Prescription Drug Management in Workers' Compensation

The First Annual Survey Report
Spring 2004

Joseph Paduda
Principal
Health Strategy Associates, LLC

203.314.2632
Jpaduda@HealthStrategyAssoc.com

Copyright 2004 HSA, all rights reserved
CONFIDENTIAL AND PROPRIETARY
DISTRIBUTION WITH EXPRESS WRITTEN PERMISSION ONLY

copyright 2004 Health Strategy Associates, LLC
all rights reserved

Prescription Drug Management in Workers' Compensation

The First Annual Survey Report
Spring 2004

Introduction

During late 2003, Health Strategy Associates completed an in-depth telephonic survey of 21 decision-makers at workers compensation payer organizations to assess their perceptions, opinions, and attitudes about prescription drug cost management in workers compensation. The respondents were medical directors, senior claims and managed care executives, and program managers. Topics included the scope of the problem, key product and service attributes, cost trends, and perceptions about solutions, third-party billers (TPB), and the pharmacy benefit management (PBM) industry. The survey was sponsored by Express Scripts, Inc.

RESPONDENT ORGANIZATIONS

Respondents represented a wide array of payers with annual prescription drug spending ranging from $2 million to $170 million. Total estimated drug costs — either provided by or estimated for the respondents — amounted to $688 million, approximately 27 percent of the total estimated workers compensation drug spending in 2003. The respondents comprised three broad groups: insurers with more than $100 million in prescription drug expense; middle-tier payers with between $40 million and $60 million in drug expense; and small-tier payers, with between $2 million and $10 million in drug expense.

Four of the top five workers compensation payers were included in the survey: The State Compensation Insurance Fund (California), Liberty Mutual, AIG, and The Travelers. At the other end of the spectrum were smaller insurers such as EMC and the Accident Fund, as well as the state of Georgia, a self-insured employer. Workers compensation insurers were the largest single group surveyed, followed by third party administrators (TPAs).

See Exhibit 1.

AWARENESS OF THE PROBLEM

In 2003, the cost of prescription drugs associated with workers compensation claims was approximately $2.5 billion. Cost control was viewed as a significant issue by respondents, with 20 percent — mostly larger payers — indicating that prescription drug costs were much more significant than other medical cost issues. Overall, drug costs were rated as somewhat more significant as other medical costs (3.8 on scale of 1 to 5, with "5" being high). And, with costs increasing at an average annual rate of 13.8 percent, respondents indicated that they strongly believe (4.0 on scale of 1 to 5, with "5" being high) that prescription drug cost control will become more important in their organizations over the near- and medium-term.

copyright 2004 Health Strategy Associates, LLC
all rights reserved

When asked if drug costs had the attention of senior management at their organizations, 81 percent answered in the affirmative. Executives were definitely viewed as concerned about drug costs (3.6 on a scale of 1 to 5, with "5" being high). Only four respondents indicated that their senior managers are not paying attention, although three of these respondents had less than $10 million in annual drug spending.

CONTROL OF PRESCRIPTION DRUG COSTS

Respondents offered wide-ranging responses about methods used to control their drug spending, from capturing the first prescription to building larger retail networks of pharmacies. However, no single solution was mentioned by more than 6 of the 21 respondents. Traditional controls, such as generic substitution, use of drug utilization review (DUR) edits and programs, and use of PBMs were among the most frequently noted controls, along with a call for more data analysis. Other commonly cited solutions included providing additional education and control tools to adjusters and case managers, access to pharmacists to discuss specific cases, and a flexible, yet tight, drug formulary.

Notably, respondents focused more on utilization controls as a means to manage costs than on price controls. In addition, responses focusing on utilization controls were much more frequent and creative than responses noting a need to control per-prescription pricing. Utilization-related responses included:

- utilization management, including addressing multiple prescriptions from multiple doctors (6);
- tighter medical management, including working to change prescribing physician behavior (5); and
- a change in formulary to restrict prescription refills (4).

