Opioid Addiction and Implications for Employers

Although the prevalence and destruction of opioid addiction have touched individuals and families across all social groups and geographies, until recently, federal and state-level efforts to confront this growing problem have lacked focus and rigor. With several legislative actions already underway and the recent enactment of the Comprehensive Addiction and Recovery Act (CARA), we will continue to see a focus on program development and treatment strategies. Employers can contribute toward curbing the opioid addiction epidemic in a number of ways and should play an instrumental role in facilitating increased awareness of and access to needed programming. These efforts will improve quality of life for employees and their dependents, as well as have a positive impact on productivity (including reduced absenteeism and decreased presenteeism). This article will explore the size and prevalence of the opioid epidemic, reflect on its implications for employers—including public policy initiatives—and suggest specific strategies for employer interventions.

by Sandra Kuhn | Mercer

Opioid addiction is a condition that cuts across geographies, social strata and industries. Its devastation is revealed in societal costs, personal struggles and loss, disrupted and broken families, lost productivity and increased crime. With such far-reaching impact, it is not difficult to imagine the cascading influence on U.S. businesses. In 2014, drug overdoses were the leading cause of accidental death in the United States, exceeding 47,000 fatalities. Of these fatalities, close to 19,000 were due to opioid pain relievers. The American Society of Addiction Medicine has estimated that opioid abuse costs employers approximately $10 billion in absenteeism and presenteeism losses alone. This article will explore the size and prevalence of the opioid epidemic; reflect on implications for employers, including public policy initiatives; and suggest specific strategies for employer interventions.

Opiates are a class of drugs that include the illegal drug heroin as well as the prescription pain relievers oxycodone, hydrocodone, codeine, morphine, fentanyl and others. In 2014, nearly 21.5 million Americans aged 12 or older had a substance-use disorder involving prescription pain relievers; 586,000 had a substance-use disorder involving heroin. Heroin addiction not only stems from use of an opioid but is the likely result when opioid medications become unavailable or too costly. In a 2014 survey of individuals in treatment for opioid addiction, 94% said they chose to use heroin because opioids were too difficult and often too costly to obtain. Heroin, by comparison, is more available and less expensive. Nearly 4.1% of the adult population (or 10 million American adults) used opioid medications in 2012-2013 without a prescription or used them inappropriately, reflecting a 127% increase from the 1.8% in 2001-2002. Another recent study
found that about 5% of adults who misused prescription opioids in the past year and 17% of those with an opioid addiction actually received treatment for addiction. The remaining affected individuals were left either without treatment resources or did not pursue treatment.8

The prevalence of pain medication use has grown with time because of a shift in prescribing guidelines and patterns. Physicians in the 1960s and 1970s were trained to use a very conservative approach in prescribing pain medications. As the years progressed, and more and different medications became available, controlled substance medications were positioned as the targeted strategies to address pain. Increasingly, physicians were directed to look at pain as a marker of overall health and use of opioids as a common practice for treatment.9

More recent news has provided insight into the availability of opioid medications to the general population and identified that more than half of patients who were legally prescribed opioid medications have leftover pills. The most common way to obtain opioids for nonmedical purposes is through family and friends, and nearly 20% of survey respondents stated that they have shared medications with another individual.10 As cited by The Washington Post recently, a JAMA Internal Medicine survey identified that nearly three-quarters of respondents said they provided their leftover opiates to someone else to help that individual manage pain. The main reason for sharing the medications is to help another person who can’t afford the medicine or doesn’t have insurance.11 These well-intentioned actions are, unfortunately, helping to ignite and further fuel addictive behaviors.

The staggering number of individuals in treatment or currently experiencing opioid dependency or addiction affects the workplace in many ways, including increased absenteeism and presenteeism. Employed persons who misused opioids accounted for 64.5% of medically related absenteeism and 90.1% of disability costs in 2011.12 Presenteeism, which is often difficult to measure, generally means employees are coming to work despite having a sickness that justifies an absence and, as a consequence, performing suboptimal work. Employees taking opioid medications might struggle with presenteeism because the medications can produce drowsiness and mental confusion, impairing attention and focus, creativity and reliability. This can have an impact on both quality of work and safety.

Employers have long offered an array of benefit programs that address a range of behavioral health and substance-use disorders. However, engagement in these programs has been relatively low. The stigma associated with treatment for behavioral health or substance-use disorder issues still prevails, although discrimination against people with behavioral health disorders seems to be declining.13 The cultural stigma likely affects individuals’ thoughts about seeking substance-use disorder treatment and can deter them from seeking help.14 Recognition of addiction as a medical condition in need of treatment rather than as a character flaw is key to reducing the stigma.

