

PRESCRIPTION FOR PERIL

How Insurance Fraud Finances Theft and Abuse of Addictive Prescription Drugs



COALITION AGAINST INSURANCE FRAUD

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**INSIGHT
SERIES**



**Coalition Against
Insurance Fraud**

About the coalition...

Founded in 1993, the Coalition Against Insurance Fraud is a national alliance of consumer groups, insurance companies and government agencies fighting all forms of insurance fraud through advocacy, public outreach and research.

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ABOUT THIS REPORT

This report examines largely unreported and elusive aspects of the crime known as drug diversion: the role insurance fraud plays in financing this crime, and the high cost to health insurers and others. These victims include health and workers compensation insurers, employers, pharmacy benefit managers (PBMs) and taxpayer health insurance programs such as Medicare and Medicaid. Combined, insurers pay roughly 80 percent of a national prescription drug bill that is projected to total nearly \$230 billion in 2007.¹

This report highlights:

- The many factors that form what one expert calls America's "perfect storm" of prescription drug abuse;
- Various forms of drug diversion, the perpetrators, and diversion's increasingly severe societal consequences;
- The significant cost to insurance companies of some types of drug diversion, the insurance industry's relatively low attention paid to the problem, and the growing risk for insurers and other payers that fail to address this problem effectively;
- How law enforcement and other fraud fighters are combating drug diversion; and
- Recommendations about how third-party payers can take effective action on drug diversion, including its detection and prevention.

Prepared by The Mahon Consulting Group LLC, this report provides a crucial context for understanding the crime's impact on insurers. This report is not a scientific or statistical study, however, nor is it exhaustive. It is based on:

- Interviews or discussions with 23 special investigation units (SIUs) of insurance companies, other insurer and industry personnel and drug diversion experts, law enforcement and other government agencies;
- Profiling one large national insurer's prescription-related SIU caseload and diversion experience, and other insurers' responses to the overall claim cost of drug-seeking members;
- Presentations at the November 2006 Annual Training Conference of the National Association of Drug Diversion Investigators;
- Reviews of published literature and data about prescription drug use, and the abuse of controlled substances in the U.S.; and
- Review of drug-diversion criminal cases.

This report addresses the dark side of America's consumption of certain prescription drugs—the criminal activity involving their prescription, dispensing, and illegal sale and abuse. It avoids judging the value and effectiveness of specific drugs when prescribed and used properly. Rather, this report objectively assesses the impact on insurers of the diversion of addictive prescription drugs for illegal uses.

As with all insurance frauds, drug diversion is the exception and not the rule. This crime challenges the nation to fight diversion effectively, but without compromising the provision of legitimate and needed benefits.

EXECUTIVE SUMMARY

America faces an explosive epidemic involving the illegal use of legal drugs, usually highly addictive painkillers. The crime wave is called drug diversion. It involves the abuse, and illegal obtaining and resale of prescription drugs on the black market.

Prescription drug diversion is one of the defining drug crimes in America today. It has few equals for sheer size, speed of growth, resistance to deterrence, harm to people from so many strata of society, and large costs to insurers. Overdoses, deaths and injuries continue growing at an alarming rate. In fact, more than 20 million Americans—nearly 7 percent of the population—will abuse prescription drugs in 2007, based on the National Survey on Drug Use and Health.

Drug diversion's alarming spread over the last five years is well-chronicled. This white paper breaks new ground by revealing a major unexplored aspect:

Insurance fraud is the main financier and enabler of drug diversion. Even so, few health insurers understand the pivotal role insurance fraud plays in a diversion epidemic that costs insurers up to \$72.5 billion a year.

More specifically:

- Swindlers and drug abusers obtain the bulk of their illicit prescription narcotics through fraudulent insurance claims for bogus prescriptions, treating phantom injuries and other illegal deceptions;
- Drug diversion drains health insurers of up to \$72.5 billion a year, including up to \$24.9 billion annually for private insurers. The losses include insurance schemes, plus the larger hidden costs of treating patients who develop serious medical problems from abusing the addictive narcotics they obtained through the swindles;
- Some health insurers are responding decisively, but far too many don't know if they even have a drug-diversion problem, let alone much it costs them annually. Drug diversion simply hasn't registered on most insurer radar screens as a serious fraud problem, financial drain or deadly threat to their plan members. Insurers generally are ill-prepared to stanch the large flow of bogus claims that allow drug diversion to flourish; and
- Insurers are potentially vulnerable to enormous liability lawsuits for failing to reasonably prevent fraud schemes that kill and injure people addicted by diversion schemes. Drug manufacturers and pharmacists already face such lawsuits. Insurers could be next.



This report reviews the vast dimensions of America's drug-diversion epidemic. It also explores the large role that insurance and insurance fraud play. Finally, it reveals practical solutions for combating this troubling problem. At bottom, loosening the grip of drug diversion will require closer cooperation by the insurance, drug, medical and other industries.

The Perfect Storm

The nation's drug-diversion epidemic has spread rapidly over the last 10 to 15 years, with gathering speed in recent years. Among the causes:

- Widespread underwriting of prescription drugs by private and public insurers. Consumers now pay less than 20 percent of the nation's \$230-billion drug bill. This compares with 56 percent in 1990;

- Explosion of prescribing and consuming legal narcotics and controlled drugs. The U.S. population grew 13 percent between 1992 and 2002, but prescriptions for controlled drugs rose 154 percent;



- Overdue recognition of pain as a medical condition, and emergence of pain management as a needed and legitimate medical discipline. However, this also has spawned “pill mills” and other schemes that masquerade as legitimate pain treatment;

- Development of more-powerful pain medications. These newer drugs have legitimate treatment value, but their greater potency also increases their appeal to addicts, and thus raises their street value;

- Widespread and legal “off-label” prescribing of drugs to treat conditions beyond their FDA-approved uses. Most notable is Actiq. Approved for treating cancer pain, it is one of the most commonly prescribed painkillers for workers compensation injuries;

- Inadequate training of physicians and pharmacists in drug diversion. Formal school curricula and continuing education programs both are lacking;

- Rapid spread of rogue Internet providers who sell OxyContin, Vicodin and other addictive narcotics to almost anyone, with few questions asked; and

- Increasing numbers of drug thefts. They range from robberies of pharmacies by addicts to large-scale heists of warehouses by rings that resell on the black market.

Detailed Findings

Schemes are diverse

Diversion schemes run the gamut. But their connecting thread is that the drugs are often obtained by bogus insurance claims.

Among the common schemes: Addicts forge prescriptions using stolen prescription pads; physicians sell prescriptions to abusers or street dealers; pharmacists are part of organized rings that resell drugs in high volume on the black market.

Insurance costs high

Conservatively, drug diversion costs insurers as much as \$72.5 billion a year, including up to \$24.9 billion annually for private insurers. Individual plans each lose between \$8.6 million and \$857 million a year, depending on the plan's size. Large diversion losses affect both traditional health insurers and workers compensation insurers.

Doctor shopping by addicted health-plan members is the largest form of drug diversion, and takes the largest financial toll on insurance companies. Almost half of Aetna, Inc.'s 1,065 member fraud cases in 2006, for example, involved prescription benefits. Most of those were doctor-shopping cases.

But the insurance costs go well beyond prescription payments. Insurers also pay for related emergency room treatment, hospital stays, physician office visits, diagnostic tests and rehabilitation. The typical doctor shopper costs insurers \$10,000 to \$15,000 a year.

Behind such cost breakdowns are large add-on expenses: In one study, WellPoint, Inc.—the nation's largest publicly traded commercial health insurer—paid \$41 in related medical claims for every \$1 it paid in narcotic prescriptions for suspected doctor-shopper plan members.

Insurer responses inconsistent

Despite such immense losses, the response by most private insurers has proven inconsistent and ineffective.

Many insurers focus almost entirely on traditional frauds by healthcare providers. They generally ignore scams by their plan members, who account for the bulk of drug-diversion costs.

Insurers that do identify doctor-shopping members often inaccurately view diversion schemes merely as low-dollar irritants that deserve low investigative priority. These insurers fail to grasp their total diversion losses.

Many insurers have pharmacy benefit management firms (PBMs) oversee their prescription payouts. But most PBMs have no anti-fraud units. They rely instead on basic audits to identify suspicious costs. And, the few PBMs that do have fraud units can address only prescription costs. They can't piece together the larger diversion cost picture, thus leaving a serious gap in analysis.

Some insurers and PBMs do impose controls such as quantity limits and prior authorizations for highly abused drugs. But they often overlook other increasingly diverted, and deadly, drugs such as methadone.

Some insurers do not cover prescriptions for off-label uses; some do on a case-by-case basis, and others have not addressed the problem at all.

Diversion has deadly impact

The diversion epidemic also is measured, even more importantly, in human tragedy. Some 19,838 people died in the U.S. from accidental drug overdoses in 2004. This is the second-leading cause of accidental deaths, behind vehicle crashes.

Much of the recent five-year surge in overdose deaths stems from prescription narcotics and sedatives, says the U.S. Centers for Disease Control and Prevention. Consider:

- Overdose deaths from prescription drugs first exceeded deaths from heroin and cocaine in 2002;
- Nearly 4,000 people died from methadone overdoses in 2004. This is more than from any other narcotic, and an increase of nearly 400 percent over five years. Methadone is so popular among abusers that a tablet retailing for \$.25 can cost \$20 on the streets; and
- Nearly 600,000 of the nation's 1.4 million drug-related emergency-room visits in 2005 involved prescription drugs—mostly narcotic painkillers.

Insurers face liability exposures

Private insurers could face a potentially enormous liability exposure from lawsuits by plan members and other victims who allege the insurer failed to detect diversion and forcefully act against it.

The alarm went off when a woman died from an overdose of multiple prescription drugs. Her estate sued two pharmacies and a doctor. Pharmacists have a “duty to warn” patients given prescriptions for dangerous quantities or combinations of drugs, the Florida Supreme Court affirmed in June 2006.

With this precedent now in play, insurers could face lawsuits alleging their own failure to warn plan members who later overdose. At bottom, insurers who passively pay claims without trying to forcefully uncover and curtail diversion could be found civilly liable if a plan member overdoses. Liability also could arise from outside the plan if, for example, a truck driver high on prescription drugs kills or injures others in a crash.

Needed Responses

Insurers

Insurers should devote more attention to detecting suspicious activity in their prescription benefit plans. Specifically:

- Conduct ongoing datamining to identify schemes by prescribers, dispensers and plan members. Doctor shopping should be a special focus;
- Develop and implement protocols for comparing prescription and medical-claim data. This will help identify inconsistencies and define the true costs of doctor-shopping cases;
- Develop restrictions against doctor-shopping abusers at the pharmacy counters. Document those programs as they apply to specific plan members;
- Develop relationships that encourage more case referrals. Insurers should work more closely with drug-diversion specialists in law enforcement. Insurers also should develop closer ties with local and county district attorneys, who often are the main sources of prescription-drug prosecutions;
- Ensure controls on approved prescription drugs are updated and meet drug-diversion concerns. Also consider more point-of-sale controls such as photo identification;
- Consider tightening coverage for off-label prescriptions; and
- Increase their role in national campaigns to increase awareness of drug diversion, and seek greater involvement in the National Association of Drug Diversion Investigators.

State Authorities

State prescription monitoring programs (PMPs) are among the strongest defenses against drug diversion. These databases house records of controlled-substance prescriptions dispensed in a state. The data can reveal patterns of illicit use and distribution. The data are readily available to prescribers, dispensers, licensing authorities and law enforcement.

But only half of states have PMPs. States that do have PMPs vary widely in the kind and amount of data collected, who can access the data, and how well the data can be mined for suspicious patterns.

States without PMPs should seek to establish them. Insurers and other involved parties should actively support such efforts. The PMPs should follow federal criteria that attract federal funding and maximize a program's effectiveness.

Insurance fraud bureaus should better understand the complete insurance costs of drug diversion, and better support case referrals from insurers.

Similarly, state medical and pharmacy licensing boards should familiarize themselves with the seriousness of this crime, and act decisively to penalize offenders.

Medical & Pharmacy Professions

The medical and pharmaceutical professions should:

- Provide their members better training in prescribing narcotics and identifying their potential abuse;
- Support strong sanctions against offenders;
- Support strong requirements for a) specializing and credentialing in pain management, and b) receiving authority to prescribe controlled substances;
- Consider reducing their off-label prescribing of frequently diverted drugs, and reexamine the large influence drug makers have in encouraging off-label prescribing; and
- Support creation and effective use of PMPs.

Pharmaceutical Industry

The potential for the pharmaceutical industry to worsen America's drug-diversion problem was highlighted by the May 2007 guilty pleas by OxyContin's maker, Purdue Pharma, and three senior executives. They were convicted of criminal misbranding and misrepresenting the drug's potential for addiction and abuse.

Drug makers face a paradox: The same products that treat pain lead a double life as illegally obtained and addictive narcotics. Their challenge thus is to reduce their drugs' illicit appeal and availability while maintaining their effective and legitimate use.

Pharmaceutical companies thus should work with drug prescribers, dispensers and diversion authorities to:

- Educate the public about given drugs' potential for abuse and addiction;
- Provide case leads to authorities when their purchase data reveal possible signs of diversion; and
- Comply with the letter of the law and use prudent restraint with off-label uses of their drugs.

INTRODUCTION

What could inspire a federal judge to sentence a Houston physician to 10 years in prison in 2005, to pay nearly \$15 million in restitution, order her never to refer to herself as "Doctor" or "M.D.," and to immediately correct anyone who calls her that?

Former physician Callie Hall Herpin sold more than 17,000 bogus narcotic prescriptions in just over a year for \$1.7 million in cash. She sometimes peddled them in batches of as many as 200 at a time to drug dealers and other buyers.

Herpin pleaded guilty to her leading role in selling phony prescriptions for the narcotic pain drug hydrocodone (usually sold under the brand names Vicodin, Lorcet and Lortab). The massive criminal scheme also involved a prescription cough suppressant, promethazine with codeine (common brand name: Phenergan with Codeine).²

To back up the prescriptions, two of Herpin's office staffers used the telephone book to compile lists of fictitious patients—complete with addresses, telephone numbers and invented birth dates. The dealer-buyers then had the phony prescriptions filled by cohorts—eight Houston pharmacists—who created their own fake patient records to back up the drugs they fraudulently dispensed.

All told, Herpin and her cohorts helped put 1.7 million hydrocodone tablets and 2,500 gallons of prescription cough syrup onto the streets of Houston between October 2002 and December 2003. These drugs had a street value of tens of millions of dollars.

“I consider you a disgrace to every physician in this country who adheres to the ethics of the medical profession and to the Hippocratic Oath,” Judge David Hittner said at Herpin's sentencing. Hittner warned that he would send her back to prison if she violates his order.

Judge Hittner sent the last of the convicted pharmacists to prison for just over three years in July 2006, and ordered him to forfeit about \$472,000 in drug proceeds. Earlier, Hittner had sentenced the seven pharmacists and three street dealers to prison terms ranging from 3 1/2 to 12 1/2 years, plus large fines.^{3,4}

Herpin testified that she was tutored in selling narcotic prescriptions by another Houston physician—Alonzo Peters III. His Texas medical license was revoked in April 2005 because he violated earlier licensing board orders concerning his prescribing of narcotics and treating of chronic pain.⁵

Peters himself was indicted in July 2006—with three other Houston-area pharmacists—for illegally distributing hydrocodone and promethazine with codeine, and laundering the proceeds. The government alleges Peters charged “patients” who were actually abusers \$500 cash for an initial office visit, and \$300 for followup visits. In exchange, he wrote them the medically unnecessary narcotic prescriptions. Peters then allegedly directed the buyers to have the prescriptions filled at pharmacies owned by his alleged co-conspirators. Peters allegedly bought a 33.14-carat diamond for \$246,000 with the prescription proceeds, plus many other expensive items.^{6,7} Peters' trial began in September 2007. The U.S. Attorney's Office in Houston announced the guilty pleas of the three co-defendant pharmacists on October 11, 2007. All face years in prison, and hundreds of thousands of dollars in fines and forfeitures.⁸

Although notable for its many players and huge volume of illegally sold drugs, Herpin's case is only one example of drug diversion, a crime that has risen to unusual prominence throughout the U.S. in recent years.

Drug diversion is the literal “diversion” of a legal drug—usually an addictive prescription drug—from its therapeutic use or destination to any illegal use, abuse and/or resale. Underlying drug diversion's rise is an ever-growing illegal demand by addicts and recreational users for many prescription drugs. Prescription drugs are second only to marijuana in the nation's illicit drug use.

“Perfect Storm of Abuse”

How serious is the problem and how large is the demand?

“Our nation is in the throes of an epidemic of controlled prescription drug abuse and addiction,” Joseph A. Califano Jr., head of the National Center for Addiction and Substance Abuse at Columbia University (CASA), said in a 2005 landmark study, *Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the United States*.

“Today 15.1 million people admit abusing prescription drugs—more than the combined number who admit abusing cocaine (5.98 million), hallucinogens (4.0 million), inhalants (2.1 million) and heroin (0.3 million),” Califano noted. “America is in a perfect storm of abuse of mind-altering prescription drugs. They include opioids like OxyContin and Vicodin that relieve pain, central nervous system (CNS) depressants like Xanax and Valium that relieve anxiety, CNS stimulants like Ritalin, Adderall and Dexedrine that boost attention and energy, and steroids...that enhance athletic performance.”

Signs of Diversion Abound

Today, signs of drug diversion are never far away, often making headlines and even embedding themselves in pop culture:

- Radio personality Rush Limbaugh admitted his addiction to the powerful narcotic OxyContin, and was accused of stockpiling 2,000 tablets in just a few months by “doctor shopping” (obtaining prescriptions from several physicians at the same time). Limbaugh reached an agreement with prosecutors in April 2006 under which a prescription-fraud charge would be dropped in 18 months if he complies with its terms.⁹
- In September 2006, Terrence Kiel, a starting safety for the NFL’s San Diego Chargers, was arrested for attempting to ship two cartons filled with pint bottles of promethazine with codeine from San Diego to his home area of East Texas. Authorities also found several quart bottles of the drug in Kiel’s San Diego home. In December, a San Diego pharmacy technician was arrested and charged with stealing the syrup from her pharmacy and supplying it to him. She pleaded not guilty, but Kiel pleaded guilty to a felony and misdemeanor on February 7, 2007.¹⁰
- Just before the 2007 NFL Super Bowl, Indianapolis Colts owner James Irsay told *USA Today* about his addiction to prescription pain medicine. His habit began after surgeries in the 1990s, and he said he had been sober since 2002. “When you see the crack addict, the junkie in the street with needle marks and the alcoholic with the bag in the gutter, you see me,” said Irsay. “People think, ‘Well, it’s only prescription drugs,’ but I’m the guy in the alley. I am all of them.”¹¹
- On March 26, 2007, the White House Office of National Drug Control Policy published a full-page “Open Letter to Parents” in more than 40 publications throughout the U.S. in an ongoing anti-drug campaign aimed at youth. The letter addressed “the intentional abuse of prescription drugs and over-the-counter cough-and-cold medicines.” Increasingly, “teens are turning away from using street drugs to prescription medications to get high,” noted the ads, which were cosigned by more than a dozen medical and pharmacy associations, other nonprofits and several government agencies. The campaign directs parents and others to www.TheAntiDrug.com, a website dedicated to the problem.¹²
- Meanwhile, Fox television’s Dr. Gregory House (*House, M.D.*) is the nation’s most-watched chronic pain sufferer, hydrocodone addict, brilliant-but-impaired physician, and drug seeker and diverter. In one late-2006 episode, under police investigation and severe pain and withdrawal symptoms (having been “cut off” by his Vicodin-prescribing and enabling colleagues), the desperate doctor scammed his hospital’s pharmacy out of OxyContin tablets prescribed for a cancer patient. House had failed to trick another physician out of a narcotic prescription by faking symptoms at a different hospital’s emergency room.