Interestingly, some of the "traditional" or "common" control measures were cited with relative infrequency. For example, there were only two mentions each of mail order, first-fill capture, and reducing TPB influence and one mention referring to a broader pharmacy network.

Response Analysis

There was no consensus on the specific steps that must be taken to control workers compensation prescription drug costs. Responses clearly indicate that utilization is viewed as a more significant issue than unit price. In fact, the more experience a respondent had with pharmacy management programs, the more that respondent focused on utilization-related solutions. One respondent with more than eight years' experience stated that price was not the issue, utilization was. Other respondents more or less echoed this sentiment.

There are two possible interpretations of this. First, it is important to note that, historically, many vendors marketing workers compensation prescription cost-management programs did not deliver significant per-unit savings, especially when compared to group health PBM rates. Therefore, responses focusing on utilization may be

copyright 2004 Health Strategy Associates, LLC
all rights reserved

driven by a belief that significant savings below state fee schedules are not available. Second, it is also possible that PBMs have failed to differentiate themselves on cost savings and, as a result, payers are seeing utilization as a differentiator.

There was also a fairly consistent recognition of the significance of the treating physician's role in prescription drug management. Some respondents were in favor of more draconian measures to address utilization, such as tighter formularies and preauthorization requirements; others appeared to favor an approach focused on educating treating physicians, adjusters, and case managers. Clearly, this indicates a belief that the ability of the payer to effectively control workers compensation drug costs is limited at best. However, there are significant differences of opinion among respondents about the best way to address the issues related to the treating physician.

LEVERS TO CONTROL COSTS

Despite the varied answers about how to fix the cost problem, respondents had similar views on what "levers" they had available to control costs. Most of the 21 respondents cited PBMs either directly (14) or indirectly (5). They also noted the strategies of directing claimants to providers, channeling, and using volume to drive discounts. Consistently, respondents noted that they used PBMs in combination with their own programs and internal capabilities to control costs.

The second most-frequently cited lever was the treating physician. Five respondents cited a desire to influence the treating physician, and four others specifically cited the ability of a "payer-side" pharmacist or physician to intervene with a treating physician, thereby influencing a specific prescription or the treating physician's prescribing pattern. The key word here is "influencing" since PBMs and payers can only change a doctor's prescription when specifically allowed by law, such as in states that make generic drugs mandatory when available. Specific approaches to influencing doctors that were cited include:

- sending letters to treating physicians to request changes in prescriptions;
- relying on the sentinel effect;
- encouraging prescribing physicians to use generic drugs;
- holding physicians accountable for the drugs they prescribe and requesting evidence why those drugs would be better than a generic or different drug in the same class;
- employing aggressive clinical management by pharmacists and other physicians to review prescriptions and intervene with the treating physician;
- raising physician awareness about the volumes and types of drugs prescribed; and
- monitoring the top physicians who are writing "dispense as written" prescriptions and working directly with them to attempt to change their prescribing patterns.

copyright 2004 Health Strategy Associates, LLC
all rights reserved

Five respondents also mentioned DUR. Surprisingly, controls that would generally be assumed as common were mentioned infrequently. These include generic substitution (3), lobbying (2), formulary (4), and pricing (1).

Response Analysis

While there is wide disagreement about what must be done to control costs, there is no lack of consensus on who must do it. PBMs are seen as the primary lever to control prescription costs. The other significant information was the focus on the treating physician as key to managing prescription drug utilization. Most PBM and payer efforts to control drug costs concentrate on DUR, formularies, mail order programs, and per-unit discounts. It was apparent that the payers are very interested in not only the prescriptions that are written, but also the physicians who are writing the prescriptions.

RESPONSIBILITY FOR PRESCRIPTION DRUG COST CONTROL

Overall, respondents rated PBMs as the entities most responsible for cost control, followed closely by internal staff, and generalist managed care organizations a distant third. Notably, four respondents believed that treating physicians were at least as responsible for controlling costs as the PBMs or internal staff.

