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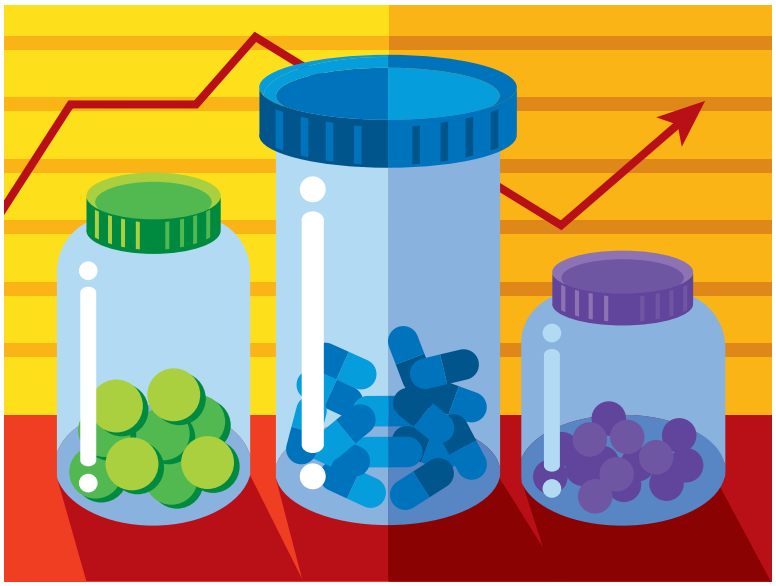

Prescription Drug Management in Workers' Compensation

The Twelfth Annual Survey Report (2014 data)

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Introduction

Prescription drugs have become a key factor in workers' compensation. Accounting for one of every six medical dollars, pharmacy's impact on disability duration, return to work and claim settlement outweighs the benefit's dollar expense. Each year pharmacy is the subject of much research on the part of such august organizations as the California Workers' Compensation Institute National Council on Compensation Insurance, the Workers' Compensation Research Institute, and others. The purpose of this survey is to add depth to our understanding of the issue, supplementing statistical and systemic research by adding the perspectives and data of insurers, third- party administrators, and self-insured employers.

This is the 12th year the survey has been conducted. For the first six years Health Strategy Associates, LLC, a consulting firm owned by Joseph Paduda, was responsible for the survey. Paduda is also the president of CompPharma, LLC, a workers' compensation pharmacy advocacy and education firm, and the responsibility for the survey was transferred to CompPharma in 2009.

As the workers' comp pharmacy sector has evolved over the 12 years, so has this survey. While the survey remains focused on PBM capabilities and program results, cost drivers and cost trends, opinions, perceptions, and attitudes about pharmacy management in workers' compensation, we have added and deleted questions over time. Special attention is paid to emerging issues, management approaches, vendors, problems and solutions, along with the evaluation of those solutions.

Once again, Yvonne Guibert conducted the survey itself; we are indebted to Yvonne for her diligent and careful work. Cal Paduda did much of the statistical analysis this year. We also want to express our thanks to the workers' compensation professionals who carefully and thoughtfully responded to the survey. Their willing participation is deeply appreciated. All responses are confidential, and care has been taken to "sanitize" responses to protect the anonymity of the respondents.

Interviews were conducted in the spring of 2015, with data on pharmacy spend and other metrics derived from respondents' 2014 results.

Editorial note — Readers should not confuse "price" with "cost." In this report, "cost" is defined as total drug expenses for a payer. Price is a contributor to cost, as is utilization, or the number and type of drugs dispensed. Think of cost as Cost = Price x Utilization.

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Key Takeaway

Pharmacy management does not occur in a vacuum. Outside factors profoundly affect pharmacy in workers' compensation including societal issues, such as the explosive growth in opioid abuse and misuse along with new laws and changes to existing laws and regulations. Overall medical trend, practice-pattern evolution, the flow of drugs into the system, the timing of patent expiration, pharmaceutical marketing practices, and the international pharmaceutical industry also influence pharmacy in workers' compensation.

Regardless of the impact of influences specific to workers' compensation such as fee schedules and claim frequency, better programs — properly implemented — deliver lower loss costs, which will translate to lower combined ratios and higher profits for work comp insurers/lower work comp costs for self-insured employers and better care for injured workers.

Background

Workers' comp pharmacy spend is between $5 and $7 billion. After much analysis, we have come to the conclusion that it is not possible to precisely calculate workers' compensation drug spend. There are several reasons for this.