How do the previous examples relate to the bigger picture? Consider:

- In 2005, Hydrocodone with acetaminophen was the No. 1 generic drug in the nation, both in volume (nearly 102 million prescriptions) and retail dollars (\$1.48 billion).^{13,14}



- OxyContin, its generic equivalent oxycodone, and oxycodone with acetaminophen, accounted for more than 27 million prescriptions in the U.S. in 2005, worth nearly \$2.5 billion at retail, according to *Drug Topics* magazine.^{15,16}
- Promethazine with codeine ranked 74th in units-sold among the nation's top-200 generic drugs, at nearly 5 million prescriptions worth \$53 million.^{17,18}
- “New users of prescription drugs have now caught up with new users of marijuana,” the White House Office of National Drug Control Policy said in a February

2007 report, *Teens and Prescription Drugs: An Analysis of Recent Trends on the Emerging Drug Threat*. Pain relievers such as OxyContin and Vicodin are the most commonly abused prescription drugs by teens. One-third of all new abusers of prescription drugs in 2005 were 12- to 17-year-olds, and prescription drugs are the drug of choice among 12- and 13-year-olds.¹⁹

- More than 86 million—or 78 percent—of the 110 million emergency-room visits recorded in 2004 resulted in the prescription or provision of at least one drug. The most common was a narcotic analgesic.²⁰ The fictional Dr. House's failure to score an emergency room prescription (thanks to an astute ER physician and the hospital's strict narcotics policy) thus defied the real-world odds.

The Difference: Insurer Financing

Although drug diversion bears many similarities to the dealing and abuse of illegal drugs, it is the polar opposite in one major respect: the vast private and public insurance programs that underwrite and pay for most of America's prescription drug use—both legal and illegal. In 2005:

- 98 percent of covered workers in employer-sponsored health plans—roughly 170 million persons—had a prescription benefit plan, and workers compensation coverage if needed;²¹
- 42.5 million Americans enjoyed prescription benefits through Medicaid;²²
- Roughly 40 million more Americans could anticipate a high degree of prescription coverage through the impending Medicare Part D program;
- At \$200.7 billion, prescription drug costs represented just over 10 percent of the nation's total health care expenditure;²³ and
- In 2007, with Medicare Part D benefits increasing taxpayer outlay, private insurers will pay an estimated \$94.1 billion in prescription drug benefits—41 percent of a national drug bill that is projected to total \$229.5 billion.²⁴

IMPACT ON INSURERS & SOCIETY

Despite its impressive financial dimensions, Herpin's crime featured no apparent fraud aimed at health-insurance programs. But many diversion cases involve a concerted effort to defraud public and private insurance programs, thus imposing heavy financial losses on insurers. Often insurance fraud also is the foundation of larger and costlier schemes involving the prescription and spread of large quantities of addictive and potentially deadly narcotics. At their darkest, some schemes deepen the addiction of patients caught up in the crimes, and even kill them.

Several flagrant cases confirm both the diverse ways the schemes are structured, and the urgent need for insurers to more closely examine how diversion affects them. Ultimately, drug diversion poses a triple threat to insurers:

- Prescription drug costs;
- Medical claims related to drug diversion and abuse; and
- Potentially major liability exposure.

Pills Pushed in Record Numbers

In August 2005, the Massachusetts medical board suspended the license of Cape Cod physician Michael R. Brown, calling him “an immediate and serious threat to the public safety and welfare.”²⁵

In 2004, 922,985 tablets of OxyContin were prescribed in Massachusetts, a state with roughly 27,000 physicians. Brown prescribed nearly one-third (or 288,859) of those tablets. He also allegedly wrote 5,756 prescriptions for hydrocodone during a 19-month period.²⁶

Reportedly found with more than \$60,000 in cash and dozens of narcotic pills and prescription pads in his car when arrested, Brown allegedly systematically bought back from some patients the narcotic pain medications that he had prescribed for them.

Brown was convicted of dozens of charges in 2007, including writing illegal prescriptions, and prescribing OxyContin and other painkillers for no medical purpose. Two trials each landed Brown 2½ to three years in prison.

Father and Son in Resale Scheme

In September 2006, Martin Bradley III and his father Martin Bradley Jr. were convicted of the large-scale diversion and resale of expensive, injectable specialty drugs.²⁷ The Bradleys paid kickbacks to physicians who wrote phony prescriptions for blood-based drugs for treating AIDS, cancer and hemophilia, according to the U.S. Food and Drug Administration. Those prescriptions then were fraudulently billed to Florida's and California's Medicaid programs and to Medicare. But instead of the drugs going to those programs' patients, they were diverted to the Bradleys' Coral Gables, Fla. firm Bio-Med Plus, which resold them on the wholesale drug market.

They received 25 and 18 years in prison, respectively, and were ordered to repay \$27.8 million and \$6.5 million in fines. Bio-Med was fined \$26.5 million and ordered to repay \$27.8 million to public insurers.

Doctor Feeds Patient Addictions

Ohio physician Jorge Martinez used his prescribing authority and patients' addictions to launch a vast billing fraud against several insurers. He was found responsible for the deaths of two patients.

In June 2006, Martinez received life in prison for mail and wire fraud, drug distribution and health care fraud resulting in death (a federal crime enacted in 1996). Martinez made \$60 million in fraudulent claims to Medicaid, Medicare, private insurers and the Ohio Bureau of Workers Compensation—receiving more than \$12 million.²⁸

A self-described pain-management specialist, Martinez saw more than 100 patients per day in his three Cleveland-area clinics. He provided patients with weekly narcotic and antidepressant prescriptions only after they agreed to undergo multiple trigger-point injections, and threatened to withhold the drugs if the patients refused to comply. He then billed their insurance plans thousands of dollars per visit. He submitted claims for more-complex injections—epidurals and nerve blocks—than he actually performed.

Martinez deliberately caused patients to become addicted to the drugs he prescribed, then exploited their addictions for his massive claims. One patient died the same day Martinez prescribed him OxyContin and other drugs. Another patient fell unconscious in Martinez' office and died soon thereafter of a multiple-drug overdose.

Another Doctor Gets Life Sentence

Five patients died from overdoses of multiple narcotics that Panama City, Fla. physician Thomas Merrill prescribed without even examining them. Merrill knew some patients were addicted doctor shoppers who were feeding their drug habits. Merrill received life in prison in July 2006. He was ordered to pay significant restitution to Florida Medicaid, the TRICARE program and Blue Cross Blue Shield of Florida.²⁹

Fraud Profits Doctor, Kills “Patient”

In March 2006, New York City dermatologist David Wexler received 20 years for illegally distributing prescription narcotics and for bilking Medicare and private health insurers. Wexler's scheme also caused the death of Barry Abler, an addicted “patient” who colluded in the fraud.³⁰ Wexler paid Abler about \$700 cash per month, and gave him prescriptions for multiple narcotics and other controlled and non-controlled drugs. Abler abused the drugs, and sold them to other abusers.

Over nine years, Wexler billed Medicare for nearly 2,000 phantom surgical excisions on Abler—including more than 1,300 on Abler's face alone—for which Medicare paid him than \$425,000. Wexler also wrote prescriptions for some of Abler's friends, and billed their health insurers hundreds of thousands of dollars for phantom skin excisions.

In May 2001, Abler was found dead in his home of an overdose of the narcotic Dilaudid (hydromorphone) and the muscle-relaxant Soma (carisoprodol). Wexler prescribed both drugs.

Drug Cocktail Earns Death Sentence

But long before the Martinez and Merrill cases, Florida physician James Graves became the nation's first physician convicted for the death of several patients by prescription overdose. Graves received 63 years in state prison in 2002 for manslaughter, multiple counts of illegal drug-distribution, and racketeering.³¹

Graves was Florida's leading prescriber of OxyContin (usually on a cash basis), which he often wrote in combination with a narcotic tranquilizer and muscle relaxant. The brew was called the “Graves cocktail” by the more than 20 pharmacists who stopped filling his potentially fatal prescriptions. Graves later was indicted for Medicaid fraud involving the cost of his prolific prescriptions.

Pharmacy Tech Forges Claims

In June 2005, an Oakland County, Mich. judge went far beyond the prosecution's recommended six-month sentence and sent Leta Marie Chrisman to prison for 17 months to five years.³²

Chrisman stole about 70,000 pills—tranquilizers, narcotic pain medications and anti-anxiety drugs—from the Costco store where she worked as a pharmacy technician. To cover up her thefts, Chrisman forged and submitted prescription claims in the names of real Costco customers. Her crimes surfaced when some patients' insurers denied their genuine claims because the bogus claims had maxed out their prescription benefits.

GATHERING STORM: CAUSES OF DIVERSION EPIDEMIC

Drug diversion is not new. Morphine was diverted and abused as far back as the Civil War. But what is new and vastly different today is the overall prescription drug and insurance benefit environment in which it takes place. The scope and cost of prescription drug abuse—coupled with the large amount bill that insurers pay—have devastating effects on the public and private sectors.

Diversion has been a focus of attention for more than 20 years, as seen in the 1987 founding of the National Association of Drug Diversion Investigators (NADDI). Today, NADDI is a thriving organization of some 300 diversion specialists in state, county and local law-enforcement and regulatory agencies. Its membership also encompasses some federal law-enforcement agencies, investigators from some insurers' special investigation units, pharmacy and medical licensing authorities, state prescription monitoring programs (PMPs), retail drug chains and drug manufacturers.

In 1990, in response to a visibly growing crime problem, the Cincinnati Police Department created a precedent-setting drug diversion squad. "In less than three years, this unit was investigating over 500 felony prescription drug cases a year and arresting more than 250 prescription drug felons in the process," says John Burke, who headed that unit for many years. He now is head of the Warren County (Ohio) Drug Task Force and 2007 president of NADDI.³³

In 1992, the U.S. General Accounting Office (now the Government Accountability Office) identified drug diversion as "a prevalent type of Medicaid fraud." GAO noted that "officials in 21 states cite such drug diversion as a problem."³⁴

That same year, the FBI concluded "Operation Goldpill"—a three-year, 50-city investigation that led to the arrest of more than 200 pharmacists, pharmacy owners and others. Among the Medicaid and insurance-fraud charges were the sale of prescription drugs to street dealers and, in some cases, their repurchase and resale by corrupt pharmacies.³⁵

Prescription Costs & Benefits Soaring

"From 1994 to 2005, the number of prescriptions purchased rose 71 percent (from 2.1 billion to 3.6 billion) compared to a U.S. population growth of 9 percent," notes the Kaiser Family Foundation.³⁶ "The average number of retail prescriptions per capita increased from 7.9 to 12.5." The role of insurance as financier of prescriptions rose sharply during roughly that same period:

- In 1990, when the nation's prescription drug bill totaled \$40.3 billion, private health insurance paid 26 percent of it, and consumers paid 56 percent;³⁷ and

- In 2005, with the nation's drug outlay at \$200.7 billion, private health insurance paid 47 percent—or \$95.2 billion. Meanwhile, consumers' expenses had shrunk by more than half to 25 percent.³⁸
- At the same time, government's share of the bill grew from 18 percent to 28 percent.³⁹

Pain Management Emerging

The Veterans Health Administration—with 1,100 medical facilities nationwide and 3.5 million patients—formally adopted pain as the “fifth vital sign” in 1999.⁴⁰ This joined blood pressure, pulse or heart rate, body temperature and respiration as the basic measures of a person's medical condition.

This precedent-setting move signaled that serious pain, either chronic or acute, is a bona fide but vastly under-treated condition in its own right. That move also showed that pain demands effective treatment and medical management that were long overdue. The growing acceptance of that truth led to the rapid emergence of pain management as a legitimate medical specialty. The new discipline involved diagnostics and various therapies and, usually the prescription of effective narcotic pain drugs combined with careful monitoring of their consumption.

While pain management's evolving into an effective and needed specialty is a positive step, it has been accompanied by unfortunate byproducts. Pain management isn't regulated, for example, and any physician can “self-designate” as a pain specialist. Pain management thus became a new frontier for the dishonest few. This has spawned “specialists” and diagnostic and/or pain centers that are merely “pill mills” that often prescribe and dispense controlled narcotics purely for illicit profit.

Pain Medications Evolving

Roughly paralleling the rise of pain management has been the evolution of pain medications. Ever-stronger and more-effective drugs have emerged to treat both chronic and so-called “breakthrough” pain. These drugs' effectiveness makes them appealing to abusers.

OxyContin, for example, came on the market in 1996. Its manufacturer, Purdue Pharma, hailed OxyContin for its effectiveness in treating the severe, intractable pain of many cancer patients. OxyContin soon topped the charts, becoming “the most frequently prescribed brand name narcotic medication for treating moderate-to-severe pain in the U.S.” by 2001, CASA noted.⁴¹ The manufacturer's “aggressive” marketing was a factor in the growth of OxyContin's non-cancer prescriptions from 670,000 in 1997 to about 6.2 million in 2002, CASA implied.⁴²

OxyContin also quickly topped the charts in drug diversion because it produces a fast and powerful heroin-like high when abused. Addicts typically ingest the drug by crushing and snorting the tablets, or liquefying and injecting them.

Among the most-visible signs of OxyContin's non-cancer uses is that the drug has ranked No. 1 in dollar volume among The Hartford's top-25 workers compensation drug costs every year since 2001.⁴³ In 2005, the insurer noted, the drug's long-standing notoriety was related to “reports of its popularity for abuse and drug-trafficking.”⁴⁴

OxyContin ranked No. 4 in total prescription dollars paid by the workers compensation industry in 2003, says the National Council on Compensation Insurance (NCCI).⁴⁵ More than one of three claims that included an OxyContin prescription covered treatment of lower-back injuries—most often strains or sprains—between 1996 and 2002, NCCI says. More than two-thirds of those claims involved permanent partial disabilities.⁴⁶

“Today, some physicians prescribe [OxyContin] like aspirin,” Mike Roberson, Medical Review and Provider Inquiry Leader at the State Compensation Fund of Arizona, said in 2004.⁴⁷ “We would implore

[doctors] to be diligent in prescribing the high-cost and highly addictive OxyContin, when another painkiller would do just as well.”

A similar example is Actiq. It ranks No. 6 in The Hartford’s 2005 cost list, rising from No. 15 in 2003 and No. 9 in 2004.⁴⁸ An extremely potent oral narcotic introduced in 1998, Actiq is a lollipop-like lozenge. Its main ingredient—fentanyl—is absorbed through the mouth lining.

Actiq is approved by the federal Food and Drug Administration (FDA) only for cancer patients. But in the first half of 2006, “oncologists, or cancer doctors, accounted for only 1% of the 187,076 Actiq prescriptions filled at retail pharmacies in the U.S.,” *The Wall Street Journal* reported in November 2006.⁴⁹

Like OxyContin, Actiq is a potent Schedule II drug, comprising the most tightly restricted legal drugs in the Drug Enforcement Administration’s (DEA) classification of controlled substances. It has a “high potential for abuse” and can be fatal if abused. Not surprisingly, Actiq has a high street value among diverted drugs—though far below OxyContin (*See Insurance Impact and Risk Exposure, p. 32.*).

Doctors Prescribing Off-Label

Actiq reveals another reason why the use of many drugs is spreading, and why it is so prominent in workers compensation: If a drug is FDA-approved to treat even one condition, physicians may prescribe it “off-label” for any purpose they choose.

Thus, “oncologists and pain specialists account for less than 3% of [Actiq] prescriptions,” *The Wall Street Journal* said.⁵⁰ At the high end of the Actiq prescribing scale: “anesthesiologists and physical medicine and rehabilitation specialists, at 29.5% and 16%.” At issue is whether Actiq’s maker, Cephalon, Inc., is encouraging the drug’s prescription for conditions other than cancer, the story noted.

Off-label prescribing goes well beyond Actiq. One of five prescriptions written in the U.S. is prescribed off-label. Of prescriptions written in 2001 for 160 commonly prescribed drugs, “an estimated 150 million prescriptions—or 21%—were for off-label use,” *USA Today* reported in May 2006 on the release of data by the *Archives of Internal Medicine*.^{51,52} What’s more, “about 15% of prescriptions were for off-label uses that lacked scientific support,” the story noted.

Among the off-label examples cited was gabapentin—brand name Neurontin—an FDA-approved drug for epileptic seizures and pain related to shingles. Neurontin placed second on The Hartford’s workers compensation payout list in 2004,⁵³ and the generic gabapentin became No. 2 in 2005.⁵⁴ This reflects its widespread use as a pain medication. The percent of workers compensation patients being treated for seizures or post-shingles pain, says The Hartford, “is dramatically smaller than the use of the drug suggests.”⁵⁵

While off-label prescribing is legal, promoting such activity is illegal. The Warner-Lambert Division of Pfizer pleaded guilty and agreed to pay \$430 million in penalties in 2004 for promoting the prescribing of Neurontin for treating migraine headaches, pain, bipolar disorder and other conditions for which it was not approved.⁵⁶ Annual sales of Neurontin reportedly grew from \$97.5 million to more than \$2.5 billion during the years of the aggressive off-label promotion to physicians (before Pfizer acquired Warner-Lambert).



Behavioral Drugs Spreading

Similar to the widespread use of powerful new narcotic pain drugs is the prevalence of behavioral drugs:



- **Anti-depressants.** Most notable are brand-name benzodiazepines such as Valium (generic name: diazepam), Xanax (alprazolam), Ativan (lorazepam), and the generic clonazepam used to treat anxiety, stress, panic and sleep disorders; and
- **Stimulants.** Adderall (amphetamine) and Ritalin (methylphenidate), both widely used in the treatment of attention deficit hyperactivity disorder, are prime examples.

Nearly 96 million brand-name and generic prescriptions were written for those six drugs alone in 2005, totaling more than \$2 billion in retail

sales.^{57,58,59,60} Those figures reflect the drugs' continuing spread. Prescriptions written for *all* central nervous system depressants and stimulants totaled 81.6 million in 2002, CASA noted.⁶¹ Like their narcotic counterparts, depressants long have been a staple of drug diverters. The abuse of stimulants for the cocaine-like high they produce also has paralleled their prolific therapeutic use in recent years.

Marketing Fuels Demand, Consumption

Contributing to such record consumption is a culture of patient demand for, and expectation of, prescription drugs. This includes controlled substances—fueled by omnipresent pharmaceutical industry marketing that in one prominent example literally “challenges” Americans to take a particular sleep medication for seven nights.

Despite their seemingly nonstop television and print ads (\$4.2 billion worth in 2005), drug makers still aim far more of their marketing dollars directly at physicians—to the tune of \$7.2 billion in 2005, notes the Kaiser Family Foundation.⁶²

Overall drug-industry promotional spending totaled nearly \$30 billion in 2005, reported a study published in the *New England Journal of Medicine* on August 17, 2007.⁶³ Among the common tactics are advertising, “detailing” of prescribers with free gifts and meals, hefty consulting fees to “objective” physician researchers and widespread funding of continuing medical education programs.

In the face of this marketing onslaught, several major medical institutions have banned the acceptance of even small gifts from drug manufacturers.⁶⁴ In late October 2007, one U.S. presidential candidate proposed strict limits on drug advertising and more-stringent FDA oversight of drug-company marketing.⁶⁵

Physicians/Pharmacists: Little Training

Contributing to the spread and abuse of controlled narcotics is the failure of physician education to keep pace with the evolving problem, CASA found. Among physicians responding to a 2004 CASA survey:⁶⁶

- 40 percent reported having no medical school training in prescribing controlled drugs;
- 48 percent reported no medical school training in pain management;

- 55 percent reported no medical school training to identify prescription drug abuse or addiction;
- 75 percent reported no medical school training to identify prescription drug diversion;
- Nearly 25 percent reported no training in prescribing controlled substances and 55 percent received no training in identifying drug diversion during residency; and
- About half of the doctors received no prescription training in continuing-education programs, and 59 percent received none to identify drug diversion.

If there is reason for optimism—and an opportunity to curb drug diversion and abuse—it lies in physicians’ desire for better training. Some 61 percent said they would welcome more education and training in prescribing controlled drugs, 69 percent in identifying abuse and addiction, and 71 percent in identifying prescription drug diversion.

CASA’s companion survey of pharmacists is equally significant, and highlights the need and opportunity for better training.⁶⁷ For example, although 48 percent of pharmacists said their profession has “a great deal” of responsibility to help prevent drug diversion and abuse:

- 40 percent reported receiving no instruction since pharmacy school in dispensing controlled drugs;
- 47 percent reported no training since pharmacy school in identifying abuse and addiction; and
- 48 percent reported no training since pharmacy school in preventing drug diversion.