Of the 21 respondents, 6 rated PBMs as *most responsible*, 11 believed PBMs to be *very responsible*, 3 rated PBMs *somewhat responsible*, and 1 rated the PBM as *slightly responsible*. This represents a very significant affirmation of the role of the PBM in controlling costs.

Additional insight can be gained by examining the relative ranking of PBMs versus the other potentially responsible entities. Eight respondents rated PBMs as having more responsibility than any other entity, with another eight believing PBMs' responsibility to be equal to that of another entity for the leadership position.

MARKET PERCEPTION OF WORKERS COMPENSATION PHARMACY BENEFIT MANAGERS

Respondents were asked their perceptions of leading PBMs and their level of interest in working with specific vendors. Their answers suggest that the market is not overwhelmed by the abilities of workers compensation PBMs in general, or any one PBM specifically.

Leading Vendor Organizations

There were few surprises in the respondents' views on leading organizations in the workers compensation PBM industry. It was apparent that respondents did not view any vendors as clear-cut leaders in this field. In fact, the most frequently mentioned leading organization was "none" (8) followed by internal staff or their own company (5).

When respondents were pressed with a follow-up question asking "*what company just pops to mind as the one doing the best job,"* no one responded instantly.

The *"none"* category included three general responses: *"don't know," "don't think there are any,"* and *"none."* Some of the responses themselves are illustrative of market

copyright 2004 Health Strategy Associates, LLC
all rights reserved

perceptions. Comments ranged from *“they are all struggling to contain costs”* to *“small PBMs do not have enough leverage, and large PBMs are not working as aggressively as they could be and leveraging their group business.”*

Response Analysis

There were relatively few responses that were based on vendor performance or that could be considered as “brand-positive." This is informative for two reasons: First, the fact that most respondents could not identify a leading organization speaks volumes about the lack of brand awareness for any of the organizations serving this market; and, second, respondents who were more sophisticated and informed about workers compensation prescription drug issues focused on issues closely related to utilization. Utilization control appears to be the most significant reason for respondent’s “value-based” answers. That is, for those respondents who cited a specific organization, their reason for that citation was most often rooted in utilization control.

KEY FACTORS FOR PBM SUCCESS

As noted previously, PBMs are clearly the primary tools used by respondents to help control workers compensation drug costs. However, respondents differed in their views on the key characteristics of a top-performing PBM. Ease of use by the claimant or insurer was cited most often as important (8). The second and third most frequently cited factors were savings and discounts (7) and size of and relationship to the pharmacy network (6). A more detailed examination of responses, however, presents a different picture.

Ease of Use

Respondents characterized ease of use in several ways. Several mentioned ease of use by claimants, while others mentioned ease of use by adjusters and employers. Closely related to these responses were statements about creativity (3), customer service (3), and being very proactive (4). Clearly, the payer wants a highly service-oriented, seamless program that is driven by the PBM. Four respondents also believed that a total focus on (or understanding of) workers compensation would aid success.

In total, 23 responses (some respondents provided multiple responses) addressed some aspect of being easy to work with. The adage that the winner is the one who is easy to do business with apparently holds true in this business.

Operational Features

Discounts and the size and composition of the PBM network were two of the leading responses identified as success factors, followed by several comments generally falling under the category of “DUR.” These responses focused on the impact that DUR has on treating physicians (4), and the ability of the PBM’s pharmacists to interact with and educate both insurer staff (adjusters and nurse case managers) and treating physicians (3).