Pharmacy is a component of workers' compensation medical expenses, which was approximately $33 billion in 2014 (Sources: National Academy of Social Insurance REPORT: Workers' Compensation: Benefits, Coverage and Costs, 2013, published August 2014, trended forward using National Council on Compensation Insurance (NCCI) medical inflation rates (4.0%) from NCCI Annual Issues Symposium State of the Line, 5/2015). Other considerations include:

- Different estimates are based on data from different states, and the various estimates use differing methodologies. The methodology used by NCCI, which produces an approximate cost of $6 billion, is based on an analysis of spend in the last year of the claim using data from NCCI-reporting states.
- In contrast, anecdotal information from payers indicates drug costs account for 11% to 16% of medical spend, or around $4-5 billion.
- The basis for determining what products or billing codes are included as drug spend varies among and between payers and jurisdictions.
- Drugs are dispensed in a variety of settings and by a variety of providers; therefore some drug costs may be included in other charge categories. For example, the use of specialty

drugs may be billed under home health care/durable medical equipment services, while long-term care and hospital-dispensed medications typically are counted as facility expenses.

- Physician-dispensed drugs may or may not be counted towards drug spend, as they can be billed on standard medical billing forms with the cost "rolled-up" under physician costs for reporting purposes.
- Some prescriptions for workers' comp injuries are filled under group health or other benefit plans. It is not possible to precisely estimate this figure, however we believe this is particularly common for patients with rich employee benefit plans.

Findings

Note: The survey uses quantitative and qualitative questions to drill down into specific issues and clarify opinions and perspectives. The quantitative questions use a 1-5 rating scale, with 1 on the low end (e.g., worse or less important) and 5 on the high end (best or most important).

Inflation/trend in drug costs

Caveat — there was more variability in cost trend across all respondents than we have seen in any previous survey; we would advise any reader to review this entire section before drawing any conclusions.

Across all 21 respondents' total drug spend, drug cost inflation increased to 6.4 percent over the previous year, reversing a trend that had seen flat or negative increases for the previous four years. However, when removing one outlier, the average of all respondents' trend remained negative, at -1.0% compared to 2013's -2.9%.

Considering the total change in spend, this marks only the second significant "increase in the rate of decrease" over the last 12 years; in 2009 we saw an increase of 9.4%. And, while the average of all respondents' trend remained negative, the 1.9 point increase over the previous year was one of just three such increases we've documented since we first began looking at this metric.

To validate and better understand this result we looked at individual respondent's trend rates. While the overall trend was up, only seven of the 21 respondents experienced increases in their drug spend. Of the entities experiencing increases, there was a significant range in inflation and little consistency between payers.

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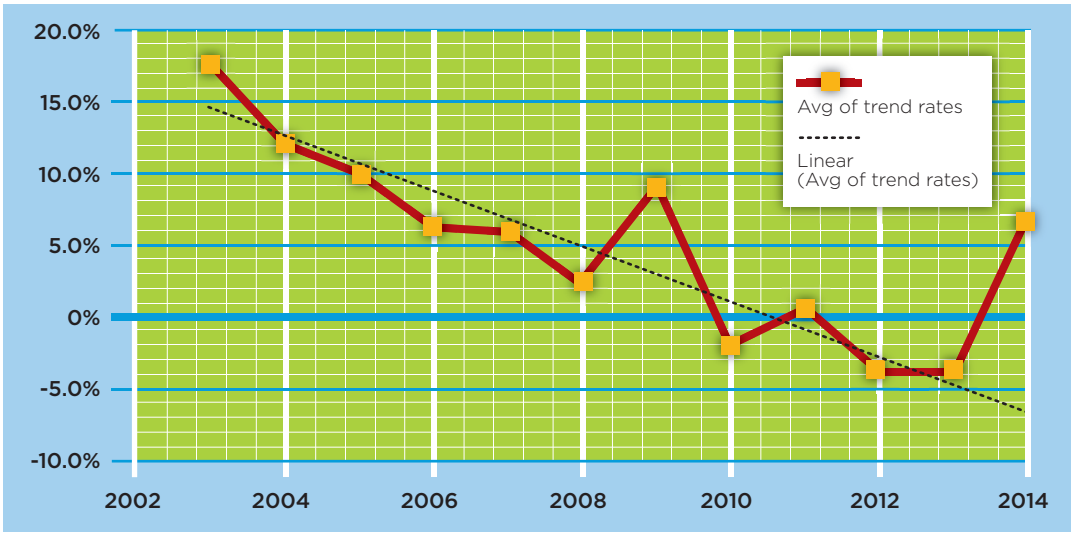
Over the first 10 years the survey was conducted, the pharmacy cost inflation rate decreased by over 21 points. Over the last year the inflation rate has increased by 10.2%. Clearly this bears additional discussion.

