The Ongoing Challenge of Pain Medications

Jan E. Berger, MD, MJ—Editor-in-Chief
President & CEO
Health Intelligence Partners

Let's take a moment and think back to 2006. That was the year that Medicare Part D went into effect, and Part D providers were challenged to create pain management programs, which were required by the Centers for Medicare & Medicaid Services as part of the program. Now let's fast-forward 9 years to 2014. Payers—both public and private—continue to struggle to address this issue.

I am often asked to help my clients identify ways to address problems that they themselves are unable to address. I begin these consulting assignments by first making sure that there really is a problem to solve. In this case, there is.

The next step is to benchmark previous attempts to address the problem; analyze success and/or failure attributes; and the final step is to identify new opportunities to address the problem.

So let's take a moment to ask ourselves—is there a problem with inappropriate prescribing of pain medications? The Centers for Disease Control and Prevention (CDC) points out that in a 9-month period in a small Kentucky community, a 53-year-old mother, her 35-year-old son, and 7 others died after overdosing on pain medications they received from a Florida pain clinic. The CDC found, by looking at 2007 statistics, that prescription pain medications killed twice as many people as cocaine and 5 times more people than heroin. Further statistics from Columbia University showed that opioid addiction tripled over a 10-year period, with 0.3% of the population being affected. Drugs most commonly abused are benzodiazepines and opioids.[1]

One important issue to consider is that there are multiple reasons for people to take pain medications—not all prescribing of pain medication is nefarious. In fact, we as a healthcare system are often underprescribing pain medication. This may be due to fear of being perceived as an overprescriber of these medications. But more often than not, it is due to the fact that providers have limited education on pain management, and that the physician and the patient have not found the correct pain management solution that addresses the very real pain that the patient may be experiencing.

The next question we have to ask ourselves is, "Should we care about this issue?" I contend that we should care. The problem of inappropriate prescribing and utilization of these medications carries both human consequences—with more than 22,000 deaths in 2010—and financial consequences. A report from the Tufts Health Care Institute found that insurers, both public and private, spend approximately $72 billion annually on inappropriate pain medication use and diversion.[2]

The real story behind the statistics, though, often varies. Often, physicians believe they are appropriately prescribing pain medication, but they are unaware that a patient is doctor shopping. On the other end of the spectrum is the physician that purposefully prescribes inappropriate and dangerous amounts of pain medication in order to create a flow of patients who are seeking easy access to pain medications.

As I stated above, the second step in looking to create an effective solution is to look at present or past activities that focused on the problem. Initially, many health plans and pharmacy benefit managers (PBMs) addressed the problem through a single-pronged approach—either proactively through quantity limits and refill restrictions or retrospectively through claims analysis. These solutions often did not fully address the problem for a variety of reasons: systems did not communicate with each other, leaving data gaps; and patients and physicians learned to game the system in order to meet their needs.

More recently, all 50 states have either created prescription drug monitoring programs or have some type of legislation that discusses the need for such programs. Unfortunately, the degree to which these programs are actively used varies greatly.

So we know we have a problem, and that past attempts at addressing the problem have fallen short. The final question, then, needs to be, "What can we do in order to be more successful in curtailing this problem of inappropriate prescribing of pain medications?" I believe

that the first step is to engage all stakeholders in this discussion. This is a very important foundational step, and unless we do this, we are resigning ourselves to another "partial" solution. I believe that up until recently, payers have taken a more passive role in addressing the problem. It could be that they do not have an understanding of the depth or implications of the problem. Another barrier to success is one that I have seen quite often, which is the payer saying there is little they can do. This generally means that they have not taken the time to really think about the options.

To conclude, there are 10 steps that we need to take if we want to start seriously addressing this issue:

1. Gain a better understanding of pain and pain management.
2. Make sure that providers are given greater understanding of how to address and treat pain within their populations.
3. Make sure that there are legitimate pain centers available for those patients whose pain is not controlled through first-line resources. We do not want to create people who become addicted to pain medications due to a lack of appropriate expertise in the field of pain management.
4. Work with all stakeholders, including governmental entities and the public, to create systems that help identify patients with potential substance abuse issues.
5. Create plan designs and incentives for prescribers and pharmacies to actively participate in an effective system.
6. Encourage health plans and PBMs to work with physicians and provider organizations to align goals and agree to take appropriate action when necessary. Plans are often reluctant to reach out to providers and discuss these situations. I understand that this type of outreach can be uncomfortable, as I have had to do this a number of times. If we all agree—and this includes providers—that there is an issue, we should be able to get over our defensiveness and have productive conversations.
7. Create broad-based longitudinal data collection systems that can easily be accessed by everyone on the healthcare continuum on a real-time basis.
8. Require use of this data proactively, prior to a prescription being written, and then retrospectively, through data analysis.
9. Have systems within e-prescribing programs and electronic medical records that would require physicians to monitor these data prior to a prescription being finalized.
10. Utilize pharmacies as a second-level "safety net" for the identification of prescriptions that should not be filled.

Where there are gaps in successful solutions, entrepreneurs can be found trying to address the issue. This is the case in pain management. Interestingly, I am seeing a rise of new companies, such as Sterling Labs and Millennium Labs, that work with payers to help to identify potentially inappropriate prescribing patterns. I will be interested to see if these companies can help payers and society as a whole to address this significant problem.

REFERENCES

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