Financial Burden of Naloxone Prescribing for Patients with Low Socioeconomic Status and Limited English Proficiency: A Case Study

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INTRODUCTION

Drug overdoses are a leading cause of injury-related death in the United States and have increased markedly over the past two decades. In 2023, there were 105,007 overdose deaths, an age-adjusted rate of 31.3 per 100,000,[1] with opioids contributing to approximately 76% of cases.[2] Rates rose from 8.9 per 100,000 in 2003 to 32.6 in 2022, before declining slightly in 2023.[1] Rhode Island reflects these national patterns, with opioids involved in 69% of overdose deaths in 2024, including fentanyl in 57%.[3] The state reported an opioid dispensing rate of 30.5 prescriptions per 100 persons[4] and a naloxone dispensing rate of 1.4 per 100 persons in 2023.[5]

CASE STUDY

A 74-year-old non-English speaking female with no history of prior substance use disorder presented to the emergency department after having sustained a right subtrochanteric femur fracture. She was admitted and underwent open reduction and internal fixation by orthopedics. Her post-operative course was uncomplicated, and she was discharged on post-operative day two with home physical therapy. Upon discharge, she was prescribed baby aspirin, acetaminophen, oxycodone, and naloxone. Arriving home, her pain was well controlled with just acetaminophen alone. Her husband, with limited English proficiency, went to pick up her medications at the pharmacy. Without understanding the indication or reason behind the naloxone prescription, he paid $75 for it because it was not covered by their Medicare plan, leading to a significant financial burden on the retired elderly couple on a fixed income.

DEVELOPMENT

Naloxone is a critical component of opioid overdose prevention strategies. Rhode Island requires prescribers to counsel patients on dependence, interactions with alcohol or benzodiazepines, driving impairment, safe storage and disposal, non-opioid alternatives, and relapse risk for those with prior opioid use disorder.[6] Naloxone must also be prescribed when opioid dosage is 50 morphine milligram equivalents (MMEs) per day or higher, when opioids are prescribed with a benzodiazepine either at the visit or within the prior 30 days, or when prescribed to patients with a history of opioid use disorder or overdose. In these cases, prescribers must document the medical necessity of opioid therapy and justify that benefits outweigh risks.[6]

The naloxone in this case was likely added to the prescriptions by an interruptive form of clinical decision support (CDS) embedded into the electronic health record. This alert occurs upon signing an opioid order that the system detects as one that potentially meets the state requirement for naloxone co-prescription. The current alert at Brown University Health fires for opioid dosage is >49 MME/day. In some scenarios the alert might trigger firing inappropriately, such as when the system is unable to calculate the MME/day, or when a patient may have an inaccurate entry of a prior benzodiazepine prescription or previous overdose. Once triggered, regardless of reason, the alert is nearly impossible to override by design, and the easiest way to continue the user's workflow is to prescribe naloxone. As a result, there is overwhelming pressure from the system to co-prescribe naloxone, even if the patient is low risk or does not meet requirements.

It is understandable that a health system would attempt to meet an unfunded state mandate with automated, cost-effective solutions to enhance patient safety. Some quasi-experimental studies have found that CDS for opioid prescriptions does indeed increase the rate of naloxone co-prescription.[7,8] However, there are several potential problems with this approach. First, interruptive alerts have multiple negative impacts on physician well-being.[9] Automated prompts to prescribe are also not the same as a comprehensive patient education and counseling about prescriptions.

Persistent barriers to access to and affordability of naloxone also contributed to the case outcome. Naloxone is available at no cost through community outreach programs and Medicaid.[10] However, previously available only by prescription, naloxone was reclassified to over the counter (OTC) status in September 2023,[11] a change that expanded public availability but altered insurance coverage. In the case presented, the patient was insured through Medicare, which had previously provided naloxone at no out-of-pocket

cost. Following the transition to over-the-counter status, Medicare Part D no longer covered naloxone, resulting in a substantial copay.

The combination of a system-based push to broadly co-prescribe naloxone even in low-risk situations and gaps in Medicare insurance coverage created unintended harm for patients with limited financial resources for whom even modest copays represent a meaningful burden. Others, particularly those with limited health literacy, may not fully understand the rationale for the prescription and assume it is an essential part of their treatment, leading them to purchase it unnecessarily at retail cost. Language barriers can amplify this effect, as patients may equate a physician's prescription with clinical necessity regardless of their actual risk. In these cases, the healthcare system unintentionally shifts the cost and responsibility to optimize public health onto patients least equipped to navigate the complexities of the healthcare system.

To address this gap, the authors propose two approaches.

First, ongoing advocacy is warranted to ensure that Medicare beneficiaries maintain affordable access to naloxone following its transition to over-the-counter status, which has introduced new out-of-pocket costs. Although Rhode Island law requires insurance coverage of at least one prescription formulation of naloxone, no active state initiatives currently extend this protection to OTC products, leaving some patients without adequate coverage. H.R. 5120, the "Hospitals as Naloxone Distribution Sites Act" (HANDS Act), was introduced in the U.S. House on September 3, 2025. The bill would amend the Social Security Act to ensure Medicare, Medicaid, and TRICARE cover naloxone provided in hospital settings at no cost to patients, beginning in 2026. Its goal is to reduce financial barriers by allowing hospitals to distribute overdose reversal medication directly to at-risk patients at discharge. The bill has been referred to multiple committees but has not yet been passed into law. Supporters, including the American Hospital Association, have urged Congress to advance it.[12] Ongoing efforts to support coverage on a state and national level is required.

Second, prescribing practices should remain patient-centered, with decisions guided by individual risk profiles whenever possible. Patient-centered prescribing emphasizes clinical context, patient understanding, and equitable access to care. Given the ever-increasing cognitive load from regulatory burdens placed on prescribers, digital tools will need to be part of the solution. EHR developers and their customers should make automated, customizable and individualized patient education materials a central feature, rather than an afterthought. CDS that prompt a change in prescribing behavior is no substitute for tools that engage patients via written, video, and other digital health tools to allow patients to better understand their care plan.

CONCLUSION

While naloxone distribution has clear public health benefits, broad system-driven prescribing practices based on noble, well-intended public health initiatives can have unintended consequences that impose undue burden on patients and communities who do not benefit from the medication, especially those with low socioeconomic status and limited English proficiency. We recommend continued advocacy to reduce costs of and ensure insurance coverage (including Medicare) and expanding beyond CDS alerts. EHR systems could better integrate automated, customizable, and individualized educational materials delivered through traditional and digital platforms to improve patient comprehension and engagement in their care plans. Doing both would maximize the public health benefit while optimally aligning access, cost, and clinical necessity to prevent future cases such as this from affecting our most vulnerable patients and communities.

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Disclosures

None exist for all authors.

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