The workers' compensation pharmacy benefit management (PBM) industry came into its own just over a dozen years ago. While PBMs such as PMSI had long been active in the space, until drug costs exploded many — if not most — payers did not utilize PBMs and those that did often did so on a file-by-file basis. With the dramatic increases in drug costs in the early part of the last decade, payers hurried to contract with PBMs and integrate them into their service offerings.

Drug cost inflation trend



Originally delivering value through lower prices, most PBMs implemented clinical management programs as the decade went on. These clinical management programs continued to become more sophisticated and more effective over time and, along with better script capture programs and more effective payer-PBM working relationships, they led to decreases in utilization. Coupled with a decline in the number of new branded drugs, a large number of popular drugs going off-patent, and effective generic conversion programs, PBMs and payers were remarkably successful in not just managing, but actually reducing total pharmacy costs over the last few years.

The single hiccup, 2009, was primarily driven by one-time events such as the re-branding of OxyContin,® a move that led to a dramatic price increase for one of the top work comp drugs in terms of dollars spent. The year 2010 was undoubtedly affected by macro-

economic factors driving down trend, specifically low employment and a slight drop in workers' compensation claim frequency. However, the loss of patent protection for some key brands likely had more to do with the dramatic decrease in trend that year. The uptick in 2011 was driven primarily by smaller payers having more a complete understanding of their drug spend from better data capture.

Except for the notable hiccup in 2009 the workers' comp PBM industry, due in no small part to its increasing focus on clinical management, tighter integration and electronic connectivity with payers, delivered improved results each year.

The 10.2 percent increase over 2013 is a significant concern we will return to several times in this report.

The size of the "problem"

In response to the question "Where do prescription drug costs rank compared to other medical cost issues at your organization?" on a scale of 1 through 5 with 3 being "drug costs are equally as important as other medical cost issues," drug costs were rated a 4, consistent with the prior four year average of 3.9+/-. Individual responses to qualitative questions on the survey also indicated continued concern with drug costs.

Moreover, respondents are concerned (4) that drug costs will be more of a problem in the next 12 months than they are today. This is somewhat higher than their views last year, when the average was 3.7.

From reviewing all survey responses and paying particular attention to new cost management programs and results thereof, it appears that while payers worry about opioids, physician dispensing, compounds, and other factors, they believe their firms — and their PBMs — will be able to mitigate the impact of these drivers.

Cost drivers

The question asking respondents to identify the single biggest problem in workers' compensation pharmacy yielded diverse answers with a common thread. It is apparent that no single entity — PBM, payer, patient, prescriber, regulator — can make a material impact or can improve outcomes associated with drugs without the cooperation of these other entities. Too often they are at cross-purposes, and often for the wrong reasons.

Clearly some payers are recognizing this fact. While that is positive indeed stakeholders' cooperation is going to be essential to enable true change.

Narcotics, addiction risk and the industry's continued concern

During the past several years long-term opioid use has become the single biggest concern identified by respondents. While program managers and work comp executives have long known about the relatively high usage of narcotics in work comp, the depth and breadth of understanding of the issue continues to increase. Throughout the survey, respondents mentioned narcotics, opioids, addiction, specific drugs, dependency, and related terms, even when responding to other questions.

The introduction of new drugs and reformulated drugs, including so-called "abuse deterrent" opioids, was mentioned by several payers in response to different questions. There appears to be some concern about the FDA's apparent willingness to increase the availability of opioids, coupled with a deep concern on the part of respondents that these abuse deterrent drugs would be "solved" by people looking to abuse opioids. Among these 21 payers, the level of knowledge about and familiarity with opioids is quite high.

For the fourth year we asked respondents to score their concern about opioids in work comp; results were within 2/10^{ths} of a point across the four years. This year, respondents judged opioids to be an extremely significant problem, giving it an average of 4.75 (up slightly from last year's 4.6). Notably, all respondents rated this a 4 or 5, a clear indicator of the level of the industry's anxiety over a problem that it was somewhat slow to fully grasp.