The opportunity? Of these pharmacists, 68 percent, 80 percent and 81 percent, respectively, expressed interest in receiving more education and training in those areas.

Payers Delegate Management

A key question is how much health payers’ large-scale outsourcing of oversight of their prescription benefits to prescription benefit management firms (PBMs) has undermined the detection of prescription fraud. Today, the nation’s roughly 50 PBMs process and pay drug benefits, both private and public, for more than 200 million Americans, says the largest PBM trade group, the Pharmacy Care Management Association.⁶⁸

Despite the many good reasons insurers and employers assign their prescription management to PBMs, insurer fraud investigators and others widely believe few PBMs go beyond routine pharmacy audits and reports when investigating for fraud.

Some PBMs have no anti-fraud units, some PBMs do have the units, and others are subsidiaries of large health insurers that have robust units. Even PBMs that are Medicare Part D plan sponsors—although they must meet specific federal anti-fraud requirements and expectations—are not required to maintain formal anti-fraud units. Nor are PBMs subject to the state-mandated anti-fraud standards imposed on insurers.

Like third-party administrators, PBMs are subject primarily to the anti-fraud influence, expectations and contractual requirements of their payer-customers. In some cases, customers and their PBMs appear to have built a solid foundation of anti-fraud cooperation. In other cases, that task remains to be accomplished or even begun.

At the same time, the electronic commerce infrastructures, built largely by PBMs, merge speed and efficiency to process the nation’s 3.4 billion prescription claims each year. But the swift processing of claims in real time at the point of sale (in 12 seconds, for example) also can be an Achilles Heel that works to the drug diverter’s advantage by limiting detailed oversight.

Internet Spurs Easy Illegal Sales

Although its influence is hard to gauge, the Internet is clearly a factor in the increasing abuse of pharmaceuticals. The large number of sales pitches for free or deeply discounted hydrocodone and other narcotic drugs that regularly hit many e-mailboxes serves as one barometer of the Internet's rapidly spreading use.

Above and beyond mail-order sales, the Internet provides even greater prescription convenience and faster service for consumers. The National Association of Boards of Pharmacy has named only 13 Internet pharmacies as Verified Internet Pharmacy Practice Sites (VIPPS).⁶⁹ This elite list includes familiar names such as Anthem, Medco, Walgreen's and Caremark. But this well-qualified handful pales next to the estimated hundreds or even thousands of illicit websites.

Beyond those few VIPPS, the Internet remains open territory for prescription schemes ranging from questionable to criminal—an "open medicine cabinet, a help-yourself pill bazaar," says outgoing Drug Enforcement Administrator Karen Tandy.⁷⁰

"For three years straight the number of rogue Web sites selling controlled prescription drugs like OxyContin, Vicodin, Valium and Ritalin has increased," CASA reported in May 2007.⁷¹ Of the 187 sites found actually selling controlled substances, only two were certified VIPPS. "Of the 16 percent of sites that claimed to require a prescription, most (57 percent) simply ask that it be faxed, allowing a customer to forge it or use the same prescription many times to load up on these drugs," said CASA.

In April 2005, for example, the DEA busted a large, suspected Internet drug ring in Philadelphia that allegedly supplied up to 2.5 million doses of narcotics—without prescriptions—each month. Tens of thousands of buyers in the U.S. and abroad bought the narcotics via the 200 websites to which it supplied drugs, including OxyContin and Vicodin, the DEA charged.

The 20 people arrested included Akhil Bansal, a physician enrolled in graduate studies at Temple University. Bansal's father, a physician in India, "was the primary supplier of the drugs," said the DEA. He also was arrested in India, along with suspects in Australia, Costa Rica and the U.S.⁷²

In April 2007, after three other defendants had pleaded guilty, the Philadelphia U.S. Attorney's Office reported, a jury found Akhil Bansal and a co-defendant guilty on all counts. Bansal awaits sentencing to what likely will be a lengthy prison term.⁷³

How big a business does such an alleged scheme represent? Some "17.4 million people visited an online pharmacy in the fourth quarter of 2004 (up 14 percent over the previous quarter); approximately 63 percent of these visited sites did not require a prescription," CASA said in citing another study.⁷⁴

The Internet likely contributes to drug diversion and abuse in another major way: The same large volume of accurate medical information that educates patients—through such sites as WebMD, drugs.com and countless online journals—also provides free medical education to drug diverters.

One such incident occurred when, four days into her second stay at a Kaiser Foundation Hospital in Manteca, Calif., Yodit Isak (aka Yodit Hiskias) was arrested in her hospital bed in March 2006.⁷⁵ Police considered her a "professional patient." Isak reportedly had researched sickle-cell anemia and faked symptoms well enough to be admitted and illicitly obtain morphine. Her scheme unraveled when a hospital nurse recognized the woman from a previous stay, under a different name, only a few weeks earlier. Police say the uninsured Isak rang up more than \$50,000 in hospital bills during her two stays.

Drug Theft Takes Large Toll

Much attention focuses on physicians and their prescribing activity as "the main cause" of increased opioid abuse, but the outright theft of narcotics also contributes heavily to the easy availability of

prescription narcotics on the illicit market and their eventual abuse, say two well-known pain medicine experts and leading advocates of an accurate perspective on drug diversion.

“A total of 12,894 theft/loss incidents were reported in these states between 2000 and 2003... primarily from pharmacies (89.3%), with smaller portions from medical practitioners, manufacturers, distributors and some addiction treatment programs that reported theft/losses of methadone,” reported David E. Joranson, MSSW and Aaron M. Gilson, PhD of the Pain and Policy Studies Group at the University of Wisconsin-Madison.⁷⁶ Their comments were published in the *Journal of Pain and Symptom Management* in October 2005. They summarized their study of DEA data on the theft or loss of controlled substances in 22 Eastern states comprising 53 percent of the U.S. population.

“Over the 4-year period, almost 28 million dosage units of all controlled substances were diverted,” in numbers ranging from 81,371 units of fentanyl to 4.4 million units of oxycodone, they said. In 2003 alone, nearly four million units of hydrocodone were diverted. “The unchecked flow of pain medications diverted from non-medical sources will not be addressed if diversion control focuses only on prescribers and patients,” the authors warned.

The theft of 1.8 million pills in November 2006 added weight to their argument. Pain medicines and tranquilizers were stolen from hospital and pharmacy wholesaler AmerisourceBergen’s warehouse in Mansfield, Mass. “Police said the conservative estimate on the drugs’ street value is \$10 million,” reported Boston’s CBS television affiliate.⁷⁷

Another method of drug diversion includes “substitution” at the point of delivery to patients, says NADDI’s John Burke.⁷⁸ The perpetrator “may remove a potent pain-relieving narcotic from a syringe and replace it with water,” Burke says. This deprives the patient to whom it is later administered of the intended pain relief.

“Nursing personnel constitute the bulk of this type of pharmaceutical diversion,” Burke reports. “In the late 1990s, our Cincinnati unit was arresting a nurse about once a week for diverting drugs from health facilities.”

Drug Smuggling Contributes

Drug smuggling is another large contributor to America’s diversion problem. In addition to the widely publicized cross-border flow of methamphetamine, “Mexican pharmacies located along the U.S.-Mexico border are a primary source of prescription narcotics, depressants, and steroids distributed in and abused throughout the Southwest region,” says the DEA.

“San Diego is one of the most significant pharmaceutical smuggling areas in the country, owing to its proximity to Tijuana, which has 10 times the number of pharmacies needed to support its population.”⁷⁹

Availability and Abuse Grows

Obviously, no single factor causes the “perfect storm” of diversion and abuse. But the CASA report does provide a big-picture view. Between 1992 and 2002:

- The U.S. population grew 13 percent and prescriptions for non-controlled drugs increased 56.6 percent, but prescriptions for controlled drugs soared 154 percent;⁸⁰
- Opioid prescriptions increased 222 percent.⁸¹ Hydrocodone and oxycodone prescriptions led with growth of 376 percent and 380 percent, respectively;⁸²
- Prescriptions for benzodiazepines increased 49 percent, and 368.5 percent for stimulants;⁸³

- Prescription drug abuse among people aged 12 and over increased 93.8 percent. Opioids led the way with a 140.5-percent increase in admitted abuse.⁸⁴ Abuse of depressants grew 44.5 percent, and stimulant abuse rose 41.5 percent; and
- By contrast, only marijuana use increased similarly among illegal drugs. Its use grew 47 percent, while cocaine use increased just over 19 percent.⁸⁵

“PERFECT STORM OF ABUSE”

The epidemic of drug diversion and abuse strikes all segments of American society. This section examines the 1) known demand for controlled-substance abuse; 2) sought-after drugs; and 3) the increasingly severe public-health impact.

The Demand

The broadest and newest data come from the 2006 National Survey on Drug Use and Health (NSDUH), conducted by the U.S. Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA). But CASA offers an important caveat: “The NSDUH is known to underestimate considerably all forms of substance abuse in the U.S. Because it is administered in the home, respondents—especially teens—tend to under-report their substance use.”

Prescription Drug Abuse: 16.3 million

Conservatively, at least 16.3 million Americans age 12 or older—or 6.6 percent of the U.S. population—admitted to non-medical use of psychotherapeutics in the “past year.”⁸⁶ Among those who used non-medically:

- 12.6 million—5.2 percent of the U.S. population—said they had used pain relievers, including more than 1.3 million people who said they had taken OxyContin;⁸⁷
- 5.06 million—2.1 percent of the population—had taken tranquilizers;⁸⁸
- 3.4 million—1.4 percent of the population—had used stimulants other than methamphetamine;⁸⁹ and
- 926,000—0.4 percent of the population—had used sedatives.⁹⁰

Even more people admitted to non-medical use over their *lifetimes*: 20.3 percent, or nearly 50 million persons. Among them, 33.4 million admitted misusing pain relievers, with 4.1 million citing OxyContin as the drug they abused.⁹¹

The highest abuse occurred among 18-to-25-year-olds, with lifetime misuse of 30 percent,⁹² and 6.4 percent (2.1 million persons) admitted to misuse in the past month.⁹³ But abuse is lower among adults age 26 and over, with 4.8 percent admitting past-year misuse and 2.2 percent (4.1 million persons) admitting misuse in the past month.⁹⁴

Nearly 2.6 million people abused prescription drugs for the first time in 2006, NSDUH also found. Nearly 2.2 million—including 533,000 first-time abusers of OxyContin—abused a pain reliever. This surpassed the nation’s first-time marijuana users. First-time tranquilizer abusers totaled 1.1 million, while first-time stimulant abusers numbered 845,000 and sedative abusers stood at 267,000.⁹⁵

Abuse Touches All Demographics

Abuse of prescription drugs cuts across all demographic lines and geographic boundaries. Based on annual averages from 2002 through 2004, for example, SAMHSA found higher incidences overall:

- Among men than women (6.5 versus 5.9 percent);⁹⁶ and
- Among Whites than Hispanics, Latinos and Blacks/African Americans (6.7, 6.3, and 3.9 percent, respectively). The highest abuses were among Native Hawaiians or Pacific Islanders (10.1 percent) and American Indians or Alaska Natives (8.1 percent).⁹⁷

Other troubling trends also highlight cause for concern among employers and insurers, SAMHSA noted. For example:

- Among 18- to 25-year-olds, past-year prescription drug abuse was highest among the unemployed—at 18.9 percent—but was 14 percent even among the fully employed;⁹⁸
- Among all fulltime employees age 18 and older, 6.1 percent had abused prescription drugs in the past year—two-thirds of them a pain reliever;⁹⁹ and
- Americans age 18-and-older with “some college” had the highest past-year abuse rate (7 percent) and college graduates had the lowest (4.2 percent). This compares with an overall abuse rate of 5.9 percent.¹⁰⁰

Geographically, the highest abuse was found in the West, especially the “Mountain” region, at 7.6 percent versus the national average of 6.2 percent. Other hot spots included New England at 6.6 percent, and the “East South Central” region at 6.8 percent.¹⁰¹

As for type of community, the highest abuse—7.1 percent—was found in “Small Metro” areas with populations of less than 250,000. Next came areas with between 250,000 and 1 million people.¹⁰²

Among adults age 18 and older, 7.2 percent—or 15.8 million people—reported having a major depressive episode (MDE) during the past year, NSDUH noted.¹⁰³ Overall illicit drug use by those people was 27.7 percent. This total includes prescription drugs, and was more than twice as high as among people who had not experienced an MDE.¹⁰⁴

Prescriptions: Key Source for Abusers

In NSDUH’s findings, about 56 percent of Americans age 12 and over obtained their most recently abused prescription pain reliever “from a friend or relative for free.” But in a follow-up question, more than 80 percent of those respondents said that “the friend or relative had obtained the drugs from just one doctor.”¹⁰⁵ (*See chart next page.*)

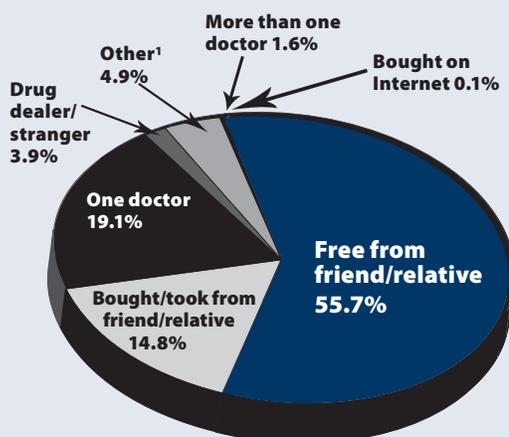
More than 19 percent of abusers directly cited “one doctor” as their most recent drug source, and only 4 percent said they bought from a “drug dealer or other stranger.” Fewer than 1 percent said they bought through the Internet.¹⁰⁶

Physician prescriptions are a major source of recently abused opioid painkillers for nearly one-third of diagnosed abusers, according to a study by Ann Kline, MS and J. David Haddox, DDS, MD—both of Purdue Pharma—and several colleagues.¹⁰⁷ The study was based on intake surveys of 5,803 people admitted to 69 methadone treatment sites around the U.S. The study reports the wide variety of ways people can buy drugs:

- 82 percent of abusers also cited dealers as a source;
- 50 percent cited friends or relatives;
- 30.5 percent cited physician prescriptions;

Doctor Prescriptions: Main Sources of Abused Painkillers

Sources for Respondents



Sources for Respondents' Friends/Relatives



Where pain relievers were obtained for most-recent non-medical use among past-year users age 12 or older. SAMHSA, National Survey on Drug Use and Health (2006).

Note: Totals may not sum to 100% because of rounding or because suppressed estimates are not shown.

The "Other" category includes "Wrote fake prescription," "Stole from doctor's Office/Clinic/Hospital/ Pharmacy," and "Some other way."

- 14 percent cited emergency room visits;
- 6 percent cited theft;
- 3 percent cited forged prescriptions; and
- 2.4 percent cited the Internet.

Teen Abuse Defies Downward Trend

Drug diversion also has deeply penetrated America's youth. For example, 12 percent of Americans age 12-17 admitted abusing psychotherapeutic drugs in their lifetimes,¹⁰⁸ and 3.3 percent had abused prescription drugs in the "past month,"¹⁰⁹ SAMHSA found in 2006. Pain relievers were the most common choice, used by 2.7 percent of youths. The good news is that prescription drug abuse has declined among these youths since 2002.

Other recent surveys, though, report even more prescription drug abuse among youths and support CASA's call to urgently resolve the problem.

Abuse of prescription opioids "remains at unacceptably high levels" even while recent abuse of illicit drugs has declined, the National Institute on Drug Abuse (NIDA), part of the National Institutes of Health, said in its 2006 survey of 8th, 10th and 12th graders.¹¹⁰

Their past-month illicit use of drugs had dropped 23.2 percent since 2001. But, of "significant concern is that past-year use of Vicodin remained high among all three grades, with nearly one in ten high school seniors using it in the past year," NIDA said.¹¹¹ And "despite a drop... in past-year abuse of OxyContin among 12th graders (from 5.5 percent to 4.3 percent), there has been no such decline among

eighth- and 10th-grade students.” In fact, “past-year use of OxyContin has almost doubled among eighth graders since 2002,” said NIDA Director Dr. Nora Volkow.

In California, meanwhile, prescription drugs were abused by 15 percent of 11th graders, 9 percent of 9th graders and 4 percent of 7th graders, said the California Attorney General’s Office in the Biennial California Student Survey released in October 2006.¹¹²

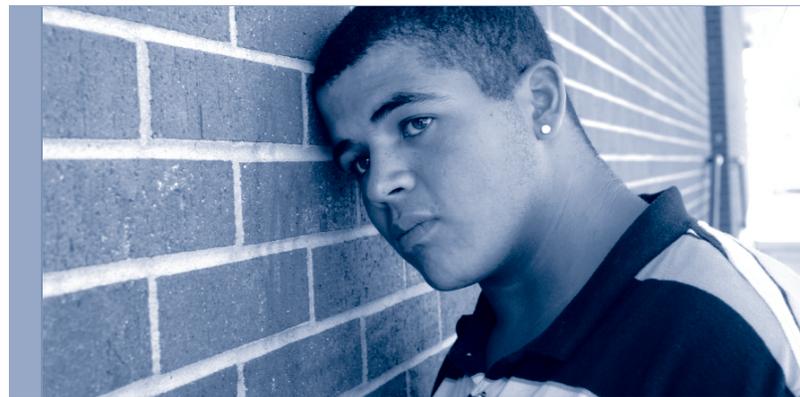
Also, 4.2 percent of eighth graders, 5.3 percent of 10th graders and 6.9 percent of 12th graders said they took over-the-counter cold or cough medicines with dextromethorphan (DXM) during the past year to get high, the 2006 MTF survey found.¹¹³ That so-called “Robotripping” owes its name to Robitussin cough syrup’s popularity as a catalyst for a DXM high.

The spread of so-called “pharming parties” is less-documented academically but often mentioned in media, government and other discussions of teen drug abuse. These are casual gatherings for pooling, trading and using prescription drugs that teens have obtained. Anecdotal news reports suggest pharming is happening, but some observers note a lack of evidence to prove how widespread it is.

Houston Lends Meaning to the Math

Houston’s illicit market for one controlled drug lends some real-world context to the data, and reveals just one aspect of drug diversion’s societal impact.

In recent years, Houston has become known as the “City of Lean.” This is one of several street names used for promethazine with codeine. It describes a user’s tendency to lean over while high on the drug. Its other street names include “syrup,” “sizzurp,” “purple stuff” and “drank.” Typically, the drug is mixed with a soft drink and/or alcohol—to which younger users often add a “Jolly Rancher” candy. Lean’s popularity in the rap and hip-hop music culture, and especially among Houston’s teenagers, has made Houston the nation’s capital of its abuse.¹¹⁴



Why Houston? Several years ago, Houston music producer Robert Earl Davis Jr. (professional name: DJ Screw) developed a remixed and slowed-down version of rap, which he named “screw.” Getting high on “lean” features prominently in many lyrics. His music genre gained wide popularity, and celebrating “syrup” highs lives on today in such hip-hop hits as “Sippin’ on the Syrup” by the Oscar-winning group Three Six Mafia. Davis himself, though, lives only through his legacy. He died of a codeine overdose at age 29 in 2001.

How pervasive and lasting is that legacy? Some 30 percent of Houston’s teenagers have used promethazine with codeine to get high at least once, according to a 2004 study led by Dr. Ronald Peters of the University of Texas School of Public Health, published in the *Journal of Drug Education*.¹¹⁵ In an earlier study, 10 percent of Houston teens admitted using “syrup” at least once in the 30 days before the study, Peters and his colleagues also noted. “Anything over 4 percent in the last 30 days is a major drug problem,” Peters told the *Houston Chronicle*.

