively new phenomenon in workers' compensation's 100-year history. Overdose deaths from prescribed painkillers have increased 300 percent since 1999, when the nation experienced approximately 15,000 fatalities, more than cocaine and heroin combined, and they originate from prescriptions, not home labs. The misuse and abuse of prescription painkillers was responsible for more than 475,000 ER visits in 2009, doubling in just five years<sup>1</sup>. Employers' workers' compensation claims are caught right in the middle of the fray.

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Pharmacy is growing disproportionately to total medical costs. Pharmacy only accounted for about 2 percent of

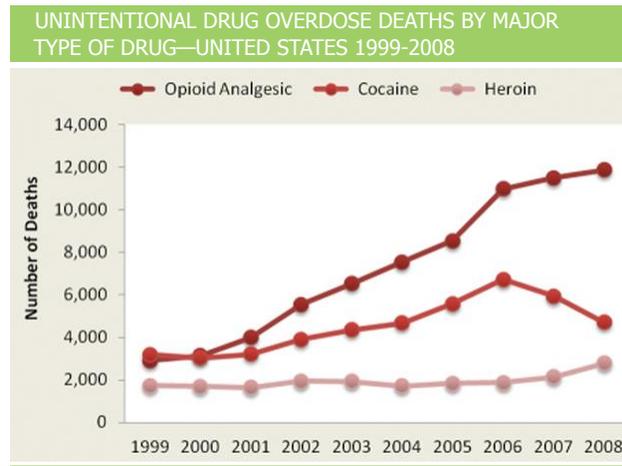


Figure 1. Source: National Vital Statistics System, Slide courtesy of National Institute on Drug Abuse

medical in 1990, grew by 400 percent by year 2001 and almost another 90 percent by 2010. Today, on average, workers’ compensation prescription drugs account for 19 percent of total medical spend, which equates to slightly less than 11 percent of “ultimate developed” total incurred claim costs<sup>2</sup>. Opioids themselves account for an average of 25 percent of that pharmacy spend, and 35 percent or greater for claims over three years old. But those are just the direct costs. The indirect impact on indemnity costs is equally dramatic. Claimants on long-term opioid care, greater than 90 days, are not typically going back to work, have become tolerant or even dependent on the drugs, and suffer a multitude of associated illnesses and debilitating side effects secondary to the drugs’ use. The Medicare Set-Aside (MSA) calculations become heavily burdened by the chronic use of these drugs of nearly indefinite duration. These losses become exceptionally expensive and very difficult to settle.

Combining the direct and indirect costs of an undermanaged pharmacy benefit program and its impact on indemnity losses caused by longer temporary total disability (TTD), greater permanency ratings, and the treatment of comorbidities, we are looking at total pharmacy representing somewhere in the neighborhood of 20 to 30 percent of workers’ compensation ultimate developed claims costs. Pharmacy is no longer of minor importance in the management of workers’ compensation claims.

## II WHAT DO PHARMACY BENEFIT MANAGEMENT (PBM) STEWARDSHIP REPORTS REALLY TELL YOU?

### Most Employers Do Not Know What They Don’t Know

The crisis is made worse by the fact that most, if not nearly all, employers simply don’t know what they don’t know about workers’ compensation pharmacy and how seriously impactful this lack of knowledge is to their bottom line. Pharmacy Benefit Management (PBM) stewardship reports are typically not quantifying the severity of the problem when they do not represent both direct and indirect savings.

Ask most CFOs and corporate risk managers how much influence prescription drugs have on their cost of claims, and the answer will typically be “a very small percentage.” They will, however, state that they are saving large sums of money from discount pricing, as communicated by their third-party administrator. Typical pharmacy stewardship reports are inadequate and not representative of the complete picture. They tell the favorable money-saving discount story that

the employer is anxious to hear. In nearly all cases, there is an absence of factual data on pharmacy clinical utilization or absence thereof (the control of inappropriately prescribed medications, unreasonable dosage, duration of use, etc.). There is usually too much fluff and not enough substance for effective employer decision making. Remember, managed care reports represent only those prescriptions processed through the pharmacy benefit management provider, which may only be between 50 to 60 percent of the total pharmacy spend. We have yet to see a stewardship report include a slide on “Total Estimated Losses in Net Savings through PBM Leakage.” The cost of leakage will normally be greater than the PBM savings from network discounts, as leakage represents the absence of clinical utilization controls.

