Letters

Use of Opioid Agonist Therapy for Medicare Patients in 2013

Despite public policy efforts to prevent opioid overdose and addiction, opioid overdose rates reached record high numbers in 2014.[1] The population that uses Medicare, the federal insurance program for Americans who have certain disabilities or are 65 years or older, has among the highest and most rapidly growing prevalence of opioid use disorder, with more than 6 of every 1000 patients (more than 300 000 of 55 million) diagnosed[2] and with hospitalizations increasing 10% per year.[3] Data on patients with commercial insurance plans (the other likely source for national population data) show just more than 1 of every 1000 patients diagnosed.[2] Prevention initiatives are essential for reducing the number of new patients with opioid use disorder, but treatment will be required for those already addicted to opioids. Opioid agonist therapy (OAT), including buprenorphine-naloxone (Suboxone) and methadone, is the most effective pharmacotherapy for opioid addiction.[4]

An analysis of Medicare data on buprenorphine-naloxone prescription allows us to make inferences on prescribers' use of this treatment. Medicare Part D (prescription drug coverage) does not pay for methadone maintenance treatment for opioid addiction. Hence, buprenorphine-naloxone (or buprenorphine alone, in the case of pregnancy) is the only covered OAT option for patients with opioid use disorder.

Methods | We examined data from individual prescribers from the 2013 Medicare Part D claims data set created by the Centers for Medicare and Medicaid Services. Part D covers approximately 68% of the roughly 55 million people on Medicare. For each of the included 808 020 prescriber National Provider Identifier numbers, the data identify each drug prescribed, number of beneficiaries, total number of claims, and total costs. Each National Provider Identifier includes location and specialty of practice. The data represent 1 188 393 892 claims that cost $80 941 763 731. We focused on buprenorphine-naloxone and how the prescription of buprenorphine-naloxone compares with the prescription of Schedule II opioid painkillers. Institutional review board approval and patient consent were waived because the data were deidentified and publicly available.

Results | We found 6707 prescribers with 486 099 claims for buprenorphine-naloxone, written for approximately 81 000 patients. Buprenorphine-naloxone prescribers equaled less than 2% of the 381 575 prescribers with 56 516 854 Schedule II opioid claims. For every 40 family practice physicians who prescribed an opioid painkiller, only 1 family practice physician prescribed buprenorphine-naloxone (71 718 vs 1793). Pain phy-

sicians averaged on the order of thousands of opioid painkiller prescriptions per prescriber compared with a negligible number of buprenorphine-naloxone prescriptions (mostly <5). Prescribers with a primary specialty in addiction medicine prescribed the most buprenorphine-naloxone per prescriber (98.8 claims per year), but there were only 100 such Medicare prescribers in the nation (Figure 1). The top 6 states by buprenorphine-naloxone claims ratio (the number of claims for the given drug subset divided by the total number of claims for all drugs) were Vermont, Maine, Massachusetts, Rhode Island, District of Columbia, and New Hampshire, all with a claims ratio more than 300 times the national average (Figure 2).

Discussion | These data do not necessarily reflect clinicians' complete practices or patient factors (eg, comorbidities or whether buprenorphine-naloxone was prescribed for its approved indication of opioid use disorder). With those cautions, important findings remain evident.

Approximately 81 000 Medicare enrollees are receiving buprenorphine-naloxone therapy (the only OAT available through Medicare Part D) despite more than 300 000 Medicare patients estimated to be struggling with an opioid use disorder and 211 200 per year requiring hospitalization for opioid overuse.[3] We believe this reflects a significant treatment gap, although we are limited in providing precise estimates; not all patients with an opioid use disorder warrant OAT, but on the other hand, opioid disorders are systematically underdiagnosed and increasing in prevalence.[5] Furthermore, more than one-third of Part D enrollees fill at least 1 prescription for an opioid in any given year,[3] putting many more patients at risk for iatrogenic addiction.[6]

Conclusions | Buprenorphine-naloxone is underused by Medicare prescribers. Geographic differences in buprenorphine-naloxone prescribing should be explored to assess state-level variations in advocacy for and barriers to its use. To combat the current prescription opioid epidemic, integration and promotion of OAT should be encouraged, and not just among addiction medicine specialists, who are far too few to meet the current and projected need. Physicians who prescribe high volumes of opioids and thus already have an established therapeutic alliance and prior experience with opioid prescribing are especially well-situated, with some additional training, to intervene when cases of prescription opioid misuse, overuse, and use disorders arise.