Street dealers typically sell the syrup for \$30 to \$40 per pint, the DEA says, but the teenagers in Peters’ studies also said common ways to obtain the drug include “unethical doctors, friends, unethical parents/child prescriptions,” and “stealing.” “Crooked doctors, you go to them and give them \$40 or \$50 and they will write you a prescription,” one teen said. “People use [their] children to play sick, and they get it and then just sell it to me,” another observed.¹¹⁶

Callie Hall Herpin and her cohorts certainly understood the strong local demand. In August 2006, Frederick Lamar Lindsay of Houston and a Northern California couple, Chuka and Jeri Ogele, also were federally indicted in San Francisco on 40 counts of possession and intent to distribute “large quantities” of hydrocodone and promethazine with codeine in Texas. Prosecutors say the couple headed a nonprofit company “allegedly set up to distribute medicine to AIDS victims in Nigeria.”¹¹⁷



Meanwhile, Houston’s ongoing experience with “lean” is rippling far beyond its epicenter. It “now represents a growing public health problem for African-American teenagers throughout the United States,” says Peters.

The Drugs

Since OxyContin emerged as a prized drug among abusers, volumes have been reported about its demand and impact: Its almost instant addictiveness, numerous cases of its theft at gunpoint

from pharmacies nationwide, the 2004 creation of a special OxyContin commission in Massachusetts, and failed state and federal legislation to ban the drug due to its “devastating effects.”

“The large profit in the sale of OxyContin—initially either being stolen or paid for by insurance—is a significant motivator for dealers, doctors and patients involved in the diversion of the drug,” said that Massachusetts commission.¹¹⁸ A prescription of 100 40-milligram OxyContin tablets might cost \$560 at the pharmacy. But its street value of \$0.50 to \$1 per milligram can make that prescription worth up to \$4,000 on the streets.

But OxyContin isn’t the only drug in illegal demand, or with an expensive black-market price tag. The DEA classifies controlled substances into five “schedules”—with Schedule I having the highest potential for abuse:¹¹⁹

- **Schedule I.** Includes illegal drugs such as heroin, marijuana, LSD and methamphetamine. They have great potential for abuse and no medical use.
- **Schedule II.** These drugs have high potential for abuse but do have accepted medical uses. This class includes such drugs as cocaine; morphine; oxycodone (OxyContin, Percocet, Percodan); fentanyl (Actiq, Duragesic); methylphenidate (Ritalin); amphetamine (Adderall); and methadone (Dolophine, Methadose) for pain and addiction to heroin and/or to legal opioids. Schedule II drugs are the most tightly controlled drugs. Thus they may be dispensed only with a written prescription. Preauthorized refills generally are not permitted, though some sequential refills soon will be authorized under a new DEA rule (*See p. 28.*).
- **Schedule III.** These substances have less potential for abuse, and thus may be dispensed upon written or phone prescriptions. Preauthorized refills are permitted. Included are hydrocodone (Vicodin, Lortab, Lorcet); anabolic steroids; and buprenorphine, a drug for treating opioid addiction and sold under the brands Subutex and Suboxone.
- **Schedule IV.** Includes benzodiazepines (tranquilizers) and many anti-anxiety drugs such as diazepam (Valium), alprazolam (Xanax) and lorazepam (Ativan); sleep medications such as Ambien, Sonata, and Lunesta; weight-loss drugs such as phentermine (Adipex); and certain painkillers such as Darvon and Darvocet.
- **Schedule V.** These drugs have the lowest abuse potential. They comprise certain codeine preparations, including promethazine syrup.

Despite OxyContin’s notoriety and highest diversion value, the Schedule III drugs—largely hydrocodone/Vicodin—are the most-abused and diverted. This is due partly to their lower cost and looser prescription requirements, drug-diversion experts say.

“Hydrocodone, oxycodone (immediate-release) and OxyContin [were] reported to be the most frequently abused and diverted opioid analgesics,” added another study reported at the American Academy of Pain Medicine’s 2007 annual meeting.¹²⁰ John P. Fitzgerald, MS, LPC, CAS and several colleagues—all of Purdue Pharma—studied 258 interviews conducted with law-enforcement officers, physicians, pharmacists and drug abuse treatment facility staff in 40 states in 2005.

Among the Schedule IV drugs, alprazolam/Xanax “appears to be the most abused drug in its class currently and is one of the top prescription drugs of abuse overall,” says Warren County (Ohio) Drug Task Force Commander John Burke.¹²¹

Among the Schedule II drugs, the stimulants Ritalin and Adderall are in high demand in the diversion market, and thus command relatively high prices. The fentanyl products—Actiq “perc-a-pops” and Duragesic patches—with street value of \$30 to \$40—cost nearly that much when purchased legitimately. This creates a smaller illicit trade.

Most recently, methadone has become one of the most-abused and deadliest Schedule II drugs.

The following list compares current retail and reported diversion market values for some controlled drugs. The retail prices are from Walgreens.com (a VIPPS). The typical street values come from several sources, including the Kentucky Attorney General’s office, the Warren County Drug Task Force and several local police departments:

DRUG	RETAIL PRICE	STREET VALUE
Schedule II		
OxyContin 40mg	\$5.66/tablet	\$20–\$40/tablet
oxycodone 40mg	\$4.54/tablet	\$6–\$8/tablet
morphine 100mg	\$4.16/tablet	\$60/tablet
Actiq 400mg	\$26/lozenge	\$30–\$40/lozenge
fentanyl 50mcg	\$24/patch	\$25–\$40/patch
methadone	\$0.19-\$0.23/tablet	\$10–\$20/tablet
Ritalin	\$1.11/tablet	\$8–\$15/tablet
Adderall	\$4.23/tablet	\$5–\$7/tablet
Schedule III		
Vicodin	\$1.47/tablet	\$6–\$10/tablet
hydrocodone/APAP	\$0.43/tablet	\$6–\$10/tablet
Schedule IV		
Valium	\$3.30/tablet	\$4/tablet
diazepam	\$0.39/tablet	\$4/tablet
Adipex (phentermine)	\$2.13/tablet	\$3–\$6/tablet
Xanax 2mg	\$3.28/tablet	\$4/tablet
alprazolam	\$0.42/tablet	\$4/tablet
Schedule V		
promethazine with codeine	\$3.35/fl.oz.	\$7.50–\$10/fl.oz.

The costs can add up quickly for abusers. A typical Vicodin abuser consumes 15 to 20 tablets a day, “and 45 to 50 per day is not uncommon,” notes Burke.¹²² Many abusers also take more than one drug at a time. For example, the muscle relaxant Soma (street value: \$3–\$4) produces an enhanced sense of euphoria when combined with Vicodin or methadone. To the diverter/seller, however, the sum of a drug’s parts can be worth more than the whole—a Duragesic or fentanyl patch that the diverter freezes and then cuts into many individually sold “chiclets,” for example.

Evolving Diversion Issues

Regulation of narcotic prescription drugs is evolving in response to the introduction of new drugs, broader therapeutic uses for existing medicines, and the emergence of pain management. But the drug-diversion marketplace also has evolved in response, thus providing major challenges for third-party payers. Several evolving and emerging issues warrant insurers’ attention:

Maker of new cancer drug seeks use for non-cancer pain

In September 2006, the FDA approved a new fast-acting fentanyl tablet called Fentora, for treating breakthrough pain in cancer patients. It is made by Cephalon, Inc., the manufacturer of Actiq. In mid-October, Cephalon announced that in a clinical trial, Fentora shows “efficacy in the management of breakthrough pain in opioid-tolerant patients with chronic low-back pain.”¹²³

The new Schedule II drug thus “may have application beyond its current indication in cancer and provide important support to our strategy for future label expansion in breakthrough pain associated with multiple chronic-pain conditions,” Cephalon says.

Patient base enlarged for opioid-dependency drug

Buprenorphine, a Schedule III drug sold under the brand names Suboxone and Subutex, is the only FDA-approved drug for treating heroin and other opioid dependency that also may be prescribed in physician offices. (Methadone, when used for treating addiction, may only be dispensed by regulated clinics.) “Because of its opioid agonist effects, buprenorphine is abusable, particularly by individuals who are not physically addicted to opioids,” said SAMHSA. “Like other opioids commonly abused, buprenorphine is capable of producing significant euphoria,” notes the DEA. “Data from other countries indicate that buprenorphine has been abused by various routes of administration (sublingual, intranasal and injection) and has gained popularity as a heroin substitute as well as a primary drug of abuse.” Twenty to 25 percent of the Subutex sold in France is destined for the drug-diversion market, the United Nations-affiliated International Narcotics Control Board said in its 2006 annual report.¹²⁴

Until recently, physicians who were registered and qualified to prescribe buprenorphine for addiction could treat no more than 30 patients at a time with it. But that limit increased to 100 patients under legislation President Bush signed in late 2006.¹²⁵

Prescribing restrictions for Schedule II drugs relaxed

Contrary to the current ban on preauthorized refills for Schedule II drugs, in September 2006 the DEA proposed allowing prescribers to issue multiple prescriptions for those substances.¹²⁶ Patients thus could obtain prescriptions for up to a 90-day supply of a drug such as OxyContin in one office visit. The multiple prescriptions could not be filled at once. They would have to be filled sequentially, on dates no earlier than those specified by the prescriber.

“Physicians must...employ the utmost care in determining whether their patients for whom they are prescribing Schedule II controlled substances should be seen in person each time a prescription is issued, or whether seeing the patient in person at somewhat less frequent intervals is consistent with sound medical practice and appropriate safeguards against diversion and misuse,” the DEA said in announcing the potential new rule.

“No physician should view the rule being proposed here as encouragement to see his/her patients (those who are being prescribed Schedule II controlled substances) on a less frequent basis; nor should any physician view this document as a signal to be less vigilant for the signs of diversion or abuse,” the agency noted. The DEA published the final version of the new rule in November 2007, with an effective date of December 19, 2007.

Methadone may be the “new OxyContin”

“Methadone, a painkiller that has been used to treat heroin addicts for decades, has emerged as an increasingly popular and deadly street drug, joining narcotics such as Vicodin and OxyContin as frequently abused prescription drugs,” *USA Today* reported on Feb. 13, 2007.¹²⁷

Nearly 3,850 people died from methadone overdoses in 2004—more than from any other single narcotic—and a 390-percent increase since 1999, notes a study released in December 2006 by the National Center for Health Statistics.¹²⁸ Roughly 80 percent of those deaths were “accidental.”

Methadone may be dispensed only by regulated clinics when used for treating heroin and other opioid addictions. But any physician can prescribe it for pain treatment. In fact, physicians increasingly prescribe methadone, partly because of the drug’s low cost. At a typical retail price of \$.19 to \$.23 per dose,¹²⁹ for example, methadone is by far the least-expensive narcotic one can prescribe. This has led more and more physicians to prescribe it as a lower-cost alternative to OxyContin and even generic opioids.

“Insurance companies favor it because it is cheap and effective,” said the *West Virginia Gazette* in a December 2006 story on the NCHS finding that West Virginia led the nation in per-capita deaths from accidental methadone overdose. Physicians who prescribe methadone versus other narcotics “find it easier...to get approval from Medicaid,” and might believe they draw less attention from law enforcement or licensing boards, SAMHSA senior public health analyst Nicholas Reuter said in the *USA Today* story.¹³⁰

Methadone’s addictive qualities and rapid spread as a pain medication have made it worth as much as \$20 per tablet on the streets. “It’s out there, it’s available, and it can be dangerous,” the DEA’s Denise Curry told *USA Today*. Pharmacies rank methadone with OxyContin and Vicodin as a high-value theft target, she also noted.

Sold under the brand names Dolophine and Methadose, methadone remains in the body far longer than other narcotics—up to 59 hours says the FDA. Taking the drug even as directed thus can be dangerous. In fact, methadone can be so deadly that the FDA—as it did earlier with fentanyl—issued a public-health advisory in October 2006. It was titled, “Methadone Use for Pain Control May Result in Death.”¹³¹ The advisory urged physicians and patients to use great caution in prescribing and consuming the drug.

The FDA also scrapped existing references to any “usual adult dosage” for methadone, and issued 17 pages of new prescribing information, including:

- The risks of death from mixing methadone with anti-anxiety drugs such as Xanax, and from the drug’s potential effect on heart rhythms in some patients; and
- The need for physicians to measure a patient’s recommended dosage very carefully.

Methadone thus might be a blessing as a cost saver for insurers, but a curse because of its large diversion impact. Diverters and abusers can obtain methadone more easily than OxyContin, but it features even more-serious patient safety concerns. It also calls more attention to the increasingly severe societal toll that diversion is taking.

Dire Consequences

Despite the heightened attention today, the sometimes-fatal effect of addictive prescription drugs is not a new development. In an award-winning series published in 2002, the *South Florida Sun-Sentinel* documented 393 prescription-drug deaths in seven area counties over the prior two years, and a 71-percent increase in such deaths in the prior year alone.¹³²

OxyContin or its generic version was present in 224—or 57 percent—of those deaths, hydrocodone in 20 percent and methadone in 23 percent. “Medical examiner records showed that these three major painkillers often were prescribed in combination with each other, or with other medicines such as Soma, a muscle relaxant, or Xanax, an anti-anxiety drug, or their generic forms,” the *Sun-Sentinel* reported.

The 393 victims—14 who were patients of just one physician—spanned virtually all walks of life. They included teenagers and seniors, the employed and unemployed, addicted chronic pain sufferers and drug abusers. Among other findings:

- 39 physicians or pain clinics had two or more patients die during the two-year period, with three physicians each losing four patients; and
- In 38 of the deaths, drugs prescribed by three or more physicians were found at the scenes, with six or more prescribers’ drugs found in one-third of those cases.

“The newspaper’s study confirmed what medical examiners, prosecutors and police in South Florida suspect: Powerful legal narcotics are killing the very people they are supposed to help,” the *Sun-Sentinel* concluded. “There are dead bodies popping up all over the place, and they’re not getting there by accident,” Broward County Sheriff’s Office Detective Lisa McElhaney told the newspaper. “Somebody is accountable for that, whether they wish to be or not.”

Port St. Lucie, Fla. “pain specialist” Dr. Asuncion Luyao routinely prescribed OxyContin, Xanax and other drugs without performing physical exams. Some patients traveled up to 160 miles to buy prescriptions from her. She received 50 years in state prison for manslaughter, racketeering and drug trafficking in April 2006.¹³³ In retrospect, the title of the *Sun-Sentinel* series—“Rx for Death”—was a grim preview of headlines that are now commonplace:

- **“Fatal Prescription Drug Overdoses Growing, Study Says”**—*HealthDay* (April 20, 2006);
- **“More Drug Overdose Deaths from Prescription Painkillers Than Cocaine or Heroin in U.S.”**—*Medical News Today* (July 25, 2006);
- **“Potent Painkiller Blamed in SMU Student’s Death”**—*Dallas Morning News* (Dec. 21, 2006);
- **“Dramatic Rise in Accidental Drug-Overdose Deaths Reported”**—*CNN.com* (Feb. 9, 2007);
- **“Deadly Abuse of Methadone Tops Other Prescription Drugs”**—*USA Today* (Feb. 13, 2007);
- **“Methadone Emerges As New Killer”**—*Los Angeles Times* (Feb. 26, 2007); and
- **“Valley Cases Show Misuse of Fentanyl Can Be Deadly”**—*Daily Item, Sunbury, Pa.* (Dec. 17, 2006).

Drug diversion “is epidemic. In South Boston and Charlestown, it’s taking lives,” says Stephen L. Hoffman, Assistant Attorney General in the Massachusetts Medicaid Fraud Control Unit.

This reality is evident in the Bay State and throughout the U.S. With 19,838 such deaths in 2004, accidental drug overdose became the second-leading cause of death from unintentional injury in the U.S., exceeded only by motor vehicle fatalities, said the U.S. Centers for Disease Control and Prevention

(CDC).¹³⁴ Such deaths soared 78 percent, the CDC said in a widely reported finding announced in February 2007. Both sedatives and prescription pain medications such as Vicodin and OxyContin were key factors.

“Nearly all poisoning deaths in the United States are attributed to drugs, and most drug poisonings result from the abuse of prescription and illegal drugs,” the CDC observed. Some 23 states saw increases in such deaths of more than 100 percent, between 1999 and 2004. Among the highest: West Virginia at 550 percent, Oklahoma at 226 percent and Maine at 210 percent.

“The largest increases were among females (103 percent), whites (75.8 percent), people living in the southern U.S. (113.6 percent), and people aged 15 to 24 years (113.3 percent),” the CDC noted.

“Prescription drug overdose deaths have been climbing through the roof,” Washington State Department of Health Epidemiologist Jennifer Sabel told the *Spokane Spokesman-Review* in the Feb. 4, 2007 edition. “Even doctors don’t really realize the magnitude of the deaths,” which rose from 45 to 411 between 1995 and 2004 in her state, she said. Narcotic painkillers accounted for 267 deaths in 2004—up tenfold from the 23 recorded in 1995.¹³⁵

These findings sharply focus the trend to which the CDC has called attention for some time. “A national epidemic of drug poisoning deaths began in the 1990s,” Leonard Paulozzi and his CDC colleagues wrote in the September 2006 issue of *Pharmacoepidemiology and Drug Safety*.¹³⁶

While “unintentional drug poisoning mortality rates increased...on average 18.1% per year from 1990 to 2002,” the authors stated that between 1999 and 2002, “the number of opioid analgesic poisonings on death certificates increased 91.2%, while heroin and cocaine poisonings increased 12.4% and 22.8%, respectively. By 2002, opioid analgesic poisoning was listed in 5528 deaths—more than either heroin or cocaine. The increase in deaths generally matched the increase in sales for each type of opioid. The increase in deaths involving methadone tracked the increase in methadone used as an analgesic rather than methadone used in narcotics treatment programs.”

New Mexico, for example, has “the highest rate of drug-induced mortality in the United States,” with deaths from unintentional prescription drug overdoses rising 179 percent between 1993 and 2003, reported CDC’s Mark R. Mueller, MPH and two colleagues in the May 2006 *American Journal of Preventive Medicine*.¹³⁷

Of the 765 New Mexico deaths caused by prescription drugs, 590 (77.1 percent) were caused by opioid painkillers, 263 (34.4 percent) by tranquilizers and 196 (25.6 percent) by antidepressants.

New Mexico’s 11.6 deaths per 100,000 residents in 2003 compared to a low of 7.2 per 100,000 in New Hampshire, says the Drug Abuse Warning Network (DAWN), a SAMHSA agency that gathers drug-abuse mortality data in six states.¹³⁸

Abuse and its dangers go well beyond youths, and most people who die from prescription narcotic misuse have taken more than one substance, the DAWN report suggests. In five of the six DAWN states, for example:

- Most deaths in 2003 were among people age 35 to 54;¹³⁹ and
- The vast majority of deaths involved multiple drugs, ranging from 66 percent in Maine to 93 percent in Utah.¹⁴⁰



Abuse Prominent in ER Visits

Hundreds of thousands of people land in emergency rooms each year from abuse. In fact, abuse-related ER visits grew 21 percent between 2004 and 2005, DAWN reported in March 2007.¹⁴¹

Of the roughly 1.4 million ER visits related to drug abuse or misuse in 2005, just under 600,000

involved pharmaceuticals, said DAWN. This almost equals cocaine- and heroin-related ER visits *combined*. In most cases, the drugs were narcotic painkillers such as hydrocodone, oxycodone and methadone, with overdoses of the latter up 29 percent over 2004. Behavioral medications also were prominent, with tranquilizer overdoses up 19 percent in 2005, and overdoses of methylphenidate or its brand counterpart (Ritalin) doubling their 2004 totals, DAWN said.

Even abuse of over-the-counter drugs factors heavily in ER visits. In November 2006, SAMHSA reported that non-medical use caused

nearly half of the 12,584 ER visits in 2005 that involved the dextromethorphan commonly found in non-prescription cough and cold medicines.¹⁴² DXM-based emergency treatments among patients age 12 to 20 were nearly three times the treatments of older age groups.

Opioids Causing Liver Failure

Among the biggest risks from abusing some opioids is liver failure or severe damage from consuming toxic levels of the acetaminophen found in many pain medicines.

“Acetaminophen poisoning has become the most common cause of acute liver failure (ALF)” in the U.S. as of 2003. It accounts for 51 percent of that year’s ALF cases, versus 28 percent in 1998, said Anne M. Larson, MD of the University of Washington Medical Center, and her colleagues. They made headlines in the medical world with their groundbreaking study in the December 2005 issue of *Hepatology*.¹⁴³ Nearly half of the 275 cases they studied stemmed from unintentional overdoses of acetaminophen. They outnumbered deliberate overdoses (suicide attempts), which accounted for 44 percent as of 2003, the report says. Of patients who overdosed unintentionally, “63 percent had used narcotic-containing compounds,” usually Vicodin.

