Curbing Overprescription of Painkillers With Interstate Data Sharing

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In 2013, the Centers for Disease Control and Prevention (CDC) brought national media attention to the overprescription of opioids by physicians, referring to it as a "national epidemic." The CDC reported in *Injury Prevention & Control: Prescription Drug Overdose* that the overall pain reported by Americans has not increased, but painkiller prescriptions have quadrupled between 1999 and 2013. Deaths also have quadrupled since 1999. The CDC further noted nearly 2 million Americans reported abusing or being addicted to opioids in 2013. The most commonly abused drugs are hydrocodone (e.g., Vicodin), oxycodone (OxyContin), oxymorphone (Opana), methadone (especially when prescribed for pain), and benzodiazepines.

Steps to Reduce Abuse of Painkillers

Overprescription of opioids remains a pervasive problem in workers' compensation. Economists with the Workers Compensation Research Institute (WCRI) analyzed long-term opioid usage in 21 states and noted that narcotics comprised 3 percent of the cost of the shorter claims and 15 to 20 percent of all medical costs in longer-term claims. WCRI identified New York, Pennsylvania, and Louisiana as the states having the highest percentages of long-term opioid users.

Dr. Leonard J. Paulozzi of the CDC believes this newfound phenomenon may be "potentially more prevalent among the injured worker population," noting that the overdose rate is highest among middle-age workers. Dr. Paulozzi sees back injuries as the major reason that doctors are prescribing more painkillers for long-term use. Denise Johnson and Don Jergler, *Opioid Epidemic Plagues Worker's Comp*, Insurance Journal, May 17, 2013.

In the past couple of years, states took individual steps to curb the overprescription and abuse of painkillers. States adopted legislation including mandatory/voluntary drug monitoring programs, enforcement measures, and educational awareness for patients and prescribers. Legislation, however, varies greatly from state to state, and this disparity actually serves to thwart the state's goal of reducing overprescription.

Steps to Reduce Abuse of Painkillers

Ten key steps have been identified to increase awareness, provide education, and reduce overprescription and abuse of painkillers by the Robert Wood Johnson Foundation in *Prescription Drug Abuse*: 1) the existence of prescription drug monitoring programs (PDMPs), 2) mandatory prescriber use of PDMPs,

3) doctor shopping laws, 4) substance abuse treatment, 5) prescriber education required or recommended, 6) Good Samaritan laws, 7) support of rescue drug use, 8) physical exam requirement, 9) identification requirements, and 10) pharmacy lock-in programs.

None of the states have adopted all of the recommended policies. The majority of states fail to require basic controls such as mandatory prescriber use of a PDMP, patient identification, and patient/prescriber education. Forty-nine states have implemented PDMPs but participation—for the majority—remains voluntary. The U.S. Department of Justice Office of Diversion Control advises that 11 states (Alaska, Arkansas, Delaware, Georgia, Maryland, Montana, Nebraska, New Jersey, South Dakota, Washington, and Wisconsin) have enacted legislation to establish their own processes, but the respective programs are not fully operational. Missouri remains the only state without a PDMP.

The differences between state programs incentivize patients to cross state lines as they attempt to access multiple providers. For patients illegally seeking prescription medications, the obvious reason is to locate a jurisdiction that has no data on their prescription consumption. This is an unintended but predictable complication to the recommended reforms. Take three of the major metropolitan areas in the northeast United States—New York; Philadelphia; and Washington, D.C. Each is within 30 minutes of a state border. In New York, for instance, the I-Stop program (New York's PDMP) has reported significant success, but there is simply no data available for doctors to determine whether their patients are crossing state lines to seek treatment and/or medications in Pennsylvania, New Jersey, or Connecticut. Further, Alabama, Georgia, and Florida all have PDMP systems, but the states do not mandate prescribers to check or enter information into the system. California and Nevada have PDMPs, but California does not mandate prescriber use of its PDMP or require ID checks.

Effective State Legislation

The PDMP Center of Excellence at Brandeis University highlighted four states in *Mandating PDMP participation by medical providers: current status and experience in selected states* that implemented legislation that made a noticeable difference. In 2010, Florida regulated pain clinics and stopped providers from dispensing painkillers from their offices, and two years later, Florida saw a 50 percent decrease in oxycodone overdose deaths. In 2012, New York required prescribers to check the states' PDMP before prescribing Schedules II, III, and IV controlled substances, and one year later, it saw a 75 percent drop in patients' seeing multiple prescribers for the same drugs. Tennessee took the same action in 2012 and reported a 36 percent decline. Oregon required mandatory PDMP, designated methadone as a non-preferred drug for pain, and provided education to patients and prescribers. Oregon reported a 38 percent decline in poisoning due to prescription opioid overdose and a 58 percent decline in methadone poisoning.

The CDC report highlights that taking minimal step of requiring prescribers to use the PDMP results in significant decreases, yet the majority of states recommend

—but fall short of—mandating prescribers to use the PDMP. The simple lesson is that with more data at hand, doctors are better positioned to treat their patients and dispense pain medication. The effects that we are seeing state to state would seemingly indicate that the systemic loopholes being exploited by advantageous actors (be they patients or doctors) could be filtered out. The future success of these efforts likely relies on the effectiveness of the follow-up steps to be taken by each state.

The problem of overprescription in smaller systems like workers' compensation is compounded by the fact that these systems often demand that employers and insurance carriers subsidize the problem. In workers' compensation, the legal presumptions in favor of injured workers and their doctors can effectively eliminate a state workers' compensation agency from being a line of defense against this sort of abuse. Instead, the permissive design of these laws can compound the issues of prescription drug abuse. In order to address overprescription of opioids, states like New York and Washington should take the additional step of adopting medical guidelines aimed at limiting and controlling situations where opioid medications are prescribed.

Sharing Data With Bordering States

Ideally, all 50 states would adopt a mandatory model PDMP accessible to all treating physicians and seek to close loopholes potentially caused by concurrent laws and systems. A practical first step would be to allow each state to share data with bordering states. For example, New York would allow Pennsylvania, New Jersey, Vermont, and Connecticut access to its PDMP for informational purposes in exchange for reciprocal access to data.

Each state should also set out to review programs—like workers' compensation —to ensure consistency with the goals and measures taken in these reforms. The important development in these PDMP programs does not appear to be how harsh or comprehensive each state program is—but how much data is available to a treating physician.

Once that data is available, efforts to curb prescription medication abuse can shift from reforming unresponsive administrative systems to zeroing in on those who abuse and exploit these systems.

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