Five respondents noted that electronic data interchange (EDI) connections were key to vendor success. This impression was supported by their ranking of EDI connectivity in a subsequent section as one of the most valued vendor capabilities.

copyright 2004 Health Strategy Associates, LLC
all rights reserved

RESPONSE ANALYSIS

Customer service is viewed as critical. Payers want their pharmacy program to be workers compensation-focused (but not necessarily workers compensation-dedicated), easy to use, and simple for adjusters, claimants, and employers. They want strong EDI connections to assist in this process, and friendly, but assertive and highly educated pharmacists on the PBM's staff to deal with recalcitrant physicians and ignorant adjusters. This emphasis on pharmacist and treating physician interaction and *counter-detailing* was repeated in several other places in the survey by many of the respondents. Counter-detailing occurs when pharmacists or other clinicians work to educate prescribing physicians on alternative therapies, potentially harmful drug interactions, or use of a generic drug instead of a brand. "Detailing" is the industry term for pharmacy company representatives' efforts to educate physicians on the benefits and uses of their company's drugs.

The respondents made it clear that *how* the service is delivered is of at least equal importance to *what* service is delivered. The individuals most able to have an impact on prescription drug delivery, formulary usage, generic substitution, and pharmacy utilization are the adjuster, the employer, and the claimant. However, if their efforts to influence prescribing behavior are not received positively, the payer's desire for potential savings may well be overwhelmed by ill will among physicians, the very people who are key to ensuring the program's success.

VENDOR CAPABILITIES

Following the more general questions about what characteristics make vendors successful, respondents were asked to rank several vendor-specific capabilities on the same 1 to 5 scale, with 1 being not important to the respondent and 5 being very important. Notably, most of the categories were operational in nature.

Each capability was assigned a score based on an average of its overall scoring by the respondents. In addition, based on the score, a rank was assigned to allow relative comparisons.

Generics

Interestingly, the capability that was ranked the highest — generic substitution — is likely the one with the least potential to control costs. According to a recent study published by the National Council on Compensation Insurance, there is less potential for savings from generic drugs in workers compensation than in group health because many of the most common prescriptions already are generic, and also because there are already mandatory generic switching laws in place in many jurisdictions today. Thus, the responses may reflect a lack of knowledge; the impact of some PBMs' marketing of generic switching as a key cost reduction strategy; or simply the knowledge that generics are much cheaper and likely to yield a big bang for the buck. Respondents did mention elsewhere a desire to work with physicians to eliminate "dispense as written" notations that allow the doctor to require a brand despite the presence of a generic alternative.

Formularies

copyright 2004 Health Strategy Associates, LLC
all rights reserved

The second highest-ranked capability (tied with *automated downloads of eligibility*) was a *workers compensation-specific formulary*. Drug formularies are schedules of prescription drugs approved for use for specific conditions. Formularies are used to manage the types of drugs that are dispensed, and may (in some cases and/or jurisdictions) affect the actual drug that is dispensed at the participating pharmacies. A few respondents noted that flexibility in the formulary, or enabling a formulary "specific to our needs," was important to them. It would appear that a workers compensation-specific formulary is a viewed as a given.

Ease of Use and EDI

Two capabilities are EDI-related and specifically address "ease of use." *Automated downloads of eligibility* and *online eligibility entry* ranked second and seventh respectively. Most responses to these two capabilities were rated as high in importance, ranging from 4 to 5 on a scale of 5; the actual ranking and scoring of *online eligibility entry* was dragged down by two scores of 1; it would otherwise have been in the top three capabilities in terms of rankings. This apparent "high value" perception is reinforced by the responses to a previous question indicating EDI as an important characteristic of a successful vendor. With larger payers, the EDI might be established directly between a PBM and the payer's own claim system. The online systems primarily benefit smaller payers, who cannot afford the time or expense to establish EDI.

Drug Utilization Review

Ranked fourth, *concurrent DUR* also appeared to be a given by most respondents. There was little comment about concurrent DUR during this part of the survey. As noted elsewhere in this report, respondents are definitely interested in DUR, but they have different perspectives on the definition of "effective" DUR. This is illustrated by the middle ranking (tenth) of *retrospective DUR* in this part of the survey, which contrasts with other responses that indicate significantly higher interest in retrospective DUR. The difference may be because respondents do not connect the term "retrospective DUR" to the more assertive, pharmacist-based counter-detailing programs they seem to favor.