The recommended daily limit of acetaminophen for adults is four grams, or 4,000 milligrams. A 10-milligram Vicodin HP tablet contains 660 milligrams of acetaminophen. So at the maximum daily dose of six tablets per day, an adult would consume just under the recommended daily limit of acetaminophen. But a Vicodin addict or abuser who consumed 15 to 20 tablets per day would ingest from 9,900 to 13,200 milligrams—or 2 1/2 to more than three times the limit.

While Larson *et al* found abusers ingested a median dose of 24,000 milligrams, the researchers also found ALF patients who had taken less than 4,000 milligrams per day. Thus, “there is no chronic form of injury, but rather a threshold of safety that may be breached with devastating results,” the authors warned.

More than one of four patients who were studied—74 total—died without a liver transplant. A majority of 178 survived their ALF episodes without a transplant, but 23 had transplants.

Acetaminophen poisoning “far exceeds other causes of acute liver failure in the United States,” they warn. And “susceptible patients have concomitant depression, chronic pain, alcohol or narcotic use, and/or take several preparations simultaneously.”



Roughly paralleling the increased ALFs from acetaminophen poisoning is a dramatic increase in the nation's annual liver transplants. Some 4,981 transplants were performed in 2001. The number increased 20 percent to 5,979 in 2005, said a 2005 *Milliman Research Report* on organ and tissue transplant costs.¹⁴⁴

A liver transplant typically costs just under \$393,000 in the recipient's first year, with thousands of dollars in prescription and medical follow-up costs every year thereafter, *Milliman* said.

INSURANCE IMPACT AND RISK EXPOSURE

As noted, drug diversion clearly poses a threefold cost threat to insurers:

- Direct costs of fraudulent prescription claims;
- Medical claim costs of prescription drug abusers; and
- Potential liability exposure from passively paying controlled-substance claims. Insurers are dangerously exposed by not decisively detecting and preventing the epidemic of abuse that causes prescription-drug deaths and injuries.

Scope & Impact: Moving Targets

Measuring exact diversion losses is an inexact science. The crime's complexity and the difficulty of gathering hard data create a formidable challenge to detecting diversion, let alone determining its cost. Even so, what data do exist paint a sobering picture.

Wide range of schemes & offenders

In its simplest form, drug diversion can involve a teenager stealing Valium or Vicodin tablets from a parent's medicine cabinet. Diversion also can involve a far-flung criminal enterprise involving dishonest prescribers and pharmacists, patients—genuine or bogus—who abuse and/or sell the drugs, and drug dealers who create lucrative street markets for the products.

Between these extremes lie many diverse combinations of schemes and perpetrators. Not all drug-diversion cases, for example, involve prescribers and/or pharmacies, or even insurance claims. Conversely, a pharmacy case with thousands of fraudulent prescription claims might not involve the actual diversion of drugs. But other cases might feature all of those elements.

Medical providers, especially, can cause enormous damage:

- In Philadelphia, two co-owners of an independent pharmacy added narcotic prescriptions to customers' real claims in order to be paid a second time for drugs they had sold to others for cash. The fraud was detected when the insurer's datamining software found simultaneous Schedule II prescription claims for patients with no corresponding medical claims for conditions to warrant narcotic painkillers. That case resulted in repayment of \$800,000 to Independence Blue Cross (IBC), says Edward J. Litchko, Senior Director of Corporate and Financial Investigations for the insurer.
- In a similar case, on April 11, 2007, former Salt Lake City physician Alexander Theodore pleaded guilty for his pivotal role in an OxyContin diversion ring in which some 230 people have been criminally charged.¹⁴⁵ Insurance coverage of OxyContin prescriptions, which

Theodore sold to patients with drug benefits—who then turned the drugs over to street dealers—was a pivotal part of the scheme. In an 11-month period, Theodore prescribed more than 73,000 OxyContin tablets—likely worth about \$400,000 at retail. Other Utah pain clinic physicians prescribed 720 to 8,500 tablets in that same period.

But in any doctor-shopping case, the drug-seeking patient might be the *only* perpetrator. The shopper might receive prescriptions after being examined for symptoms that are real, exaggerated or phony. Unknown to each other, the prescribing physicians, facilities and pharmacies might provide services and drugs in good faith based on the patient’s deceptions.

In most doctor-shopping cases, the insurance impact includes both:

- The prescription cost of the diverted drugs; and
- Related medical claims involving prescribing or directly providing the drugs—for physician and/or emergency room visits and diagnostic and/or therapeutic treatments.

Those medical services usually are provided in good faith, and cost insurers considerable money. But it can be nearly impossible for insurers to include, let alone recoup, those costs in fraud cases against individual doctor shoppers. For example, an insurer might lose tens of thousands of dollars in medical claims related to \$1,500 of fraudulent claims for a drug seeker’s narcotics.

But in other cases, insurance claims are a primary source of profits for a dishonest prescriber. Consider former Ohio doctor Kyle Howard, who pleaded guilty to Medicaid fraud in 2004.¹⁴⁶

Howard had long billed Medicaid, private insurers and the Ohio Bureau of Workers’ Compensation for 25-minute office visits with 40-70 patients—or the equivalent of 16 to 29 hours of work per day. Howard’s alleged sale of drug samples (packaged in urine-specimen cups) and prescription catering to drug-seeking patients paled in comparison to his fraudulent insurance claims. Howard pleaded guilty, and was ordered to repay \$221,000 to various insurers and forfeit \$400,000 to the area drug task force.

Conversely, some insurers report diversion schemes by physicians who sell prescriptions for cash and do not submit medical claims. This is presumably to avoid appearing on the insurers’ radar screens, and bolster a possible legal defense against complicity in a fraud scheme.

“The majority of our diversion cases have had few medical claims or none at all,” says Kandyce Cowart, a senior investigator at Blue Cross Blue Shield of Louisiana and President of NADDI’s Louisiana Chapter. “In South Louisiana we have a great number of illicit pain clinics that operate with cash-only transactions, and as a result we’re seeing cases of tremendous drug utilization—\$2,000 to \$3,000—with no corresponding medical claims.”

In some of those cases, “people have sought out our plan just for prescription coverage,” Cowart notes.

Similarly, a physician prescribing OxyContin to several members of a phony employee group took umbrage at being scrutinized during the insurer’s investigation, IBC’s Litchko says. “He wanted to know why, because he hadn’t submitted medical claims to us, we were even questioning him,” Litchko recalls.

Costs of Abuse & Doctor Shopping

If drug diversion’s insurance impact is compared to pain, the larger high-dollar diversion cases would be acute or “breakthrough” pain for insurers. The smaller doctor-shopping cases would be the chronic, more-frequent—and costlier—pain. All told, the large volume of smaller doctor-shopping schemes may bleed the most money from insurers, one smaller claim at a time.

“Most big provider-based diversion cases are going to be detected and stopped eventually, but the little-fish member cases are costing payers much more in the long run,” says Richard N. Southworth, CFE, AHFI, a veteran healthcare investigator and President of TGJ Consulting Services. Longtime diversion expert and fellow TGJ consultant Cecile Custer, RN, agrees. “In my experience, 90 percent of drug diversion is committed by members,” she says. Most is typically through doctor shopping.

“Law enforcement agencies who concentrate on prescription drug diversion on a full-time basis are likely spending over 40% of their time investigating doctor-shopping cases,” NADDI President Burke says on the association’s website.

In the eight-million-member Federal Employee Health Benefits Program (FEP), more than half of which is administered by the nation’s 39 Blue Cross Blue Shield plans, “we do between 80 and 100 doctor-shopper cases a year,” says Charles Focarino, Director of the Blue Cross Blue Shield Association’s (BCBSA) system-wide FEP Special Investigations Unit. “Ninety percent of the cases we refer to law enforcement are doctor shoppers, and the other 10 percent are pharmacies and prescribers.”

Aetna, Inc. has one of the private health-insurance industry’s strongest anti-fraud units and all-around approaches to fraud. Aetna stands out for the resources and attention it devotes to potential fraud by providers *and* plan members. Unlike most health insurers, the company dedicates several investigators to cases involving plan members and pharmacies. Those cases comprise nearly 40 percent of Aetna’s overall fraud caseload.

Nearly half (48 percent) of the Aetna member/pharmacy anti-fraud team’s 1,065 active investigations as of November 2006 involved prescription benefits. Doctor shopping “typically is the most common drug diversion scheme that we see,” said Pharmacy Team Leader Tabitha J. Kielb. Of her team’s 513 open prescription cases at that time:

- One-third involved drug over-use by the member;
- Another 20 percent involved prescription forgery, while a small fraction involved identity-related prescription issues; and
- About 10 percent of the investigations focused on provider over-use, or excessive prescribing.

Doctor shoppers also can be prolific:

- One Aetna member obtained prescriptions from 72 physicians over 22 months; another member from 66 doctors in a similar period;
- A large Virginia health insurer saw claims for 400 emergency room visits throughout the Washington, D.C. area by one member over 305 days;
- One FEP member obtained 386 prescriptions worth \$39,000 in two years;
- A Louisiana health insurer busted a husband-and-wife team who visited up to three ERs in one night; and
- An Ohio woman filled prescriptions from 69 physicians at 21 pharmacies in a three-state area. Her claims amounted to \$80,000, the Warren County task force notes.

Utah’s insurance fraud bureau opens eight to 10 doctor-shopper investigations each month from referrals by the state’s Department of Commerce, which monitors Utah’s controlled substance database. “There are many more potential cases, but that’s the most we can handle in a given month,” notes Joe Christensen, head of the fraud bureau.

The typical doctor shopper sees five to 10 prescribers and generates \$10,000 to \$15,000 a year in drug and medical claims, says NADDI’s Burke. Christensen cites even higher costs: “Over a year’s time

in a given doctor-shopping case, an insurer might be paying for fewer than 5,000 Lortab pills but more than \$100,000 in medical and emergency room claims,” he says.

The aforementioned FEP member’s \$39,000 in prescriptions paled compared to an accompanying \$144,000 in medical claims, notes Focarino: “It’s not uncommon to see \$2,000 in prescriptions but \$15,000 in emergency room claims—typically for complaints such as migraines, pelvic pain and low-back pain.”

Several insurance-industry analyses agree, especially about the potential magnitude of medical claims involving drug-seeking and -abusing patients. Those costs have been researched and quantified to varying extents, unlike fraud estimates. They also represent one aspect of drug diversion over which third-party payers can:

- Take effective corrective and preventive actions;
- Reduce high expenses; and
- Lower liability risks by preventing casualties from drug abuse.

Medco: Doctor shopper costs 7 times higher

Medco Health Solutions, one of the nation’s largest PBMs, studied 1,000 prescriptions of members who were suspected abusers. “...these members likely engaged in serial acts of ‘doctor shopping,’ and received multiple concurrent prescriptions that were filled by numerous retail pharmacies,” Medco found in a 2005 analysis.¹⁴⁷

The results provide “a striking profile of people who file excessive prescription claims for drugs of potential abuse and how their risky habits are bilking the healthcare system,” the company said.

Among the findings:

- “Members in the high-utilization category filled prescriptions at five different pharmacies and received prescriptions from six different doctors.” Some came from as many as 21 physicians;
- “Nine out of 10 prescriptions...were dispensed by a retail pharmacy;”
- “Nine out of 10 cases...involved excessive claims for narcotics (opioids),” while the remaining 10 percent comprised anti-anxiety drugs, muscle relaxants and hypnotics;
- “On average, monthly prescription spending by high-utilization patients during the three-month analysis period exceeded \$400, nearly seven times the monthly drug costs of members without excessive prescription claims;” and
- Many suspected abusers were older, Medco found: 50 percent were age 40 to 49. They were more than four times the number of high-using members age 20-29, and 11 times those members age 30-39.

WellPoint costs: \$41 in claims for \$1 in prescriptions

Startlingly, abuse suspects incurred \$41 in claims for office visits and outpatient treatment for every \$1 in narcotic prescription claims, says Jeffrey Sterling, Esq., who oversees the prescription-related anti-fraud operations for WellPoint, Inc.

In a pilot project that formed the basis for a program to identify and address doctor-shopping members, WellPoint analyzed the drug costs and related medical expenses of 100 members suspected of doctor shopping (not including cancer patients and/or those with recent surgeries).

The members had obtained multiple narcotic prescriptions from five or more prescribers and five or more pharmacies over a specific 90-day period. After quantifying their prescription sources and costs, WellPoint totaled their claims for physician office and outpatient facility visits during those 90 days:

NARCOTIC PRESCRIPTION EXPENSES	
Prescriptions	1,217
Prescribers	689
Pharmacies	608
Total Paid Narcotic Claims	\$20,233
Related Medical Services	
Office visits	4,131
Outpatient facility visits	958
Total Visits	5,089
Related Medical Claim Costs	
Office visits	\$450,148
Outpatient facility visits	\$382,024
Total Claim Costs	\$832,172
Averages Per Member	
Prescriptions	12
Prescribers	7
Pharmacies	6
Office visits	41
Outpatient facility visits	10
Narcotic prescription costs	\$202
Medical claim costs	\$8,322
Medical Costs to Rx Costs	\$41 to \$1

“With most narcotic prescriptions written for generic drugs, a doctor shopper’s total prescription cost will tend to be relatively low. But if a company looks only at the narcotic dollars, it’s not going to get much of a picture of that patient’s true cost impact,” Sterling says. “Especially with Schedule II drugs, the patient has to have a written prescription each time, so you have to look closely at the office and emergency room visits.”

Thus, “doctor shopping is the biggest chronic problem” regarding drug diversion’s impact on third-party payers, he adds.

Opioid Abusers Cost \$14,000 More Per Year

Drug diversion’s greatest impact on third-party payers—private and public—lies in the excess medical expenses related to narcotics abuse—regardless of how the abuser obtained the drugs, says research led by the Boston-based Analysis Group, Inc.

Patients “who were opioid abusers had health care costs that were more than 8 times higher than those of non-abusers,” said a study in the July/August 2005 edition of the *Journal of Managed Care*

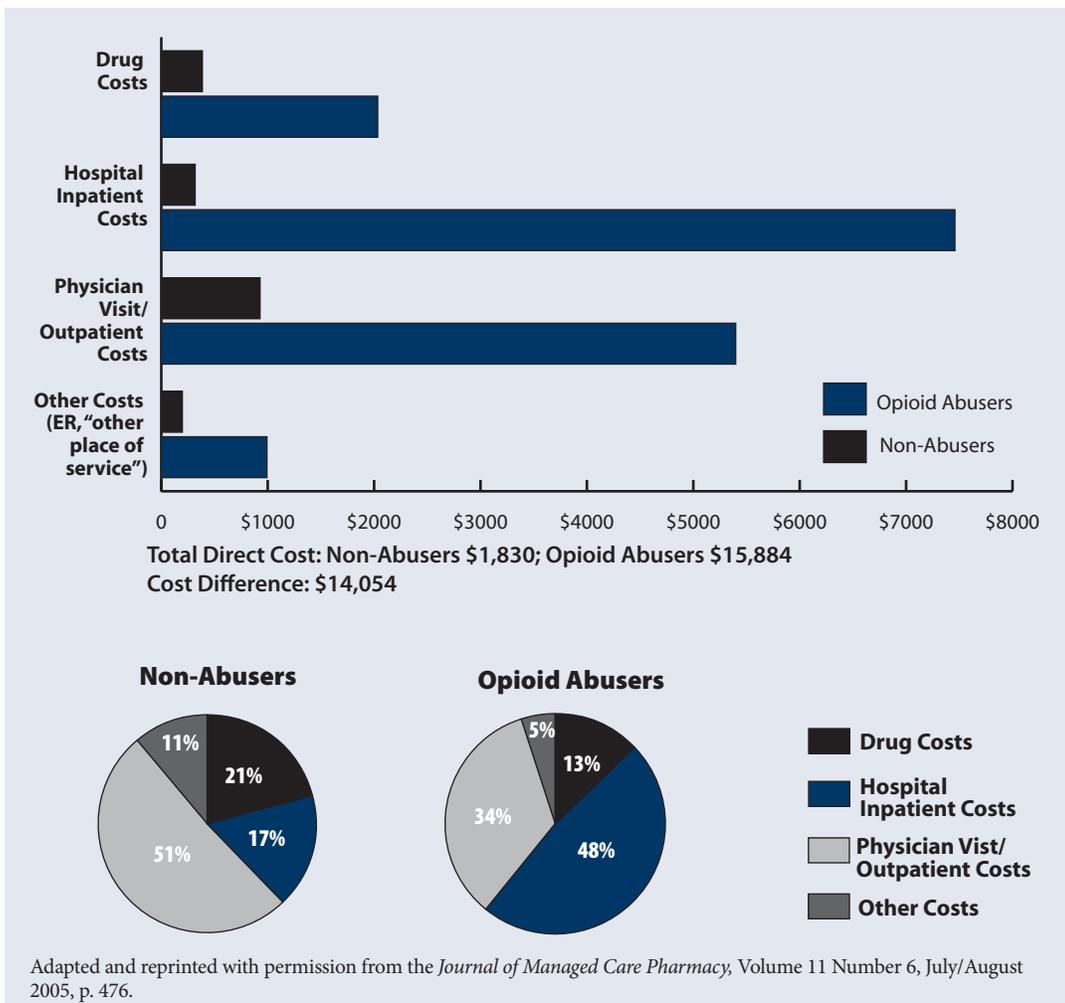
Pharmacy by Alan G. White, PhD, Howard G. Birnbaum, PhD *et al.*¹⁴⁸ “The total average per-patient direct health care payer cost for opioid abusers was \$15,884 compared with \$1,830 for non-abusers...the excess annual cost burden of opioid abuse was \$14,054 per patient,” they said.

The researchers used claim data for two million insured members of 16 large self-insured employers across a wide range of industries nationwide between 1998 and 2002. The study measured “the per-patient costs incurred by payers arising from all medical and pharmacy claims made for patients diagnosed with opioid abuse.” That diagnosis required at least one claim with one of four ICD-9-CM codes relating to opioid dependence, abuse or poisoning by opiates and related narcotics (excluding heroin).

The researchers’ final patient groups consisted of 740 opioid abusers and 2,220 non-abusers. Except for the absence of an opioid-related diagnosis, the non-abusers met the same criteria as the abusers (i.e., “aged 12 to 64 years, continuously enrolled in a health care plan during all 12 months of the study period, and having at least 1 medical or prescription drug claim during that year.”)

The researchers avoided skewing the results toward the cost of onset and immediate treatment of opioid abuse itself. Rather, “the goal was to capture a payer’s typical direct medical cost burden for the average annual cost of illness for all patients diagnosed with opioid abuse who may have been in different stages of their abuse: onset, treatment, management and/or recovery.”

That average annual cost difference, in 2003 dollars, broke down as follows:



In 2007 dollars, the excess annual cost of an opioid abuser totals \$16,485, assuming an annual medical cost inflation of 4.3 percent since 2003.¹⁴⁹ Among the study's other key findings:¹⁵⁰

- Diagnosed opioid abuse rose 60 percent between 1998 and 2002, from five per 100,000 people to eight per 100,000. This was a significant increase. But it was small compared to the 2005 NSDUH finding that 1.9 percent of the U.S. population—or 1,900 persons per 100,000—admitted abusing opioids within the “past month;”
- 71.1 percent of abusers had a claim history of psychiatric diagnosis and mental disorder treatment, compared to 8.4 percent of non-abusers;
- Abusers were 12.2 times more likely to have had at least one hospital inpatient stay, and four times more likely to have had an emergency-room visit;
- Opioid abusers averaged 18.7 physician or outpatient visits compared with seven for nonabusers;
- Opioid abusers averaged 41.6 prescription drug claims each, compared with 13.8 for nonabusers;
- Nearly 50 percent of opioid abusers were diagnosed with some chronically painful condition (most commonly “low back pain,” found in 19 percent). This compares to the 17.3 percent of non-abusers who had a pain diagnosis; and
- The prescription and use of opioids was not uncommon even among non-abusers: 20 percent had claims for long-acting painkillers (e.g., extended-release oxycodone, fentanyl and methadone), short-acting opioids (e.g., hydrocodone) or both.