Without near-term clinical intervention into a claim involving both early and high-dose prescribing of opioids, the savings from drug repricing is but a fraction of the total potential savings in ultimately developed total claims costs.

### So What Is the Problem?

The problem is that executive information provided to employers by their TPAs and managed care organization’s (MCOs) is falling short of telling the whole story. We have found that TPAs simply do not know what the employer is actually spending on pharmacy. The reason is that between 40 and 50 percent of pharmacy is dispensed and billed by physicians, or the claimant filled their prescriptions without a pharmacy card, and the pharmacy sold the script to a third-party, who subsequently bills the TPA. In these cases, the

paper bills seldom go through the pharmacy benefit management company, where formulary controls and clinical edits may be applied. There are some exceptions out there, with TPAs having the sophistication to extract pharmacy from physician-embedded billings and out-of-network paper bills and consolidate that information into the claimant’s pharmacy file. They are, however, few in number. When combined with consensus data, our marketplace data as a whole suggest a mere 60 percent of pharmacy is running through PBMs. CorVel Corporation, a TPA that integrates its bill review and pharmacy platform, in its exhibit below, “visibility” refers to the actual identification of all pharmacy, including paper bills. Penetration only refers to the percent of total pharmacy going directly through the PBM. Employers whose TPAs report penetration in the high 80s or greater should view that as a big red flag and ask for proof.

Physician dispensed drugs cost anywhere from 10 to 300 percent more when prescriptions are not run through the PBM<sup>3</sup>.

Employers must consider that 40 to 60 percent of pharmacy without point of sale controls is very costly. Has your TPA or MCO designed a specific program to address this leakage?



## Generic vs. Brand Penetration Report

When evaluating the effectiveness of a PBM to increase savings through the use of generic substitution, there are three significant reports that a TPA, carrier and other payors must consider: **1) generic substitution;** **2) generic efficiency;** and **3) upcoming patent expiration dates.** Employees should specifically understand these reports and what they do and do not represent.

## The PBM Penetration Report

PBM Penetration reports, also known as retail pharmacy Network Utilization reports, are crucial to evaluating the performance of a workers' compensation PBM; if pharmacy is not running through the PBM, the employers simply will not realize the savings from their structured program.

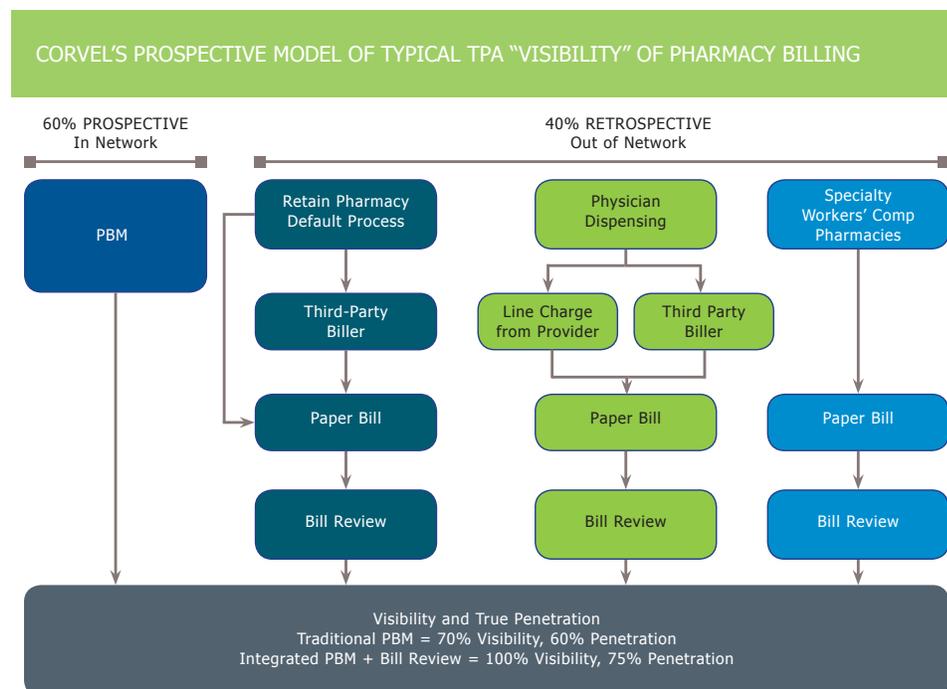
PBMs have varying methods of encouraging this utilization, but it is only through a measure of Network