Mail Programs

Mail programs were ranked fifth. These programs can deliver significant savings over retail delivery, but they have yet to make significant inroads across a substantial portion of the payer industry.

Results Reports

The issue of reporting results tied for fifth in rankings. This issue is closely related to that of savings. While some of the more sophisticated respondents voiced skepticism or frustration about the reports they receive from vendors, others appeared to trust what their vendors were reporting. The skepticism typically involved complaints that vendor reports were self-serving. Some felt that reports did not accurately represent true savings because items that were difficult to quantify or interpret such as "avoided prescriptions" and "prevention of early fills" were often counted as savings. The respondents who did not voice complaints were typically smaller payers.

copyright 2004 Health Strategy Associates, LLC
all rights reserved

Clinical Programs

Clinical programs, described as PBM clinical staff contacting treating physicians to discuss alternative treatments, ranked as seventh, which seems low compared to the respondents' overall stress on utilization measures. The narrative answers discussing these programs primarily came from relatively sophisticated, larger entities with more and deeper experience in this area. The answers lend support to the idea that these types of programs are significantly more important to payers than the raw ranking would indicate.

Network Ownership

Respondents were clear in their dislike of vendors renting pharmacy networks from other organizations. They cited several concerns, including lack of responsiveness due to additional layers of communication (payer, PBM, network, and pharmacy); lack of workers compensation-specific contracts potentially leading to increased TPB activity; higher costs due to middlemen; and potential data quality and communication issues.

In contrast, the level of interest in the workers compensation capabilities of the vendor is likely higher than illustrated by the raw score and rank. Answers to previous questions about topics related to workers compensation expertise show that while this is a characteristic that is valued, respondents also saw the benefit of the buying power and pharmacy relationships inherent in a large PBM with strong group health business. To some respondents, owning a pharmacy network is a critical issue; there were three scores of “5” for a *workers compensation-only network*, as well as several comments that workers compensation expertise is critical to the success of a network.

Savings Below Fee Schedule and Average Wholesale Price and Reporting

Savings below fee schedule (FS) was rated as more important than savings below average wholesale price (AWP), but both just barely ranked in the top 50 percent of valued capabilities. There were several skeptical statements about AWP, most of them referring to it as a "moving target" or a meaningless baseline. However, it would be a mistake to construe this to mean that respondents do not care about savings. Some vendors may not have touted their savings, or may have blended in DUR and other soft-dollar savings, and therefore may have either confused the issues or raised the level of skepticism in the market about savings. It is my experience that savings, especially in today’s environment, are key to program success.

Quantifying Savings

Respondents were asked the open-ended question, *“how does your organization calculate savings for prescription drugs?”* Most respondents (13) measure their savings as the difference between FS and the paid amount. Some measure savings as the difference between charges and paid (4), thus including amounts billed in excess of FS. Others used other evaluation criteria, including:

- impact of UR interventions (7 responses);
- generic to brand ratio (2 responses);
- don’t or can’t evaluate (2); and

copyright 2004 Health Strategy Associates, LLC
all rights reserved

- blocked prescriptions that never occurred (1).

Most of the more sophisticated respondents base savings on paid amounts less than FS, with only one comparing savings to AWP. In addition, narrative comments lend support to the prior statements about savings reports having limited value.

The Importance of First Fill

The capture of the initial prescription, or "first fill," is viewed as important for a number of reasons. In addition to obtaining a discount, capture of the first fill ensures early entry into the DUR process and reduces administrative expenses via electronic submission of the bill. Respondents were asked to rate the importance of capturing the first fill on the 1 to 5 scale, with 5 being high importance. The average score was 4.2, with no score less than 3. Respondents were asked to describe the best way to accomplish first fill. Most respondents talked about an electronic link between the payer, the PBM, and the pharmacy; others described some form of card, employer letter, or other means of informing the pharmacy at point of service.