Health Insurers Lose Billions

Overall, drug diversion costs health insurers up to \$72.5 billion a year from opioid abuse alone (excluding stimulants, sedatives and steroids). This includes up to \$24.9 billion annually for private insurers. Annual excess costs for the largest private insurers could approach \$1 billion each. These estimates combine Analysis Group findings with NSDUH abuse data. They allow several cost scenarios that, even conservatively, reveal a surprisingly large financial drain. The cost scenarios reflect these facts and assumptions:

- Opioids are by far the most-abused prescription drugs;
- Annual excess cost of diagnosed opioid abusers is \$16,485 in 2007 dollars;
- 4.4 million current opioid abusers, based on the NSDUH's 2005 finding of “past-month” abuse by 2.1 percent of the U.S. population age 12 and above—or 5.2 million persons—reduced by 16 percent to reflect the uninsured (assumes the NSDUH's “past-month” group comprises a “harder core” of opioid abusers than the higher percent who admitted “past-year” use.);
- Private insurers will pay 34.3 percent of national healthcare expenses for 2007;¹⁵¹ and
- U.S. population of 304 million for 2007.¹⁵²

Two of the following scenarios, however, use even more-conservative assumptions:

Scenario A: Insurer Excess Costs (fully loaded)

This “fully loaded” scenario multiplies the number of opioid abusers, minus the uninsured, by the average annual excess cost of diagnosed opioid abusers.

- **\$72.5 billion total cost:** 4.4 million abusers x \$16,485
- **\$24.9 billion private insurance cost:** \$72.5 billion x 34.3 percent

Scenario B: Insurer Excess Costs (more conservative)

This conservative scenario multiplies the insured opioid abusers by the average excess cost computed by the Analysis Group—but arbitrarily eliminates its in-patient component to adjust for undiagnosed abusers.

- **\$37.7 billion total cost:** 4.4 million abusers x \$8,572
- **\$12.9 billion private insurance cost:** \$37.7 billion x 34.3 percent

Scenario C: Insurer Excess Costs (most conservative)

This most-conservative estimate arbitrarily assumes only a one-percent incidence of opioid abuse multiplied by the conservative excess annual cost listed above:

- **\$18 billion total cost:** 2.1 million abusers x \$8,572
- **\$6.2 billion private insurance cost:** \$18 billion x 34.3 percent

Scenario D: Excess Costs for Individual Plans

Diversion costs individual private health plans up to hundreds of millions of dollars annually (excluding schemes in which a provider deliberately does not submit medical claims). Using the most-conservative cost figures, and assuming only one percent of a plan’s members are abusers, individual plans can incur these excess annual costs:

Plan size	Excess annual costs
■ 10 million lives x 1 percent abusers = 100,000 members x \$8,572	\$857 million
■ 1 million lives x 1 percent abusers = 10,000 members x \$8,572	\$85.7 million
■ 500,000 lives x 1 percent abusers = 5,000 members x \$8,572	\$42.9 million
■ 250,000 lives x 1 percent abusers = 2,500 members x \$8,572	\$21.4 million
■ 100,000 lives x 1 percent abusers = 1,000 members x \$8,572	\$8.6 million

Exact losses are impossible to measure, however. Current research has gaps such as:

- There are indications of the higher drug and medical costs of likely doctor shoppers, but what percent of prescription drug abusers engage in doctor shopping?
- The excess drug and medical costs of the average diagnosed opioid abuser are known, but do they differ much from the overwhelming majority of abusers who have not been formally diagnosed? Is the undiagnosed abuser a more-active and thus more costly drug seeker, or does the diagnosed abuser cost more by virtue of receiving substance abuse treatment?
- Though there are concrete cost data on abuse of opioid painkillers, there are no cost findings on abuse of stimulants or sedatives.

Liability Risk Growing

Beyond the direct impact on overall medical outlays, insurers might incur a major liability risk from paying diversion-related prescription claims. Consider this plaintiff attorney’s closing argument in a hypothetical liability lawsuit against an insurer:

“Ladies and gentlemen of the jury, as you’ve heard and seen, the basic facts of this case have never been in dispute.

“On August 7, 2006, a delivery truck driven by John Brown crossed the median strip on Florida’s Turnpike and crashed head-on into a car carrying my client Mary Smith, her husband Scott, and their 11-year-old daughter Jennie.

“Scott and Jennie Smith both were killed instantly, and so was John Brown. Mary Smith was severely injured and, after a long hospital stay and several surgeries, she is permanently disabled. She can’t work or support her surviving child, eight-year-old Scott, Jr.

“As you heard the medical examiner testify, John Brown’s autopsy showed that as Mr. Brown drove down the turnpike, he practically had a drugstore’s worth of prescription painkillers, tranquilizers and muscle relaxers in his system. They included the narcotic Vicodin; the tranquilizer Xanax; and a muscle relaxant called Soma that many prescription drug abusers take to feel even more euphoric. All the drugs were at levels that would have made John Brown as incapacitated and as dangerous as the worst drunk driver.

“Mr. Brown was a crash waiting to happen. Tragically, all members of the Smith family were his innocent victims.

“The reason we’re all here is that this awful crash, the tragic deaths of Mary Smith’s spouse and daughter, and her own devastating injuries could have been prevented.

“They could have been prevented if only the one party with a clear view of the serious threat John Brown posed—TheBest Health Plan, his health insurer—had bothered to look at the information and act on the warning signs that were right under its corporate nose. Let’s review why:

“You’ve heard testimony that TheBest Health Plan paid for 42 prescriptions between January 1 and August 5, 2006—for narcotic painkillers, controlled tranquilizers and muscle relaxants—that John Brown obtained from six physicians and filled at six pharmacies.

“You’ve heard five of those physicians and all of the pharmacists testify that they didn’t know—and had no way of knowing—that Mr. Brown was obtaining the prescriptions and drugs at the same time. It’s possible that he deceived them by faking pain and other symptoms. The sixth physician, who for several years has been our state’s largest prescriber of OxyContin, has been indicted on drug trafficking charges.

“You’ve heard testimony that during those same seven months, TheBest Health Plan also paid for five emergency-room visits by Mr. Brown. Each visit occurred at different hospitals along Mr. Brown’s regular driving route between Miami and Orlando. He received prescriptions for narcotic pain medications at each facility.

“You’ve heard testimony and seen the statistics—both nationwide and from Florida—about a ‘national epidemic,’ a ‘public health crisis’ of abuse and diversion of prescription drugs.

“You’ve seen headlines in local and national news stories, and many studies, about the growing number of prescription drug overdoses and deaths. The brutal truth is that these overdoses and deaths occur throughout the country, and especially here in South Florida.

“You’ve heard expert witnesses testify that all of the controlled drugs John Brown obtained—for which TheBest Health Plan paid—are classified by the DEA as ‘drugs of abuse’ with street values that far exceed their retail prices.



“You’ve heard expert physicians, pharmacists, and the federal Food and Drug Administration testify to the incapacitating, and potentially deadly, impact of consuming those drugs improperly. Mr. Brown put his own life—and the lives of others—at grave risk.

“You’ve heard those same experts testify that Mr. Brown’s prescription and emergency room activity was typical of drug-seeking and doctor-shopping behavior. He had no medical condition to warrant the quantities and combinations of the drugs.

“You’ve reviewed the Florida doctor-shopping law, which makes it a crime not to tell a prescriber from whom you’re obtaining a prescription for a controlled drug, or the drug itself, that you’ve obtained a prescription within the previous 30 days.

“You’ve also reviewed the Florida Insurance Fraud statute, which makes it a felony to cause a practitioner to file a health insurance claim containing any false, incomplete or misleading information. This

includes a diagnosis based on symptoms that one has faked.

“Now let’s see what TheBest Health Plan could have done—but didn’t.

“You heard experts testify about how some health insurers and government programs handle cases such as John Brown’s, and that such information has been presented at many industry conferences:

- They thoroughly review their prescription claim data through reports that they generate themselves and/or by scrutinizing the reports that they require of their PBMs. This helps identify potential doctor shoppers like the late Mr. Brown and other aberrant behavior by health-plan members, prescribers or pharmacies.
- When they do identify a plan member whose narcotic prescription patterns resemble Mr. Brown’s and have no rational medical use, they:
 - Advise the member of the insurer’s identification of potential drug-related risks to his or her health;
 - Restrict the member to using only one specific pharmacy for all prescriptions;
 - Advise all involved prescribers of that patient’s prescription history, and request that they detail how that full picture might alter their prescribing and, if appropriate:
 - Refer the matter—as state law and regulations require—to insurance-fraud units and perhaps other law-enforcement agencies.

“You’ve heard testimony that TheBest Health Plan routinely received controlled-substance data reports from its PBM, but never routinely reviewed them—or had a policy and procedures for taking specific actions.

“You’ve heard testimony from Florida’s insurance fraud division—and from the insurer itself—that TheBest Health Plan did not make any formal report or referral about John Brown’s apparent doctor shopping.

“Finally, you’ve heard testimony that in recent years our state legislature has repeatedly refused to create a statewide prescription-monitoring program. If such a program had been in place, every prescriber that John Brown saw and every emergency-room physician who examined him could have seen that Mr. Brown was a potential drug seeker, and could have handled his case accordingly.



“Many other states have maintained such programs for years. In fact, Kentucky’s monitoring system is so effective that many of its drug-seekers and diverters are coming to Florida to buy prescriptions here that they’ll abuse or sell back home.

“Without a monitoring program today, though, we’re left with one truth: Between January 1 and August 7, 2006, *the only party anywhere* in a position to see what John Brown was doing, and the kind of threat that he posed, was TheBest Health Plan, the insurance company that received those dozens of claims.

“TheBest Health Plan was negligent, ignoring every alarm bell that John Brown’s prescription claims sounded. The insurer never warned John Brown, never contacted the prescribers, and never informed his employer of the dangerous behavior of Mr. Brown—a truck driver, of all people.

“TheBest Health Plan kept paying the claims—every one. John Brown obtained huge, medically worthless quantities of narcotics and other highly abused prescription drugs for at least seven months. He also took the drugs in incapacitating amounts before getting behind the wheel of his truck that morning.

“But Mr. Brown had a silent partner that bought most of the drugs for him without batting an eye: TheBest Health Plan.

“Now, TheBest Health Plan’s lawyers will argue that as a doctor shopper, Mr. Brown broke the law and that under the company’s policy, he alone was responsible for the consequences of his illegal actions. They’ll tell you that TheBest Health Plan met its obligation under his group policy by paying claims for legitimate prescriptions and medical exams that physicians performed in good faith.

“But you’re being asked to judge corporate responsibility—or the lack of it. TheBest Health Plan operates in a real world that’s overflowing with prescription drug abuse and the increasing toll that it’s taking on our society. Indeed, that toll is too often taken on people like John Brown and their families, and on innocent victims like the Smith family.

“TheBest Health Plan had a larger obligation: *not* to pay controlled substance claims irresponsibly and with reckless disregard of the dangers that were so obvious in its own data. This is especially true because TheBest Health Plan was the *only* party that could’ve spotted those dangers. But it didn’t come close to meeting that larger obligation.

“Your verdict cannot undo Mary Smith’s loss of her beloved spouse and daughter or her own injuries, but you *can* do two important things:

- “Make sure TheBest Health Plan now will compensate Mary after failing to apply even a minimum standard of responsible oversight and prudent intervention to prevent her loss and disability; and
- “Ensure that the insurance companies that finance those drugs should do much more than simply pay the bills. We live in an age when prescription drugs are being used in deadlier ways every day.

“We respectfully ask you to find for Mary Smith. And beyond the actual damages, we ask that you award her large-enough punitive damages to achieve those worthy goals.”

An extreme example? Several elements come from actual prescription drug cases:

- A fatal Long Island, New York accident was caused by a taxi driver under the influence of drugs. “He was arrested for driving while impaired by drugs,” says a Suffolk County Police detective. “He admitted to taking several prescription drugs as well as cocaine.” The victim’s spouse, who was a passenger in the car when it was hit by the cab, survived to care for the couple’s two sons. In February 2007, the cab driver, John Prowse, received 5 to 15 years in prison.^{153,154}

- A commercial truck driver, who was a member of an insurance plan, obtained narcotics from several emergency rooms along his route.
- A Georgia family reportedly settled a malpractice lawsuit against a physician charged with murder in the December 2005 overdose death of their son. The family's attorney says they were unaware of their son's prescription drug use until discovering insurance statements related to "numerous prescriptions for painkillers, and one for 90 doses of methadone."^{155,156} On October 20, 2007, a Camden County, Ga. jury found the physician, Noel Chua, guilty of the murder of 20-year-old Jamie Carter III, and guilty of seven controlled-substance violations. Chua received life in prison plus five years.¹⁵⁷
- The widow of a Kentucky coal miner killed in a 2006 mine accident filed a wrongful-death lawsuit in 2007. The suit by Stella Morris alleges H & D Mining knew illicit drug activity was "rampant" at its mine but didn't try to stop the abuse. The U.S. Mine Safety and Health Administration says the victim and a fellow employee involved in the accident tested positive for marijuana and painkillers. "We want to send a message to coal operators that you cannot knowingly allow drugs to be used in your mines and expect to escape liability if that causes an accident," said one of the plaintiff's attorneys.¹⁵⁸

Also, the argument that only an insurer likely could see warning signs and have a duty to intervene comes from a Canadian health insurer, ManuLife Financial. The company noted in the December 2004 issue of its *Employee Benefits News*:¹⁵⁹

"Recognizing that prescription narcotics represent relief for many, and a potential for abuse, misuse and addiction by a minority, insurance companies have an important role to play in protecting the health and wellbeing of plan members, as well as the financial investment of plan sponsors.

"Indeed, as payers of prescription drug claims, insurers are in a unique position to enforce measures designed to control the risk. This is because insurance companies, as the final link in the chain, have access to prescription and claims payment information that doctors and pharmacists aren't usually privy to.

"Working together with the patient, his or her doctor, and pharmacist, insurers can apply strict controls that measure and monitor the patient's use of prescription narcotics...In extreme examples of abuse, misuse and addiction, options include denying the claims for prescription narcotics, or sometimes even more drastic measures...When the evidence warrants it, we alert the industry to situations and refer cases for investigation by the police."

How real is the risk that such a case will play out in real life? "It's a long shot at best, but people take long shots all the time," says noted insurance and healthcare fraud attorney Kirk J. Nahra of Wiley Rein LLP, in Washington, D.C. In a case such as a drug-seeking truck driver, an insurer might have cause for such concern and take action such as notifying the driver's employer, he says.

Some insurer fraud investigators cite serious concerns about the potential risk of not identifying and intervening in apparent prescription drug abuse or resale. "It's on the horizon, because a payer can see in its claim data what's going on—even such things as repeated denials for early refills," says WellPoint's Sterling. "If we don't do something when we see those and other patterns indicative of abuse, then we're in effect enabling or facilitating the activity."

The insurer's perception of potential liability was "a very significant issue" in its handling of the case of James Hill, a Shreveport, La. physician who was the state's leading prescriber of OxyContin, agrees Kandyce Cowart, of Blue Cross Blue Shield of Louisiana. Hill received 200 months in prison in March 2007 after pleading guilty to healthcare fraud and distribution of controlled substances. The sentencing judge described Hill as "a drug dealer with a medical license."¹⁶⁰

In the real-life case of the drug-seeking trucker, meanwhile, the potential liability impact of not taking action was front-and-center when the SIU considered how to handle the matter, including its decision to advise the employer, the insurer's SIU director noted.

Pharmacies Already in Court

For insurers, potential liability for abuse and other diversion schemes remains a potential risk. For pharmacies, however, that risk already has reached the courts. The rationale also could be applied to insurers: that there is “duty to warn” patients and/or prescribers in cases involving “repeated and unreasonable prescriptions with potentially fatal consequences.”

In June 2006, the Florida Supreme Court upheld an Appeals Court decision that a pharmacist has a legal duty to warn a patient when presented with prescriptions for dangerous quantities and/or combinations of prescription drugs—regardless of the prescriptions' validity.¹⁶¹

That decision cleared the way for negligence suits by Robert Powers against two Florida pharmacies and a prescribing physician. Powers was the husband of a patient who died of an overdose after being prescribed six narcotic painkillers, a muscle relaxant plus an anti-anxiety drug for her chronic back and neck pain.

“Allegedly, [the patient's] doctor prescribed and the defendant pharmacies filled without question or cautions to anyone prescriptions for OxyContin, Percocet, Soma, Xanax and diazepam repeatedly over a six-month period, often within days of filling previous such prescriptions in the same pharmacy. The filling patterns continued until Mrs. Powers collapsed and died in her home. The cause of her death was determined to be a combined drug overdose,” reported the July/August 2006 newsletter of the American Society for Pharmacy Law (ASPL).¹⁶²

“Florida pharmacists are already required to know prescription medications and the risks presented by taking particular drugs, such that they should be able to evaluate and explain the operative risks of taking a medication or series of medications,” the Appeals Court observed. (This knowledge, of course, also resides within the medical and pharmacy staffs of health insurers and/or their PBMs.)

“Most importantly,” the Appeals Court found “that the circumstances as alleged in the Powers case could give rise to liability,” and that the pharmacists' duty to warn could arise “where the potential degree, likelihood and probability of harm was so great,” ASPL said. Could “some action by the pharmacies more than simply acting as a filling agent for a physician have prevented a death?” the Appeals Court asked.

The key questions for insurers and PBMs thus are:

- When (not if) will a plaintiff charge that a claim payer was negligent—that rather than apply its clinical knowledge and unique view of prescription activity to prevent patient harm in a given case, it simply acted as a passive “paying agent”?
- Are there potential “enterprise liability” exposures involving diversion by network prescribers and pharmacies (i.e., providers that a payer has credentialed, admitted and maybe even recruited into its HMO and/or PPO network)?
- How can payers reduce that liability by detecting and intervening in cases involving repeated, unreasonable and potentially fatal prescriptions?

WORKERS COMPENSATION: HIGH IMPACT

Drug diversion also affects workers compensation insurance, magnifying that insurance line's already serious concerns with 1) the ever-growing medical expenses of the nation's workers compensation outlay, and 2) within those medical expenses, the large share that prescription drug costs represent.

Medical expenses totaled a projected \$22.7 billion—or 58 percent of the workers compensation industry's total outlay—in 2005. This significantly outweighs the projected 42 percent paid in indemnity, or workers' income replacement benefits, reports the National Council on Compensation Insurance (NCCI).¹⁶³

Prescription drugs likely accounted for an estimated 10 to 12 percent of those medical expenses (13.4 percent in 2003 but declining slightly since then due to a moderation in annual drug-cost increases that began in 2004).¹⁶⁴ Still, the workers compensation industry's annual prescription tab approaches \$3 billion. It is largely driven by narcotic painkillers, and controlled anti-anxiety and sleep medications.

Three categories of drugs accounted for 85 percent of all workers compensation prescriptions in 2003, according to NCCI:¹⁶⁵

- Anti-inflammatories and painkillers at 52 percent;
- Muscle relaxants at 21 percent; and
- Central nervous system drugs at 12 percent.

Of the top 20 drugs paid for by workers compensation insurance that year, nine were narcotics or other controlled substances, NCCI says. More recently, of The Hartford's top 25 drugs paid for in 2005, 15 were controlled—and 11 of those were narcotic pain medications.

The “long tail” of many workers compensation claims further magnifies concerns about drug costs (i.e., claims that do not resolve quickly and evolve into chronic, sometimes years-long medical and prescription payouts). “Eighty percent of claims generally resolve within 10 to 12 weeks,” says The Hartford's Medical Director, Robert Bonner, MD, MPH. But if a claim continues for more than six months and the claimant is placed on a longterm narcotic regimen, that regimen likely will continue indefinitely: “Once patients start on the drugs longterm, they rarely go off them,” Bonner says.