Penetration that these methods can be proven to work. In order to perform this measurement, the TPA typically must provide the PBM with copies of its out-of-network or paper bills, so that the PBM may use these to calculate its degree of success at promoting network participation.

## Example Payor with \$10M in Annual Drug Spend at a Fee Schedule

	PBM 'A'	PBM 'B'
Effective discount rate	-15%	-10%
Calculated Savings off fee schedule	\$1,500,000	\$1,000,000
Actual penetration rate	50%	90%
Actual savings off fee schedule	\$750,000	\$900,000

It is also crucial that a TPA understands how competing PBMs define what is included in the measure of Network Penetration. Therefore, the following questions should be asked of your TPA:



1. Are first-fill prescriptions included in the calculation?
2. Are prescriptions that are not actually processed online ever considered to be “network” transactions?
3. What prescriptions are excluded from the calculation, and under what circumstances?

### Clinical Savings Report

It is a poorly kept secret that the more drugs that are processed, the more money a PBM makes. In fact, the business model for both pharmacies and PBMs is dependent upon the sale of drugs. Consequently, the PBM industry has been compared to the “fox watching the henhouse” when it comes to the curtailment of prescribing, especially with regard to opioids. Hence, this is truly a case of “buyer beware” when it comes to the evaluation of PBMs. If the expectation is to simply provide a discount off of fee schedule, then there are plenty of providers that can offer an efficient processing platform at a low-cost model (keeping in mind the statements in the previous section regarding network penetration). On the other hand, if the expectation is for the PBM to provide the payor with the tools necessary to curtail over utilization of prescription drugs and to identify potential fraud, waste and abuse via a clinical pharmacy program, then both the program and its measurement must be clearly defined and understood.

### III THERE IS A CRISIS IN OPIOID PRESCRIBING PROLIFERATION AND THE SUBSEQUENT MISUSE AND ABUSE OF THESE OPIOIDS

#### Opioids Influence on Impacting both Pharmacy and Overall WC Costs?

The financial impact of pharmacy, especially opioids and opioid/acetaminophen combination analgesics, is

“Workers prescribed even one opioid had average total claims costs four to eight times greater than claimants with similar claims who didn’t get opioids.”

becoming clearer as new research data is being published at an increasing rate. Previously, pharmacy was only looked at in terms of its percentage to total medical spend. As we have addressed thus far, that percentage has been communicated as artificially low due to substantial underreporting of total filled prescriptions through the PBM.

Its total impact on claims is just now being estimated from large population data. Potentially, the author believes savings from combining (1) the reduction in overexpenditure in total pharmacy, (2) the potential reduction in costs of treatment for addiction recovery and morbidities secondary to opioid use, and (3) the reduced number of disability days and permanency ratings from those claimants on long-term pain management, and (4) proactive management of Medicare Set-Aside settlements, could potentially equate to 8 to 15 percent of total incurred costs.

That’s a powerful incentive to gain control of pharmacy.

The recent Hopkins-Accident Research Fund Study (2012) <sup>4,5</sup> found “workers prescribed even one opioid had average total claims costs four to eight times greater than claimants with similar claims who didn’t get opioids.” Other research has documented similar results <sup>6,7</sup>.