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Figure 1. Average Prescription Claims Per Prescriber By Specialty
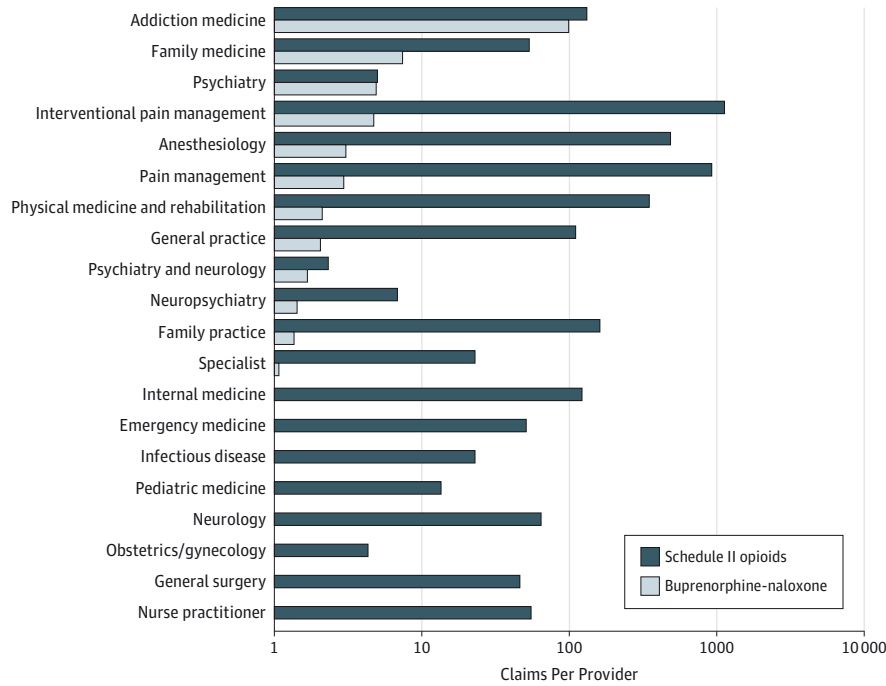
Values depicted on a logarithmic scale. Average claims per prescriber for buprenorphine-naloxone by specialty include addiction medicine, 98.8; family medicine, 7.4; psychiatry, 4.9; interventional pain management, 4.7; anesthesiology, 3.1; pain management, 3.0; physical medicine and rehabilitation, 2.1; and general practice, 2.0. The most prolific prescribers of Schedule II opioids by average claims per prescriber include interventional pain management, 1124.9; pain management, 921.1; anesthesiology, 484.2; physical medicine and rehabilitation, 348.2; family practice, 161.1; addiction medicine, 131.5; and internal medicine, 122.0.

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Figure 2. Ratio of Buprenorphine-Naloxone Claims vs All Drug Claims By State
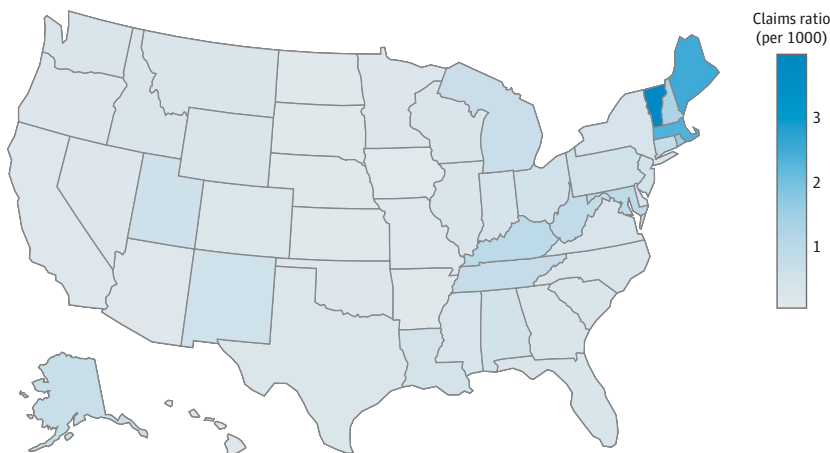
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