The cost of drugs, supplies and other expenses accounts for 19 percent of medical expenses in the first year of a claim. Those costs comprise 53 percent in years six through nine of a long-lasting claim, NCCI says.¹⁶⁶ In that context, “a workers comp claim can be a guaranteed paycheck for a physician-prescriber, who has a financial incentive to keep the patient in treatment and/or on prescriptions,” says Steven K. Piper, Director of the Medical Investigation Unit of Travelers Insurance.

“As a reinsurer, we're seeing the phenomenon of non-catastrophic claims spiking just like catastrophic claims—for example, back injuries that cost \$50,000 to \$70,000 a year—much of it due to prescription costs,” adds Lewis P. Palca, Chief Claim Officer of General Reinsurance Corporation.

The growing use of generic drugs might, in fact, be a two-edged sword: It lowers unit costs, but potentially magnifies existing problems involving high usage, Palca says.

Increasing the vulnerability of workers compensation is the system's combination of state funds, private insurers and PBMs, plus the lack of consistent practices and controls across the industry. Some private insurers, for example, exert greater controls on prescriptions than do group health insurers. But a state fund such as the Ohio Bureau of Workers' Compensation was one of the largest victims of Dr. Jorge Martinez's multi-million dollar diversion schemes.

Diversion is not the norm in workers compensation for Travelers, says Piper. Still, “we have seen one claimant prescribed many more drugs than he could possibly consume. But without surveillance or testimony, it’s difficult to make a diversion case in such situations. When we do see an injured worker on an inordinate amount of narcotics, we look at the physician specialty and generally find that the prescriber is a general practitioner, not a pain specialist,” he notes.

“We have much more control in workers comp than we do, for example, in auto bodily injury claims,” says Piper. “In workers comp, although multiple specialists might be involved in a given claim, we don’t allow the claimant to obtain prescriptions from more than one physician.” Also, “The claim handler and nurse attached to each claim can see both the claimant’s medical and drug histories while managing the claim,” he notes.

Among the company’s other defenses: a pain management workgroup that includes its medical director and the SIU, and a pilot project to address the off-label prescription of Actiq by working with the prescribing physician upon “the very first instance.”

The Hartford has “taken a very hard stand regarding off-label uses of Actiq and Fentora,” the cancer-approved fentanyl drugs, says Bonner. “We block every new prescription and write to the prescriber explaining the off-label concerns.” Of the physicians who respond, “rarely do they try to justify such prescriptions of Actiq,” he adds.

The Hartford does not focus on drug diversion per se. But “in addition to our new off-label stops, we do have edits in our claim system for such things as early refills and pill quantities—with OxyContin, for example. And we look at any claim that involves the use of more than two prescribers or pharmacies,” Bonner says. The company also plans to launch a chronic pain management program to better address narcotic prescription and usage.



State Programs on Alert

Prescription costs—and abusive or fraudulent prescribing and consumption—also have garnered much attention among state-run workers compensation funds in recent years. Prescription costs are “out of control” and “a threat” to the program, the Arizona State Compensation Fund (SCF) said in May 2004.¹⁶⁷ “It’s easy to spot one source of inflated medical costs—the over-prescribing of OxyContin,” the SCF noted.

“Not only are policyholders saddled with the expense of the drug itself, they often have to pay for drug rehab programs for drug-addicted injured workers who must complete detoxification programs before they can return to work,” says Mike Roberson, SCF Medical Review and Provider Inquiry Team Leader.

In Ohio, “A team of analysts reports that claims payers overpay tens of millions of dollars for prescription drugs in workers comp claims,” *Risk & Insurance* magazine reported in July 2005.¹⁶⁸

A high percent of its payments were for “prescriptions with no logical relationship to the work injury,” suggested an independent analysis of BWC claims data obtained under the Freedom of Information Act. A later analysis of 2 million claims paid by the BWC and four other workers compensation payers revealed that about \$25 million of the \$179 million in payments involved “questionable” claims. “All told, about 9 percent of prescriptions, or \$16 million of total paid prescriptions, had no evident relationship to the work injury,” the magazine reported.

Among the other findings:

- A higher percentage of brand-name prescriptions for the most potent pain narcotics such as OxyContin and other Schedule II drugs;
- \$12,000 for annual OxyContin use for a 1990 workers compensation claim of neurotic depression; and
- \$13,000 for annual OxyContin use for a 1986 claim of carpal tunnel syndrome.



Cleveland pharmacist Philip Parsons, who performed the study with healthcare analytics firm Archestral, Inc., noted his “shock that [claim] controls could be so loose.”

“The Ohio team’s findings, especially in context with reports from NCCI, imply that pharmacy management in workers compensation is at an immature stage, and faces unique challenges

compared with health plans,” wrote *Risk & Insurance*. “Powerful pain medications impose problems far greater than high medication costs.”

With so much smoke, is there a large abuse and diversion fire burning in workers compensation? Anecdotal signs strongly suggest yes, though formal data are lacking. “It seems fairly intuitive that [diversion] will take place,” says Steven Piper, of Travelers Insurance. Beyond individual abuse, he notes, “workers comp indemnity benefits aren’t huge, and selling prescription drugs represents a way for some claimants to supplement that indemnity income.”

COMBATING DRUG DIVERSION

Current Efforts Inconsistent

Insurers that adopt well-run diversion programs can realize potentially significant savings over time. WellPoint reduced drug and medical claim costs of the 100 suspected doctor shoppers in its study by 40 percent. That effort saved more than \$333,000 in just one year, says Jeffrey Sterling.

Medco also reported in 2005: “A high utilization management program was instrumental in identifying potential abusers and restricting them to the use of a single pharmacy, thus reducing excessive drug utilization by 32 percent among the high utilization population and decreasing benefit sponsor drug costs by nearly 20 percent.”¹⁶⁹

But such efforts may be among the exceptions. Overall, one word describes the approach to drug diversion by the insurance industry and other third-party payers: Inconsistent. The insurance industry’s scattered response increases its vulnerability to drug diversion and legal liability. The industry hasn’t even defined, let alone universally adopted, anti-fraud best practices. Consider:

- Some payers’ anti-fraud units monitor for signs of doctor shopping or other diversion by members. But drug diversion tends to be “out of sight, out of mind” when the insurer focuses almost exclusively on provider fraud, or when its PBM oversees prescription benefits. “Most insurance companies don’t even look at it,” says Utah’s Insurance Fraud Director Christensen. Indeed, “We have our own PBM, but the SIU never has prescription fraud cases,” one managed-care firm’s SIU director notes. “In general, hospital fraud and prescription fraud

historically have been two somewhat neglected areas,” says BCBSA’s Focarino. “With respect to prescription benefits, our FEP SIU’s focus is on patient safety, the loss of FEHBP resources, and related fraud issues.”

- Some insurers and other payers want to be more attentive, but lack the systems capability or claim data. Still others think member doctor-shopper cases are purely low-dollar matters and give them low priority. But they do not always consider the often-large medical claim impact (legitimate or otherwise) of those cases, or the potential liability exposure.
- Very few PBMs have bona fide SIUs. Most rely on desk and onsite pharmacy audits to identify provider problems and claim adjustments. They provide their client payers with periodic reports on member, pharmacy and prescriber activity. Express Scripts, Inc. (ESI), by contrast, maintains a robust SIU with several Accredited Health Care Fraud Investigators, Certified Fraud Examiners, a CPA and nurses; and Focarino cites the Federal Employee Program’s retail-pharmacy PBM, Caremark, as having “the best proactive prescription-fraud unit in the United States.” But ESI, Caremark or any PBM sees only the prescription data. Thus it must maintain a close relationship with the client payer’s SIU to assemble the total drug and medical picture of a case, notes Dwayne Luby, ESI’s Senior Director of Pharmacy Compliance and Program Integrity.
- Some insurers and PBMs place up-front controls (e.g., prior authorizations, quantity limits and early-refill limits) on highly abused drugs such as OxyContin or Vicodin, but not on increasingly diverted drugs such as methadone. Some don’t cover off-label uses of drugs such as Actiq and Fentora. Still others have not addressed the subject at all.

Insurers Must Be More Active

Insurers must combat drug diversion more actively and visibly. The financial and human losses alone require a stepped-up response. But insurers also risk government imposing punitive requirements if they appear to be passive contributors to the problem. Insurers thus should be the unquestioned leaders in national efforts to address the problem. But the fact is, insurers are conspicuously absent. For example:

- Only six insurer personnel were among the roughly 300 delegates to the 2006 NADDI Annual Training Conference. Only a handful attended the 2007 conference.
- Although one of the nation’s largest health insurers—WellPoint—funded a large portion of the landmark 2005 CASA diversion study, that report’s only reference to insurers was that “federal and state governments should...require managed care and private health insurance companies to reimburse physicians and dentists for time spent screening patients for substance abuse and addiction, referring them to treatment if needed, and collaborating with pharmacists to prevent diversion and abuse.”¹⁷⁰
- Similarly, no third-party payers or their trade associations are among the organizations formally supporting the White House Office of National Drug Control Policy’s media campaign aimed at curbing prescription drug abuse by teens.

Insurer Best Practices

Several best practices would greatly help if insurers adopt them more widely:

1. Understand Dollar Impact

Broadly, payers cannot afford to treat drug diversion in a “low-dollar” vacuum at the case level. The overall dollar costs already are unacceptably high, and the potential for legal liability could magnify those

costs even more. Payers must better research—and measure—the large costs that doctor shopping and other diversion add to total medical expenses.

2. Deploy More Resources

With the advent of Medicare Part D, the Centers for Medicare and Medicaid Services (CMS) provides a valuable roadmap for all payers via 1) the many fraud-detection requirements it imposes on plan sponsors, and 2) its emphasis on identifying doctor shopping and other diversion schemes.¹⁷¹

More datamining. CMS calls for plan sponsors and Medicare Drug Integrity Contractors to engage in ongoing datamining—beyond routine audits—to identify schemes by drug prescribers, dispensers and Medicare enrollees. “Pharmacy has become one of the top areas of interest and inquiry among all of our prospects and clients,” because of that mandate and growing attention to overall prescription costs, says Adam Crafton, who heads IBM’s Fraud and Abuse Management System operations.

Better comparing of prescription and claim data. In addition to detection-based datamining, payers also should develop standard investigative protocols and system capabilities for comparing prescription and medical claim data. This also requires an effective working relationship with the payer’s PBM, be it an internal “captive” or external contractor.

“Not having easy access to prescription claim data can be a problem,” says WellPoint’s Jeffrey Sterling. “In our case, we have our own PBM, and our SIU has ready access to its claim data. The SIU establishes specific parameters as to the claim data it wants to see on an ongoing basis.”

The SIU at Independence Blue Cross has “all medical, ancillary and prescription-claim data, along with all member benefit data, all provider demographics and other information all on one server,” says Ed Litchko. “We can look at OxyContin or anything else from virtually any angle we choose.”

Focused training and information sharing. Both NADDI, through its year-round regional and national programs, and The National Health Care Anti-Fraud Association, through periodic training programs, are excellent sources of training in detection and investigation. They also offer strong opportunities to share information, and develop broader and fruitful referral relationships with state and local law enforcement units focused solely on diversion cases.

Better case referrals and avenues, including district attorneys. “When we refer a doctor-shopping or other member prescription-fraud case to a state department of insurance, we always specify the state drug statutes we believe might have been violated,” says Aetna’s Tabitha Kielb. Even then, many cases aren’t investigated because of their low-dollar size, she notes. But without the cited statutes, the odds are even smaller that a state fraud bureau will investigate (*See Appendix.*).

That reinforces the value of forming strong relationships with the drug-diversion units represented in NADDI. They routinely investigate such cases, and refer many for prosecution by local or county district attorneys, many of whom routinely prosecute drug crimes that might be “too small” for state or federal prosecutors. “In the Washington, D.C. area, we refer many cases to a federal, state and local police drug-diversion task force,” says Focarino. “Typically, the fundamental charge is obtaining controlled substances by fraud.”

Those referral avenues can pay dividends: One of the most significant diversion convictions and sentences of recent years—the 30-120 years handed to former Pennsylvania doctor Richard Paolino in 2002—was the work of the Bucks County, Pa. District Attorney’s office, IBC’s Litchko notes.

3. Adopt More Point-of-Sale Controls

“Thirty-five to 40 percent of our caseload would go away if pharmacies asked for photo identification in connection with controlled substance prescriptions,” says Dennis M. Luken, a veteran detective with the Warren County (Ohio) Drug Task Force and also President of Pharmaceutical Diversion Resources, in Cincinnati.

Says Aetna's Kielb: "In cases where a member advises us that he or she did not pick up given prescriptions, with the member's approval we will direct the pharmacy to require photo identification on subsequent scripts. We then have to hope that the pharmacy honors the edit." Aetna saved \$2 million in just the first year after adopting a date-of-birth edit aimed at third-party prescription fraud, Kielb notes.

Point-of-sale controls now are widely applied to over-the-counter drugs that contain the precursor substances to crystal methamphetamine. Tighter controls on prescription narcotics would be equally useful.

4. Restrict Suspected Doctor Shoppers

WellPoint has developed a program to identify potential doctor shoppers and greatly restrict their ability to fund that abuse with insurance benefits. Simply investigating and referring doctor-shopper cases to law enforcement "doesn't address the immediate need to stop the drug-seeking behavior," says Sterling. WellPoint uses its established detection criterion of obtaining narcotic prescriptions from five or more pharmacies or prescribers in 90 days, and rules out members with cancer or who have recently undergone surgery. The system enables WellPoint to:

- Identify a given potential drug-seeker;
- Write a letter advising the member that the insurer is watching for harmful drug use; and
- Require the suspect to select only one pharmacy for future prescriptions.

If the patient fails to select, WellPoint then *specifies* the only pharmacy where it will cover the patient's prescriptions. The insurer also warns it may cancel the person's coverage if he or she doesn't comply with the restriction or otherwise violates the policy.

WellPoint also contacts each of that patient's prescribers, advising them of the patient's prescription history. It also asks those prescribers to note whether they knew of the patient's other prescriptions, and what action they might take as a result. Usually, "the doctors didn't know that the patient was obtaining narcotic prescriptions from the other providers, and they indicate that they will no longer prescribe for that patient," Sterling notes.

"The program works on all levels. We're able to see and give the prescribers the full picture and, in a given case, document that we've taken reasonable and responsible steps to address the patient's activity," Sterling says. Some cases might be referred to law enforcement, and "in others we might refer the matter to Case Management if we identify what appears to be more of a potential dependency or addiction problem with a legitimate narcotics user."

Finally, "although the program's primary function is to identify and address individual doctor shoppers, it also turns up problematic pharmacies and prescribers," Sterling notes.

Although pharmacy restrictions are not uniformly used throughout the insurance industry, they are not uncommon. Government plans such as the military's TRICARE program are excellent examples. "Our regulations prohibit the program from spending government funds to support a person's addiction," says Program Integrity Director Rose M. Sabo. "Our Operations Manual for Contractors specifies that patients who engage in drug-seeking behavior will be restricted to one prescriber and one pharmacy."

By contrast, says Focarino, the FEP's SIU can impose a pharmacy restriction only if a doctor-shopper member consents as part of a plea agreement. Otherwise, the FEP can only request that the member voluntarily agree to such a restriction. "As a result, we see a lot of recidivism among doctor shoppers," he notes.

TRICARE also links the program's managed-care organizations, and its prescription and dental plans. This automatically triggers matches of medical, dental and prescription claims. "These and other financial controls have a huge impact," says Sabo.

5. Tighten Reimbursement

More health insurers are restricting coverage of Actiq to cancer patients, as do the workers compensation restrictions by The Hartford and Travelers. This follows states such as Colorado, whose Medicaid program adopted the restriction in January 2005. “Under our policy, we cover a given member’s initial script, but absent a cancer diagnosis, we will not pay for any further prescriptions of Actiq,” says BCBS of Louisiana’s Kandyce Cowart.

Some plans also require a prescriber to explain in writing the medical necessity for a given non-cancer related Actiq prescription as part of their prior-authorization process.

6. Monitor New Exposures

The relatively rapid emergence of methadone as an abused, diverted and deadly “drug of abuse” illustrates payers’ need to closely monitor new and emerging developments in drug diversion. It further reveals the new exposures they pose, and the implications for payers’ formulary and other drug-use controls and policies.

The DEA Office of Diversion Control and NADDI are among the best sources of monitoring for such front-line information. Periodic reports published by SAMHSA also provide the “big picture” of drug diversion.

7. Expand Prescription Monitoring

State prescription monitoring programs (PMPs) are among the most-effective ways to detect and prevent diversion—if funded adequately and used properly. These programs also create a larger, central and standardized source of information. While a PMP doesn’t eliminate an insurer’s anti-fraud obligations and potential legal liability, it does reduce reliance on payers as the sole source of data needed to thwart diversion. But only about half of states now have PMPs. Insurers should play lead roles in working to ensure the remaining states create these important programs.

Prescription Monitoring: Vital Defenses

The concept is simple: Create a system to house the records of every narcotic prescription in a given state. This allows closer monitoring of prescription activity by patients, prescribers and dispensers. It also allows better detecting of potential abuse and criminal behavior—before prescribing a controlled substance and afterward.

This powerful idea is manifested in today’s state-based PMPs, which are data repositories fed by mandatory reports from prescribers and dispensers. They are accessible to prescribers, pharmacies, licensing authorities and law enforcement agencies. The level of access, and by whom, vary with each state.

California created the nation’s first PMP in 1939, followed by Hawaii in 1943. PMPs have evolved into sophisticated electronic data systems since the early 1990s, many of which house increasingly current records. Some PMPs respond to Web-based queries in just seconds.

Some 24 states maintained such databases as of April 2007. Ten states have authorized PMPs that await startup. They include Tennessee and Arizona, which authorized programs in 2007. Bills are pending in another eight states (*See Appendix*).

PMPs can vary widely from state to state in several key aspects:

- **Drugs reported.** Some cover only DEA’s Schedule II substances, and others oversee all Schedule II through V drugs plus non-scheduled muscle relaxants;

- **Other data collected.** Ohio records source-of-payment data on each prescription, including PBM and major medical payments. This provides unique data that in time should provide valuable insights into diversion funding;
- **Reporting frequency.** Some require weekly reporting of prescriptions, and others require monthly reporting;
- **Access.** Only state licensing authorities can access PMPs in some states, while others allow licensing authorities, prescribers, dispensers, grand juries and law enforcement. Law enforcement usually specifies controls such as two authorizing signatures. Patients in some programs also may access, but not alter, their own data;
- **Inquiry volume.** Some PMPs report as few as two queries per month, and others up to 6,000 per week;
- **Use of data.** Some serve as passive repositories that are not actively datamined. Others proactively detect abuse and diversion, and refer cases to law enforcement; and
- **Host agency.** These can range from departments of justice and public safety, to departments of health and state licensing boards.

State PMPs have gained momentum since the 2005 enactment of the National All Schedules Prescription Electronic Reporting Act (NASPER). The Act provides federal grants to establish more programs, but those programs must meet requirements, including:

- Weekly reporting of prescription data;
- Ability to interface with at least one other state system;
- Data security and penalties for unauthorized disclosure; and
- Availability of data to prescribers and pharmacies, other state PMPs, the U.S. Department of Health and Human Services and state Medicaid programs, and for research.



Kentucky has one of the best-known and most-effective PMPs. Founded in 1999, “KASPER” collects data every eight days on more than eight million prescriptions per year for Schedule II through V drugs, from some 1,500 dispensers in the state. KASPER is housed in the Office of Inspector General of the state’s Cabinet for Health and Family Services.

Overall, about 6,000 reports were requested *per week* in 2006. Physicians request more than nine of every 10 KASPER data reports. Reports requested by fax are provided in two to eight hours, and Internet requests are delivered in 15 to 20 seconds.¹⁷²

A physician who is suspicious of a patient’s prescription-related behavior can quickly access any KASPER data about that suspect’s controlled-substance prescription history. The physician then can prescribe or not prescribe, based on that data. KASPER’s annual operating cost is \$350,000, which includes a full-time pharmacist and 1.5 administrative full-time equivalents.¹⁷³

A vivid example of PMPs’ effectiveness highlights the problems of not having a PMP: Growing numbers of prescription traffickers from Kentucky and other Southeastern states were making “drug runs” to Florida to obtain drugs to abuse and/or sell back home, the *South Florida Sun-Sentinel* reported in December 2006.¹⁷⁴ This was attributed to Florida’s lack of a PMP.