High among respondents' concerns was the risk of addiction or dependency for claimants taking opioids; respondents said they were "very concerned" (4.5, compared to last year's 4.3). Most respondents have a full range of programs in place today. Last year, the only program that hadn't been (almost) universally adopted was pharmacist review of specific flagged claims. That has changed. Payers are finding this type of review is more cost-effective than a physician review; it is commonly provided by PBMs at no or little additional cost.

Physician dispensing

The concern over physician dispensing continues to grow driven by payers' own experiences and research results from the California Workers' Compensation Institute (CWCI), Johns Hopkins University and Accident Fund Holdings, Inc., National Council on Compensation Insurance (NCCI), and the Workers' Compensation Research Institute (WCRI)

quantifying the significant cost added to the system by physician dispensing.

Other recent research published by WCRI indicates physicians now account for almost half of prescription dollars in Pennsylvania, over half in California, and over two-fifths in Illinois, Maryland and Florida. (Sources: WCRI, Physician Dispensing in Pennsylvania, Second Edition, Dongchun Wang, Te-Chun Liu, Vennela Thumula, September 2014 and WCRI, The Prevalence and Cost of Physician-Dispensed Drugs, Donchung Wang, Te-Chun Liu, Vennela Thumula, September 2013.)

Physician dispensing also drastically and artificially inflates the cost of workers' compensation pharmacy costs. Physician-dispensed prescriptions typically cost three to ten times the amount of the same prescription filled by a retail pharmacy.

More recent studies (Johns Hopkins University/Accident Fund and CWCI) point to longer claim duration, more claimants prescribed opioids for longer periods, higher overall medical costs, higher indemnity expense, and poorer outcomes associated with claims with physician-dispensed drugs compared to similar claims without physician-dispensed drugs.

In addition to poorer claim outcomes, there are several additional concerns with physician-dispensed drugs. Physician dispensing unnecessarily creates a health and safety risk for the injured worker receiving these prescriptions. In addition to their non-occupational health physicians, injured workers often see multiple physicians for their work-related injuries, each of whom may prescribe multiple medications. These independent doctors often do not know the prescribing patterns of his/her peers or all of the other drugs the injured worker is taking. Nor do they usually know the patient's entire medical history.

Since state regulations and fee schedules drive reimbursement, geography continues to be a dominant factor. In 2009, drug repackaging/physician dispensing of drugs was a major issue for payers with significant business in the southeast and California. While California, Illinois, Connecticut, and Arizona and other states addressed the issue via reimbursement regulations, there appears to have been a significant increase in physician dispensing in Pennsylvania, Michigan, and North Carolina over the last few years.
In 2013, Florida implemented legislation capping the price of repackaged physician-dispensed drugs at 112.5% of AWP plus an $8 dispensing fee, however the net result will almost certainly be higher costs for Florida's employers. Most payers had been refusing to pay dispensers' bills, citing an interpretation of the state statute that allowed payers to reprice according to their contracts with retail pharmacies.

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National payers and those operating in jurisdictions without strong controls on physician dispensing are quite concerned about physician dispensing/repackaging. Excluding respondents working primarily or exclusively in states with severe limits on physician dispensing (Massachusetts, Montana, New York, Ohio, Texas, and Washington), concerns about physician dispensing remain high with a rating of 4.0, a considerable increase over 2014's and 2013's 3.6 and 2012's (3.9). Six respondents rated their concern about physician dispensing a 5 (extremely concerned) and four rated it a 4 (very concerned).

In past surveys we asked respondents for perspectives on physician dispensing/repackaging, and their consistent, universally negative responses made further surveying on this issue pointless. Instead, a few years ago we began asking respondents operating in states where dispensing exists to specify concerns regarding physician dispensing of repackaged drugs. Respondents cited the following:

- Patient safety; physician-dispensed drugs do not go through the Drug Utilization Review (DUR) process. (all but four respondents)
- Potential duplicate therapy. (all but five)
- Higher cost due to repackaged drugs being priced higher than the same medications at retail stores. (all but four)
- Unnecessary medications or medications not related to claimant workers' comp injury. (all but four)
- Extended disability duration. (all but four)
- Higher overall medical cost. (all but three)

Clearly respondents continue to have strong concerns about physician dispensing that extend beyond the obvious cost issue into patient safety and claims outcomes.