There are a multitude of costs directly linked to prescribed opioids. Many can occur after only a short-term use following an injury and then increase in frequency and severity as the claim ages. These increased costs can be summarized into the following categories:

- ❖ Increased frequency of emergency room visits from overdose
- ❖ Death
- ❖ Addiction treatment
- ❖ Comorbidities (illness)
- ❖ Abuse and misuse of prescribed drugs

It is estimated that about 35 percent of patients receiving long-term treatment with opioids may be addicted<sup>9</sup>. Addiction is individual in nature. It can affect some patients after only a few weeks and not others after many years of chronic use.

Medical research suggests opioids, as a pain management tool, can only reduce a patient's pain by 30 to 40 percent. Therefore, it is common for opioids to be prescribed in combination with other, non-opioid, analgesics such as acetaminophen.

Research from 1998-2000 showed acetaminophen was the leading cause of acute liver failure in the United States<sup>8</sup>. Extra Strength Tylenol was reformulated just for this reason. Yet, it is not unusual to find numerous claims involving the long-term use of acetaminophen at or well exceeding maximum FDA recommended dosage. Combine the daily intake of acetaminophen at high levels with alcohol consumption, which would not be uncommon, and liver toxicity increases proportionally. Liver failure may result in the need for liver transplants for which the employer is responsible.

The list of comorbidities secondary to opioid therapy seems endless. The following are the most typical side effects and are frequently found with those on long-term therapy<sup>9,10</sup>.

- ❖ Respiratory depression (very common)—slow, shallow breathing causing sleep apnea, which can result in heart attack and stroke.
- ❖ Hyperalgesia (the patient becomes more sensitive to pain)
- ❖ Serious fractures
- ❖ Depression
- ❖ Infertility
- ❖ Decreased libido
- ❖ Erectile dysfunction
- ❖ Bowel obstruction
- ❖ Chronic constipation
- ❖ Immunosuppression
- ❖ Myocardial infarction



- ❖ Tooth decay (from dry mouth)
- ❖ Testicular atrophy
- ❖ Chronic obstructive pulmonary disease

Each of the above disorders becomes secondary to the prescribing of drugs for pain relief and in and of themselves become compensable medical conditions, rapidly increasing the medical and indemnity cost of claims. These expenses are not necessary in the treatment of most workers' compensation claimants.

If the employer and TPA understand and integrate countermeasures into their claims management program to address the following facts, significant improvement can be experienced with claims outcomes<sup>11</sup>

- ❖ Evidence of long-term efficacy of chronic noncancer pain ( $\geq 16$  weeks) is limited and of low quality. Opioids are effective for short-term pain management. But for many patients with chronic pain, analgesic efficacy is not maintained over long time periods.
- ❖ With daily opioid use, physical dependence and tolerance can develop in days or weeks.
- ❖ Successfully tapering chronic pain patients from opioids can be difficult, even for patients who are motivated to discontinue opioid use.
- ❖ Estimates vary. Between 4 percent and 26 percent of patients receiving chronic opioid therapy have an opioid use disorder.
- ❖ Opioids have significant risks besides addiction and misuse. These risks include respiratory depression and unintentional overdose death.
- ❖ No randomized trials show long-term effectiveness

of high opioid doses for chronic, noncancer pain. Many patients on high doses continue to have substantial pain and related dysfunction.

- ❖ When treating chronic pain, dose escalation has not been proven to reduce pain or increase function, but can increase risk.

### The Impact of Opioids on Pharmacy Spend on Claims Open Greater Than 2-3 Years

A study by the NCCI in 2009 determined that although opioid use declined over time, its use could continue for many years. A more recent study<sup>12</sup> found that high use of opioids in the first quarter following an injury is related to that injured patient continuing to receive opioids in subsequent quarters. One conclusion that may be drawn from this study is that early intervention to ensure guideline compliance may also lead to a decrease in use in subsequent years.