“Out of state drug dealers and addicts are traveling long distances to visit Florida pain clinics, targeting the state because its lax oversight of prescription drugs makes scoring pills easier,” the newspaper noted. “This was the case for more than two dozen people from Kentucky who drove 1,000 miles each way...returning with doses of Oxycotin, Endocet, Percocet, methadone.” The *Sun-Sentinel* also reported that “Eight people involved in the trips pleaded guilty to [federal] drug-trafficking charges...and several more are being tried in Kentucky state courts.”



“Drugs prescribed by Florida doctors caused the deaths of five people in Kentucky, according to prosecutors,” said the newspaper. “One man died from a fatal overdose during the 18-hour drive home.”

Florida’s unfortunate experience was nothing new. “The effectiveness of Kentucky’s system drove illicit drug seekers to surrounding states like Indiana, Ohio, Virginia and West Virginia. Each in turn, created tracking programs,” the *Sun-Sentinel* said.

Florida Governor Jeb Bush signed into law House Bill 1155 in June 2007. The law expresses the legislature’s intent to promote implementing of electronic prescribing—including “the electronic review of the patient’s medication history.” The law also imposes more point-of-sale and record-keeping controls on dispensing some controlled substances. For overdose deaths, attending law enforcement officers must prepare full reports on all controlled substances—and their prescribers—found “on or near the deceased or among the deceased’s possessions.”

But it is unclear if Florida will adopt a full monitoring program, or whether the reporting and access provisions will be consistent with other state PMPs.

Complete information on PMPs and each state PMP is available from the National Alliance for Model State Drug Laws (www.natlalliance.org).

Broad Action Steps

The U.S. has about 20 million admitted prescription-drug abusers in 2007, including more than 15 million Americans who abuse narcotic pain relievers. This assumes a population of 304 million and no increase in non-medical use of the drugs.

In fact, rates of “past-year use for pharmaceuticals are stable at high levels,” says the U.S. Justice Department’s 2007 National Drug Threat Assessment.¹⁷⁵ “The availability of diverted pharmaceuticals drugs is high and increasing, fueled by increases in both the number of illegal on-line pharmacies and commercial disbursements within the legitimate pharmaceutical distribution chain.”

No one party—the medical or pharmacy professions, law enforcement, licensing boards, legislators, prescription payers or the pharmaceutical industry—can address the epidemic alone. But each can play a vital role. Equally important, everyone should collaborate.

Medical Profession

Based on the 2005 CASA findings, the medical profession can 1) better protect the vast majority of prescribers who practice honestly and ethically, and 2) have a large impact in these ways:

- Greatly increase abuse and diversion training of physicians, both in medical education curricula and in continuing professional education programs;

- Support stronger requirements for specialization and credentialing in pain management and prescription of controlled substances;
- Support creation of more state PMPs, and urge physicians to use them;
- Formally discuss the widespread off-label prescribing of some controlled substances, and its impact. This might be a positive alternative to waiting for the proverbial legislative or regulatory shoe to drop;
- Support the ongoing examination, and potentially greater limiting, of pharmaceutical manufacturers' means of influencing physicians' prescribing behavior; and
- Support strong licensing sanctions and other penalties against physicians found guilty of drug diversion.

Pharmacy Profession

The pharmacy profession can have a greater impact:

- Increase the abuse- and diversion-related training in pharmacy education curricula and continuing professional education;
- Support creation of more PMPs, and urge pharmacists to use and strictly comply with them;
- Exert closer point-of-sale scrutiny of certain prescriptions and patients. Also consider developing protocols in conjunction with PBMs and other prescription payers; and
- Support strong licensing sanctions and other penalties against pharmacists guilty of drug diversion.

Government & Licensing Authorities

Lawmakers and medical licensing boards have the unique authority to establish and enforce stronger approaches to drug diversion:

- Create PMPs in states without PMPs. Kentucky's KASPER system and federal grant standards are excellent models with strong criteria;
- Develop and apply controls such as New York State's Official Prescription Program. New York now requires that all written prescriptions in the state be written on state-supplied forms specially designed with unique identifier numbers and other features to help prevent fraud and identify doctor shopping. Universal use of the forms has produced \$60 million in Medicaid fraud savings in the first six months of accounting oversight and saves private insurers an estimated \$75 million per year, the Department of Health says;¹⁷⁶ and
- Swiftly and decisively penalize the small fraction of prescribers and dispensers who facilitate drug diversion and abuse. These actions illegally enrich them, and can kill abusers.

Pharmaceutical Industry

For drug manufacturers, developing more-powerful and effective narcotics and other controlled medicines—focusing especially on pain—can be a Catch-22: The same drugs that treat pain often have a double-life as illegally obtained and abused substances. This is especially true of drugs such as OxyContin and Actiq.

Reducing the illicit appeal and availability of prescription drugs without compromising their legitimate use is the heart of the challenge. Among the measures are: Changing the drugs' chemical makeup, thwarting their potential for abuse, and manufacturers' limiting their promotion of off-label prescribing.

Drug manufacturers should voluntarily work with prescribers, dispensers and drug-diversion authorities to:

- Acknowledge and educate all concerned about their products' potential for abuse;
- Provide intelligence to authorities when their purchase data reveal potential diversion; and
- Comply with the letter and spirit of the law requiring prudent restraint with their products' off-label uses.

Federal guilty pleas of criminal “misbranding” by OxyContin’s manufacturer Purdue Pharma and three senior executives in May 2007 highlight the industry’s potential to deepen America’s diversion problem. Purdue misled prescribers, regulators and patients about OxyContin’s potential for abuse and addiction. Purdue must pay more than \$600 million in fines, and the three executives must pay nearly \$35 million combined. Purdue, meanwhile, earned \$2.8 billion from OxyContin while committing the crimes.¹⁷⁷

State Insurance Fraud Bureaus

Although rarely a first line of investigation and referral for prosecuting diversion crimes, state insurance fraud bureaus still can play valuable roles. Fraud bureaus should:

- Better understand and appreciate the high insurance impact of drug diversion;
- Work with insurers that refer diversion cases to learn their true dimensions, and support those cases accordingly. Fraud bureaus can model their efforts on the Utah Insurance Fraud Division’s pursuit of diversion cases; and
- Become involved with the National Association of Drug Diversion Investigators. This will foster a better joint appreciation of drug diversion’s insurance impact and implications.

CONCLUSION: COST OF INACTION

The abuse of prescription drugs is a crime wave and public-health problem of epidemic levels. But few understand how widely insurance fraud is helping trigger, and finance, this epidemic. Though some health insurers are responding effectively, far too many are slow to see this 800-pound fraud gorilla in their collective living room.

Inaction is breeding serious and damaging consequences.

Fraud-fueled drug diversion imposes a multi-billion-dollar drain on insurance companies. This comes at a time when they are urgently trying to squeeze excessive costs from the struggling healthcare system. And despite compelling evidence of a national problem, most insurers have little idea how many billions of dollars drug diversion is stealing every year. Nor have most insurers mounted effective efforts to combat the problem, let alone measure exactly what they’re up against.

The courts also may punish health insurers for inaction. Lawsuits over deaths and grave injuries to diversion victims could open up a Pandora’s Box of liability exposures for insurers and other allied industries. Insurers will be challenged to combat drug diversion before courts force them to act at legal gunpoint. Warning shots already are being fired in court actions today.

A related issue is the insurer’s fiduciary responsibility to protect the health plan’s assets: Will an insurer face legal action if large fraud losses cause significant financial damage?

But fraud-fueled drug diversion is more than a financial millstone that undermines stockholder value. Inaction also breeds human tragedy. Victims struggle with addiction, and die from overdoses. Their lives, hopes and dreams are ruined by easy access to legal narcotics. Drug diversion strikes at Americans from all incomes, education levels and walks of life—even youths in school yards.

The drug-diversion threat is real, and accelerating. This white paper lays out the evidence in unmistakable detail. Health insurers thus have a historic opportunity—and imperative—to respond.

Their challenge is to attack all facets of drug diversion. This includes improved detection of the crimes—from large-scale frauds by pharmacies to the smaller doctor-shopping cases by drug-seeking members. It also means better training throughout the healthcare pipeline, enlisting public support through better awareness campaigns, and numerous other steps.

But healthcare providers must enforce order, yet allow responsible access to life-enhancing drugs when patients truly need them.

Combating fraud and drug diversion is a sound business decision. But it's also a corporate responsibility to the public. Health insurers have an extraordinary position of influence. Their actions—and inactions—ripple relentlessly through the lives of millions of Americans. And consequences follow. In the crucial years ahead, what choices will health insurers make?

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APPENDIX 1

Doctor-Shopping Statutes, July 2006

1. Connecticut

CONN. GEN. STAT. ANN. § 21a-266(h) (West 2006): *“No person who, in the course of treatment, is supplied with controlled substances or a prescription therefor by one practitioner shall, knowingly, without disclosing such fact, accept during such treatment controlled substances or a prescription therefor from another practitioner with intent to obtain a quantity of controlled substances for abuse of such substances.”*

2. Florida

FLA. STAT. ANN. § 893.13(7)(a).8 (West 2006): *“It is unlawful for any person:...To withhold information from a practitioner from whom the person seeks to obtain a controlled substance or a prescription for a controlled substance that the person making the request has received a controlled substance or a prescription for a controlled substance of like therapeutic use from another practitioner within the previous 30 days.”*

3. Georgia

GA. CODE ANN. § 16-13-43(a)(6) (2005): *“It is unlawful for any person:... To withhold information from a practitioner that such person has obtained a controlled substance of a similar therapeutic use in a concurrent time period from another practitioner.”*

4. Hawaii

HAW. REV. STAT. ANN. § 329-46(1)&(2) (Michie 2005): *“It is unlawful for any person knowingly or intentionally to visit more than one practitioner and withhold information regarding previous practitioner visits for the purpose of obtaining one or more controlled substance prescriptions for quantities that:*

(1) Exceed what any single practitioner would have prescribed or dispensed for the time period and legitimate medical purpose represented; and

(2) Would constitute an offense pursuant to part IV of chapter 712.”

5. Maine

ME. REV. STAT. ANN. Tit. 17-A, § 1108.1 & .2.A (West 2006): *“A person is guilty of acquiring drugs by deception if, as a result of deception, the person obtains or exercises control over a prescription for a scheduled drug or what the person knows or believes to be a scheduled drug, which is in fact a scheduled drug, and the drug is:*

A. A schedule W drug. Violation of this paragraph is a Class C crime;

B. A schedule X drug. Violation of this paragraph is a Class C crime;

C. A schedule Y drug. Violation of this paragraph is a Class C crime; or

D. A schedule Z drug. Violation of this paragraph is a Class D crime.

2. As used in this section, "deception" has the same meaning as in section 354, subsection 2 and includes:

A. Failure by a person, after having been asked by a prescribing health care provider or a person acting under the direction or supervision of a prescribing health care provider, to disclose the particulars of every narcotic drug or prescription for a narcotic drug issued to that person by a different health care provider within the preceding 30 days..."

6. Nevada

NEV. REV. STAT. ANN. 453.391.2 (Michie 2005): *"A person shall not... While undergoing treatment and being supplied with any controlled substance or a prescription for any controlled substance from one practitioner, knowingly obtain any controlled substance or a prescription for a controlled substance from another practitioner without disclosing this fact to the second practitioner."*

7. New Hampshire

N.H. REV. STAT. ANN. § 318-B:2.XII-a (2006): *"It shall be unlawful for any person to knowingly acquire, obtain possession of or attempt to acquire or obtain possession of a controlled drug by misrepresentation, fraud, forgery, deception or subterfuge. This prohibition includes the situation in which a person independently consults 2 or more practitioners for treatment solely to obtain additional controlled drugs or prescriptions for controlled drugs."*

8. South Carolina

S.C. CODE ANN. § 44-53-395(A)(3) (Law. Co-op 2005): *"It shall be unlawful... for any person to withhold the information from a practitioner that such person is obtaining controlled substances of like therapeutic use in a concurrent time period from another practitioner."*

9. Utah

UTAH CODE ANN. § 58-37-8(3)(a)(ii) (2006): *"It is unlawful for any person knowingly and intentionally: ... to acquire or obtain possession of, to procure or attempt to procure the administration of, to obtain a prescription for, to prescribe or dispense to any person known to be attempting to acquire or obtain possession of, or to procure the administration of any controlled substance by misrepresentation or failure by the person to disclose his receiving any controlled substance from another source, fraud, forgery, deception, subterfuge, alteration of a prescription or written order for a controlled substance, or the use of a false name or address..."*

10. West Virginia

W. VA. CODE ANN. § 60A-4-410 (Michie 2006): *“It is unlawful for a patient, with the intent to deceive and obtain a prescription for a controlled substance, to withhold information from a practitioner that the patient has obtained a prescription for a controlled substance of a similar therapeutic use in a concurrent time period from another practitioner...”*

APPENDIX 2

State Prescription Monitoring Programs

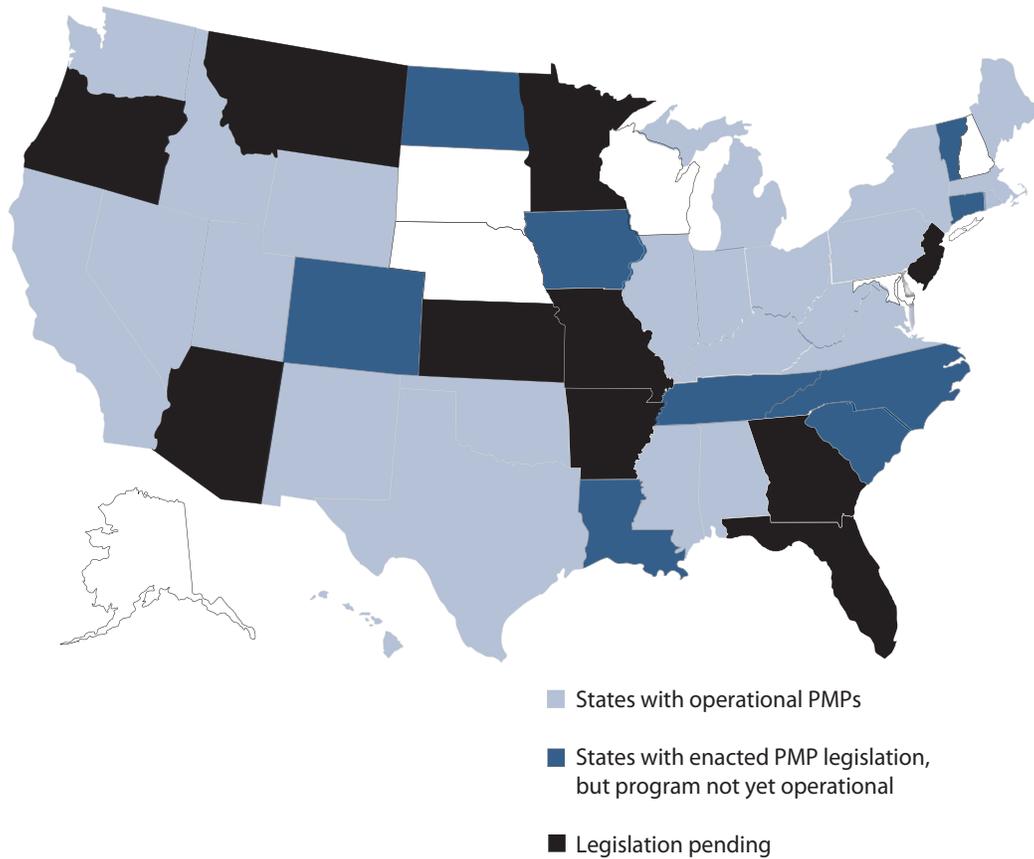
Please note: The National Alliance for Model State Drug Law defines an “operational” Prescription Monitoring Program as a program that is currently collecting prescription data and can respond to requests for reports by those authorized to make these requests.

States	PMP	Status of Enabling Legislation
Alabama	Operational	Enacted
Alaska		
Arizona		Pending
Arkansas		Pending
California	Operational	Enacted
Colorado		Enacted
Connecticut		Enacted
Delaware		
District of Columbia		
Florida		Pending
Georgia		Pending
Hawaii	Operational	Enacted
Idaho	Operational	Enacted
Illinois	Operational	Enacted
Indiana	Operational	Enacted
Iowa		Enacted
Kansas		Pending
Kentucky	Operational	Enacted
Louisiana		Enacted
Maine	Operational	Enacted
Maryland		
Massachusetts	Operational	Enacted
Michigan	Operational	Enacted
Minnesota		Pending
Mississippi	Operational	Enacted
Missouri		Pending
Montana		Pending
Nebraska		
Nevada	Operational	Enacted
New Hampshire		
New Jersey		Pending
New Mexico	Operational	Enacted
New York	Operational	Enacted
North Carolina		Enacted
North Dakota		Enacted
Ohio	Operational	Enacted
Oklahoma	Operational	Enacted
Oregon		Pending
Pennsylvania	Operational	Enacted
Rhode Island	Operational	Enacted
South Carolina		Enacted
South Dakota		
Tennessee		Enacted
Texas	Operational	Enacted
Utah	Operational	Enacted
Vermont		Enacted
Virginia	Operational	Enacted
Washington	Operational	Enacted
West Virginia	Operational	Enacted
Wisconsin		
Wyoming	Operational	Enacted

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APPENDIX 3

Map of State Prescription Monitoring Programs



Prepared by the National Alliance for Model State Drug Laws, current through April 17, 2007.

Washington's PMP applies to licensed practitioners and is used for disciplinary purposes or for disciplinary board supervision of a practitioner's practice.

APPENDIX 4

Resources

Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services

- National Health Expenditure Statistics and Projections

www.cms.hhs.gov/NationalHealthExpendData/

Drug Abuse Warning Network, Substance Abuse & Mental Health Services Administration, U.S. Department of Health & Human Services

- Prescription Drug Abuse Mortality Statistics
- Prescription Drug-Related Emergency Treatment Statistics

<http://dawninfo.samhsa.gov/>

Drug Enforcement Administration, Office of Diversion Control, U.S. Department of Justice

- Cases Against Doctors—Criminal & Administrative
- “Drugs of Concern”
- News—General & Case-Specific
- Related Web Links

www.deadiversion.usdoj.gov

Drug Topics Magazine

- Pharmacy Facts & Figures—Drug Sales by Units & Dollar Volume

www.drugtopics.com/drugtopics

Henry J. Kaiser Family Foundation

- Prescription Drug Usage, Cost & Insurance Trends

<http://kff.org/rxdrugs/index.cfm>

National Alliance for Model State Drug Laws

- Model Laws
- State Prescription Monitoring Programs & Data

www.natlalliance.org

National Association of Boards of Pharmacy

- Verified Internet Pharmacy Sites & Accreditation Information

www.nabp.net

National Association of Drug Diversion Investigators

- Abused Pharmaceuticals Brochure
- Law Enforcement Grants
- News Desk
- Regional/National Networking
- Regional/National Training Conferences

www.naddi.org

National Center for Addiction & Substance Abuse at Columbia University

- Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the U.S. (2006)
- Conferences
- Newsroom
- White Papers & Reports

www.casacolumbia.org

National Council on Compensation Insurance

- Workers Compensation Prescription Drug Use Reports

www.ncci.com

National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health & Human Services

- Monitoring the Future Survey
- Prescription Drugs of Abuse
- Bulletins & Reports on Prescription Drug Abuse

www.nida.nih.gov/drugpages/prescription.html

National Survey on Drug Use & Health, Office of Applied Studies, Substance Abuse & Mental Health Services Administration, U.S. Department of Health & Human Services

<http://oas.samhsa.gov/nsduh.htm>

U.S. Food & Drug Administration, Center for Drug Evaluation & Research, U.S. Department of Health & Human Services

- Comprehensive Prescription Drug Information

www.fda.gov/cder/index.html

Walgreens.com

- Drug Information and Prices

www.walgreens.com/library/finddrug/druginfosearch.jsp

APPENDIX 5

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