Many noted that point-of-service notification strategies were inherently difficult, required significant employer participation, and were potentially problematic due to the potential for fraud. The fraud concern appeared to be that claimants would be able to use the card to fill prescriptions that were unauthorized or unrelated to workers compensation. This is likely not a significant issue because all cards are inactive until and unless activated by the payer and vendor.

A majority of respondents also stated that there was really no way to ensure capture of the first prescription, despite all the programs, education, EDI linkages, and the like. Their less-than-optimistic comments indicated that despite seeing first fill as potentially valuable, they are struggling to find effective, workable solutions. A sampling of their comments on how to best capture first fill illustrates this struggle:

- Use effective communication with a cardless program.
- Combine an at-risk PBM with a flawless, real-time electronic link between the insurer, PBM, and pharmacy.
- We are looking at it, and trying to figure it out … it requires the employer providing information to the injured worker at the moment of injury; when this happens it works well, but it doesn't happen a great deal today.
- Ideally, we would look to the pharmacy to identify the injured workers carrier and thus the PBM at point of service … this is very tough.
- Give them cards in their claim kits, then activate them upon notice of injury. This requires that employers read their claims kits, and make the call to the claims center to activate the card, but this is better than nothing, because mailed cards are usually late anyway.

The net result is there are no easy answers to a successful first-fill program, and it is acknowledged that all parties play a part in capturing the first script.

copyright 2004 Health Strategy Associates, LLC
all rights reserved

WHICH PHARMACY CHAINS?

When asked which pharmacy chains must be in their networks, respondents indicated a preference for as many as possible. Two respondents stated that all chains must be in the network, one asked for the top 20 chains, and one for the top 10. When these responses are added to the responses naming specific chains, the following results are obtained. See exhibit 2.

When asked what chains would be "nice to have" almost all responses were limited to regional and independent entities.

NETWORK DIRECTION

Most respondents (19) try to direct injured workers to network pharmacies. Those that responded negatively (2) either had new programs or were "not yet" directing. There is a strong interest, at least an intellectual one, in directing injured workers to network pharmacies. Several respondents added the caveat that they only directed in states where it is legal to do so.

The follow-up question, *"are you aware of what you can and cannot do to direct?"* was also answered positively by almost all respondents.

When asked why they would direct, respondents mentioned increased savings (7), the need for DUR and related topics (6), expectations of higher quality (4), improved administration (3), and data collection issues (2). This question also reinforced the responses to the earlier question referring to what a PBM must do to be successful. In this section, "control" was specifically cited by 5 respondents. The responses related to data and administration may also be viewed as a desire to capture information and effectively manage a program.

RESPONSE ANALYSIS

These survey results are somewhat surprising because they directly contradict my first-hand knowledge of what is occurring in the market today. In my experience, the commitment to directing as evidenced by the actual amount of direction is much lower than the survey results would indicate. My sense is that payers are giving lip service to direction, but in fact most adjusters and nurse case managers are doing little to direct, even in those jurisdictions where it is legal to do so. As proof, one has only to review the penetration rates previously cited. Remember, many of these payers have PBM networks comprised of most of the nation's pharmacies. Therefore, one has to wonder why penetration rates across the board are not in the high 90s.

MAIL PROGRAMS

When asked if their mail penetration rates were equal to about 2 percent (the typical mail order penetration rates), 7 respondents stated they were, 8 stated their penetration was higher, 4 did not know, and 1 did not respond. One responded that it did not employ mail programs because the payer wanted injured workers to have to get out and go to the pharmacy as part of the firm's return-to-work strategy, and therefore, it believed a mail

copyright 2004 Health Strategy Associates, LLC
all rights reserved

order program would be counter-productive. Claimant concerns about tampering and security of prescriptions traveling through the mails was mentioned as a factor twice. Other than those three comments, there was very little interest or concern expressed about home delivery programs. From a cost reduction perspective, this seems to be a missed opportunity because most PBM programs provide additional payer discounts for prescriptions ordered through the mail.