New and emerging issues

For the second consecutive year, compounds were a leading concern. Thirteen of 20 respondents cited compounds when asked to identify "any emerging or new issues in comp pharmacy that are particularly concerning."

Drug prices were high on the radar for five respondents, while opioids remained a concern for seven (although technically opioid usage is not a "new or emerging" issue).

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How respondents are controlling drug costs

All respondents save five had implemented significant changes to their pharmacy clinical management programs over the last year. If anything, the industry strengthened its efforts to address drug issues last year.

The three top cost drivers — opioids, compounds, and physician dispensing — were the subjects of most respondents' 2014 pharmacy management initiatives, with opioids by far the most common. Respondents noted several approaches to controlling cost, with a more diverse range of solutions and more specificity in solutions than we've previously seen.

The majority of the respondents implemented programs, upgraded approaches, hired staff, or altered DUR processes pertaining to opioids. This shows how seriously these respondents take the issue.

As we've noted for the last two years, payers continue to innovate at a rapid pace, pushing their PBMs and internal clinical departments to analyze, intervene, and take timely action. In the past, programs tended to be relatively "soft," involving letters to physicians and patient education, but now more payers are addressing claimant usage of opioids more assertively. Payers are contracting with third-party vendors, hiring staff and in some cases creating departments specifically to identify and deal with doctors who exhibit potentially problematic prescribing patterns. They also are requiring physicians "test for drug abuse" and comply with urine drug monitoring guidelines.

Mail order

Mail order penetration has been up and down over the last seven years. Continuing the trend of improving statistics, 2014's average was 4.65%, a third of a point lower than 2013's result.

Mail order remains a major opportunity.

Drug testing

This was the fourth year we asked respondents if they were using a urine drug testing (UDT) program. Four years ago half of all respondents utilized a UDT program to monitor claimant compliance.

This year three-quarters of respondents have implemented or will implement a drug

testing program. While most have a "formal" program in place with one or more contracted providers, several payers are a bit more ad hoc, identifying specific claimants that meet pre-set criteria for drug testing. As states adopt guidelines addressing opioids, we can expect more payers will have to comply by demonstrating their programs are consistent with those guidelines.

Compound medications

New to the survey this year was a question pertaining to the number of compounds prescriptions the respondent had processed in 2014. In total, respondents paid for over 63,000 compounds. In comments, many indicated that both the price of the average compound and the volume of compounds had increased dramatically quarter-over-quarter. We will try to quantify that growth in next year's survey.

How about those PBMs?

Respondents are pretty happy with their incumbent PBMs. Asked to rate their current PBMs' customer service, the average response was 4.1 ("very satisfied"). Of note, this reflects continued satisfaction with PBMs as last year's rating was identical.

Conclusions

The near 10% growth in costs over the last two years is troubling indeed, as is the explosive growth of compounds, an unproven and potentially unsafe "alternative" to traditional medications. Add the continued and seemingly intractable problem of long-term use of opioids to this mix, the seemingly-unstoppable expansion of profiteering physician dispensing firms, and it is not hard to understand why respondents continue to lose more sleep over pharmacy than other medical cost issues.

Pharmacy management in workers' comp has evolved dramatically over the 12 years we've been conducting the survey. From a focus on the price of the pill and the size of the retail pharmacy network in 2003 to today's concern about opioids, compound drugs, physician dispensing, data and reporting we've witnessed a remarkable increase in sophistication and understanding. Yet, despite all the attention and resources dedicated to this issue, payers' levels of concern about pharmacy management remain quite high.

Perhaps it is more accurate to say "because" of all the attention paid to the issue, payers' levels of concern are quite high. The hard-won insight into the myriad issues inherent in

pharmacy management, coupled with a deep understanding of the long-term implications of poorly-managed drug regimens plus the susceptibility of work comp pharmacy to bad actors makes it a "soft target" indeed.

Finally, as the respondents noted, we'd be remiss if we didn't acknowledge the significant impact of external factors on workers' compensation pharmacy, chief among them the nation's growing addiction to prescription pain medications. This is a societal issue, but one that has a deep and damaging impact on comp, driving up costs, prolonging disability and killing claimants.

CompPharma is a consortium of workers' compensation pharmacy benefit managers (PBMs) that identifies and prioritizes industry-wide problems and then develops and delivers solutions. CompPharma's member PBMs are:
Coventry/First Script
Express Scripts
Healthesystems
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