### The Impact of Pharmacy, and Opioids in Particular, on Medicare Set-Aside Calculations and Settlements

The 80:20 "Pareto's Rule" applies to many things, including workers' compensation. Approximately 20 percent of a claim's medical cost is for pharmacy, while the claim is open, and 80 percent for medical expenses. When the claim moves to the closure stage and a Medicare Set-Aside (MSA) is required, this percentage is inverse; 80 percent of the MSA cost is pharmacy, and the numbers can



be staggering, so staggering that many self-insured companies want to leave the medicals, or at least the pharmacy, “open” and settle the indemnity.

CMS regulations coupled with the increased use of opioids in older claims (up to 40 percent of medical cost according to the NCCI’s 2011 data) are the major cost drivers. An effective PBM program will apply clinical protocols to get ahead of the claim and ensure that therapy is within guidelines and cost-effective measures are in place well before time for an MSA.

#### IV HOW SHOULD CHRONIC PAIN PATIENT CLAIMS BE MANAGED?

##### First, Make Sure All Is As It Appears

The hydrocodones, oxycodones, and morphine sulfates seen time and again with long-term claims may not always be actually taken by the patient, may be taken in higher dosages than prescribed or even taken alongside illicit substances. The Workers’ Compensation Research Institute, in a study involving 17 states, found that fewer than 7 percent of treating doctors conduct baseline and periodic urine drug screens. That number has apparently doubled in recent years but is still a very low percentage given the following concurrent research facts:

- ❖ 71 percent of workers’ compensation claimants on chronic opioid therapy greater than three months are not taking their pain medication as prescribed due to misuse or abuse<sup>13</sup>.
- ❖ 38 percent of patients were found to have no detectable level of prescribed medication; 29 percent had nonprescribed medication; 27 percent had drug levels higher than expected; 11 percent had

illicit drugs. (Based on a sample of 939,000 drug screens)<sup>14</sup>

Does your PBM/TPA ensure all opioid-prescribed claimants are being routinely drug tested?

##### What Is the PBM’s Role?

Ideally a PBM will have access to all data involving pharmaceuticals, which includes not only those prescriptions processed online via the PBM but also those prescriptions processed through a third-party biller, processed via a group healthcare PBM (and available through the states’ PDMP databases), or dispensed by a physician or delivered via an implantable drug delivery device, such as an intrathecal morphine pump. Each PBM may have different methodologies to obtain this data, but the end result should be to provide you with a complete picture of what your claimants are receiving in terms of number of opioids, number of physicians, total dosage, duration, etc. Only with this kind of 360-degree view can your PBM evaluate guideline compliance.

##### What Is the Adjuster’s Role?

There is no short supply of evidence-based medical treatment guidelines for the long-term treatment of chronic pain for adjusters to follow<sup>15</sup>.

The adjuster’s primary role is to stay on top of claims with prescribed opioids, either within the first 10 days of an acute injury or where these opioids are being prescribed beyond 45 days. What this translates to is:

- ❖ Not overriding formulary denials without specific justification and seeking medical guidance from internal professional staff to assist in making override decisions.
- ❖ Engage the PBM as often as necessary if medical reports show the onset of illnesses not normally associated with workers' compensation claims and are typically side effects from prolonged opioid use.
- ❖ Follow PBM recommendations for engaging the treating doctor in modifying prescribing patterns.
- ❖ Ensure physician-patient agreements are in place where opioid use extends beyond 30 days.
- ❖ Encourage the treating doctor to make use of tools for assessing the risk of opioid addiction in advance of prescribing opioids.
- ❖ Ensure the opioid prescribing doctor conducts a baseline urine drug test, where opioids are being prescribed beyond 30 days, and for patients under age 65, periodic, unannounced random urine drug tests are conducted.
- ❖ Only approve referrals to qualified pain specialists.
- ❖ Above all else, engage and challenge the treating doctor as to the validity of continuing opioid prescribing, where periodic medical reports do not indicate progress in work and life skills functions and reduction in pain.

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