**Shifting Social Policy and Culture**

The Affordable Care Act, the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008, the Medicare Improvements for Patients and Providers Act of 2008 and recent passage of the Comprehensive Addiction and Recovery Act (CARA) provide a broader context for how social policy and culture is shifting. CARA’s definition of addiction as a chronic condition is historic. The law also provides direction on a wide array of treatments and services, spanning from primary prevention to recovery support.

CARA includes provisions expanding provider types and allowing grants for treatment program improvements, which have the potential to hold down costs to employers and improve access to treatment for employees and their dependents.15

CARA provides midlevel clinicians (e.g., nurse practitioners and physician’s assistants) the authority to prescribe buprenorphine, a drug used in the treatment of opioid addiction. This shift not only allows for increased access to treatment providers but may facilitate opportunities for smaller clinics to hire more midlevel clinicians and keep within their operating budgets. CARA also allows federal health officials to award grants to states and communities for expanding and improving treatment recovery.16 Because of the increasing awareness of opioid addiction, existing resources and treatment options will not meet the expected demand for education and more proactive identification strategies.

Prior to CARA’s enactment, states were implementing changes to limit the duration of first-time opioid prescriptions, expanding access to naloxone and enhancing prescription drug monitoring programs. Some reports suggest prescription patterns among today’s physicians are starting to change, in part, because of enhanced prescrip-
tion drug monitoring programs. These programs have been around since the 1930s but have been updated and expanded since 2000 to address the growing rate of opioid addiction.

An analysis conducted by Bao et al. showed that implementation of a prescription drug monitoring program resulted in a sizable reduction in the prescribing of Schedule II opioids (the subset of prescription opioids considered to be at highest risk for abuse and misuse). The author of this study acknowledges the reductions may be the result of increased awareness about controlled substance misuse and, as a result, physicians becoming more cautious when prescribing. In addition, recent state-based legislation governing the use of prescription drug monitoring programs, including mandatory registration and program use, may be influencing reduced prescription rates.

As social policy takes shape and change begins to take hold, the number of individuals who have access to behavioral health and substance-use disorder services will continue to increase. Treatment centers also will come under more regulation and scrutiny. The availability of insurance coverage and capital from investors has fueled the launch of new facilities as well as the growth of many existing providers. There is a flurry of activity at the state level and among health plans to provide more oversight and to challenge billing and treatment practices. Inconsistent licensure requirements for addiction centers across different states have created a need for this increased focus. In fact, treatment centers are far more varied from state to state than other types of health care or residential care facilities.

The Employer's Role

Employers can contribute toward curbing the opioid addiction epidemic in a number of ways. Federal and state public health messaging can be carried forward into the workplace to not only educate but also help reduce the stigma attached to substance-use disorders. These awareness campaigns should include messaging around the dangers of sharing medications and the prevalence of addiction and should promote resources and programs. Identifying community resources and collaborating with them to offer and promote prescription drug "takeback" initiatives is an effective way to reduce the availability of unused prescription painkillers. Finally, more employers are training managers to understand how to approach employees who exhibit signs of distress and refer them to appropriate programming.

Understanding the impact of opioid use within an employee population is an initial step in determining the focus—or breadth—of a communications campaign and in identifying the resources and programs needed to assist in prevention and treatment efforts. Employers should look at whether data points to particular geographies or employee groupings that have higher-than-typical use of opioid medications. Employers can also look at whether their employee population experiences medical or behavioral health conditions commonly associated with use of opioid pain medications (e.g., depression and back pain) at or above benchmark norms.

Employee assistance programs (EAPs) were among the original venues for substance-use disorder treatments in the 1960s and 1970s. Today, the vast majority of employers offer broad-based EAPs providing counseling for behavioral health and substance abuse concerns as well as support programs and services for a variety of work/life issues.

These programs are typically underutilized but could offer an initial entry point through education and screening for employees and dependents with concerns about their use and misuse of pain medications. The EAP can be an effective “first stop” for the vast majority of employees and dependents who may be affected by opioid use. These counseling and assessment services can help direct them to resources and treatment programs (offered through the health plan and specialty third-party providers) and can help alleviate the broad array of stressors throughout the family system that often accompany addiction. Ensuring that the EAP vendor is equipped to detect opioid use and misuse and can integrate with other benefit programs is essential to realizing the value the EAP can bring. Employers can boost engagement through promotion, personalized messaging around the value of EAPs and making the program easy to access.

Behavioral health and substance-use disorder benefits typically offered through a health plan or a third-party specialty provider need to be reviewed to ensure they’ve kept pace with increased utilization and demand for services.

Ensuring that plan members have adequate access to in-network treatment facilities can be an important step, particularly in more rural areas. Increased use of out-of-network facilities for substance-use disorder treatment is a growing trend. Members often select an out-of-network facility because of the targeted marketing strategies employed by destination facilities. But a lack of nearby options also drives decisions. Identifying gaps in network adequacy and work-
Endnotes


8. Ibid.


14. Ibid.


16. Ibid.


19. Ibid.

20. Ibid.

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