THIRD-PARTY BILLERS

The strong consensus among respondents was that TPBs are a problem. Most respondents voiced this opinion (17), while others stated that they did not have enough information to comment (4). For those citing TPBs as a problem, the average score was 4.0 on a 1 to 5 scale, with 5 being *a significant problem.* However, these statistics may not tell the whole story as evidenced by comments.

The ranking itself was problematic for several respondents. They noted that today, TPBs are part of the problem, but if they could work together, TPBs could well be part of the solution. Therefore, several respondents scored the TPBs based on their present experience, but noted that their scores would change drastically and positively if the TPB's business model and processes changed. These respondents noted that TPB connections and strong relationships with the pharmacies could benefit the payers if the TPBs were to work with the payers instead of on the side of the provider. There was a sense that payers (and their proxies) should "work to find a way to work with TPBs since they are potentially a part of the solution."

Describing why TPBs were a problem brought out many of the same issues raised in other parts of the survey. Seven respondents noted that TPBs reduced savings and interfered with payer control over prescription drug management; six noted that TPB processes led to administrative issues and hassles, including data capture and quality issues; three stated that TPBs hampered DUR programs; and one respondent was concerned about potential fiduciary liability if TPBs failed to pass payments along to the appropriate pharmacy.

Several respondents also noted that specific data issues were problematic because the failure to capture specific detailed codes could lead to duplicate bills being paid and duplicate prescriptions authorized.

ADDRESSING PROBLEMS WITH THIRD-PARTY BILLERS

There were a variety of responses to a question about how respondents were addressing the TPB problems. Seven respondents believed it was the PBM's job to address TPBs; seven respondents were using network direction, employer education, channeling, and other techniques to get claimants to participating pharmacies; three respondents were taking a hard line, stating that they were going to use, or were using, legal or other means of "hard ball"; and two respondents did not think there was a solution to the issue.

copyright 2004 Health Strategy Associates, LLC
all rights reserved

Of the respondents who were most concerned about TPBs (scoring them at 4.5 or higher), three were pursuing legal means; three were using channeling/network direction techniques; two believed it was the PBMs' responsibility; and one did not know how to address TPBs. Each of these methods is focused on getting claimants with their PBM cards into the right pharmacy as early as possible. Assuming that the pharmacy complies with the pharmacy network contract, no claims presented by workers with a PBM card should ever go to a TPB. This means that, in reality, even directing to network pharmacies is not always 100 percent successful in eliminating the TPB presence.

The narrative responses regarding the PBM's role were primarily focused on educating the pharmacies and working with them to capture the prescription. Card programs were mentioned several times, as were programs to switch the subsequent prescriptions to the PBM program. The latter was discussed in terms of occurring after the initial fill was completed and a claim was open; the PBM would then contact the pharmacy to notify it of appropriate direction of any subsequent fills. In addition, a couple of respondents stated that they were contacting the TPBs in a "nice" way to inform them that they were not going to be accepting any more prescriptions for that particular claimant.

SUMMARY

The results of this survey indicate a significant awareness of the importance of prescription drug costs, a focus on PBMs as the primary solution, but a lack of distinction among the PBMs themselves. Clearly, the workers compensation industry is looking for solutions that emphasize customer service, utilization control, seamless processes, and assistance in working with and educating payer staff.

Given the respondents' belief that the problem will only grow over the next 12 to 24 months, it is likely payers will accelerate their interest in finding new answers to the fastest growing component of their medical expenses.

# # #

copyright 2004 Health Strategy Associates, LLC
all rights reserved