Prescription Drug Management in Workers' Compensation

The Fifth Annual Survey Report
Spring 2008

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Introduction

This is the fifth year that Health Strategy Associates, LLC has surveyed executives and senior management at workers comp payers about prescription drug management. Again, it is focused on opinions, perceptions, and attitudes about pharmacy management in workers comp, with special attention paid to cost drivers, management approaches, vendors, problems, and trends. Both quantitative and qualitative measures were used in the survey, and the questionnaire was structured in such a way as to "triangulate" on specific issues, to confirm opinions and perspectives thereby providing readers with confidence in the survey's findings. The quantitative questions used a 1-5 rating scale, with 1 on the low end (e.g. worse, or less important) and 5 at the high end (best, or most important). Note – not all respondents answered all questions, thus response rates/numbers will not always correlate with the total number of payers.

This is the third year that Cypress Care, Inc. has sponsored the Survey. We are indebted to Cypress Care for their continued support. As in past years, the sponsor's role was limited to financial support; they played no role in constructing the questionnaire or developing this report.

Finally, we also want to express our thanks to the workers comp professionals at twenty payers who took up to forty-five minutes to carefully and thoughtfully respond to the survey. In many cases, the respondents also had to track down data and identify other experts in their organization to participate in the telephonic interview. 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.

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.

Background

Pharmacy management does not occur in a vacuum. Outside factors profoundly affect pharmacy in workers comp; factors that include overall medical trend, practice pattern evolution, the flow of drugs into the system and timing of patent expiration, pharmaceutical marketing practices, federal and state laws and regulations, and the international pharma industry.

Closer to home, pharmacy is a component of workers' compensation medical expenses, which totaled approximately $30.2 billion in 2007 (source NASI 2005 WC Report, 8/2007, trended forward using NCCI medical inflation rates from NCCI SOL, 3/2008). In comparison, workers comp drug costs were about 14.5% of workers comp medical expenses ($4+ billion) (source NCCI, 2007 Rx study). Pharmacy costs are also impacted by the number of comp injuries and their severity. Here, there is good and bad news. Injury rates are on a steady decline of about 3-5% per year, but the "severity" or medical cost of claims is increasing significantly, especially for claims that involve time away from work. In fact, medical costs comprise almost 60% of claims expense, a dramatic increase over prior years.

Respondents

Respondents were decision makers and operations staff in carriers, TPAs, large employers and managed care firms, with 2007 drug expenses ranging from $1 million - $147 million. Respondents' total Rx expenditure amounted to $777 million, or 18.5% of total estimated workers' compensation drug spend.

(Note Bolded names denote respondents participating for two or more years, most have participated for all four surveys)

Specialty Risk Services	**The Hartford**
Wells Fargo Insurance Services	**Liberty Mutual**
American International Group **Bunch and Associates**	**North Dakota Workers Compensation Fund** Major Employer (anonymity requested)
Crawford .	Louisiana Workers Comp Corp
Employers Mutual	**One Beacon**
Broadspire	Workers Comp Trust of CT
Travelers **Sedgwick**	**State Compensation Insurance Fund of California**
Employers Insurance	**Safeco**
Federated Insurance	**Beacon Mutual**

Findings

Inflation/trend in drug costs

This year we are reporting trend rates two different ways. In past surveys, we calculated the inflation rate based on the average of all respondents' rates of inflation. However, this biases the trend rate towards the experience of the smaller payers, as their figures are given the same weight as their larger competitors'. For this and subsequent years, we

will provide two inflation figures – one that is consistent with the prior methodology and a new number that is based on the change in the total expenditure from one year to the next.

Using the 'new' methodology (total drug costs from all respondents divided by those respondents' prior year drug costs), the inflation rate was 4.9%. For the fourth year in a row, respondents reported their pharmacy inflation rate was less than the prior year's trend, although the 'decrease in the rate of increase' slowed in 2007 to 6.1% from the prior year's 6.5%. It is important to note that this is based on respondents' total drug costs year-over-year; while the injury rate declined, and both medical expenses, and drug prices went up, the overall drug cost inflation rate continued to moderate significantly. By way of comparison, in 2006 the inflation rate was 6.5%, 2005 drug costs increased 10% over the prior year, with rates going up 12% in 2004 and 18% in 2003.

Looking at individual respondent data, Rx cost changes ranged from a decrease of 12.8% to increase of 21.8%. Similar to last year, the lowest increase occurred at sophisticated payers, defined as those with detailed knowledge of their company's drug costs, a deep understanding of industry processes and issues, and operating advanced drug management programs and initiatives. Somewhat different from last year, many of the smaller payers (defined arbitrarily as those with less than $10 million in spend) enjoyed results ranging from a decrease of >10% to increases in the mid-single digits.

Interestingly, there was little difference between larger and smaller payers' inflation rates. This is a marked difference from the 2007 report, where larger payers experienced lower inflation.

For those payers experiencing higher costs, the inflation was attributed to

- Higher utilization
- Higher cost medications and higher priced drugs
- Physician prescribing patterns
- More claimants getting more drugs

The perspectives of respondents experiencing higher costs were markedly different from the respondents with better results. They appear to be more reactive and passive, attributing cost increases to factors beyond their control or only marginally controllable. As an example, one respondent noted there are "lot of new drugs in the market, as soon as [a claimant starts using a] generic it goes to something else"; another sees "stronger narcotics being given more often – better living thru chemistry, people are used to staying on drugs longer."

While these statements may be factually correct, it is also apparent that the respondents experiencing lower cost increases dealt with these same issues assertively and proactively. Their attitude was "this is a problem and this is how we're fixing it".

Last year saw significant price increases after implementation of Medicare's Part D program in January of 2006. In 2007, national figures (across all pharma payers, not just

workers comp) indicate drug price increases were almost negligible at 1% (source US DoL BLS report, 9/2007), led by decreases in prices for generic drugs. While the WC drug 'formulary' is not directly comparable to the broader pharma industry, clearly drug price inflation has moderated considerably. The reality of the market provides an interesting contrast to respondents' views of pricing.

The size of the 'problem'

How big a problem are drug costs? On the 1 through 5 scale, with 3 being "drug costs are as important as other medical cost issues", drug costs were viewed as "slightly more significant than other medical cost issues" (3.6). This was entirely consistent with last year's study. Of note, no respondent indicated drug costs were less important than other medical cost issues.

Clearly, the industry's efforts to better manage drug costs are paying dividends. However, payers are not complacent. In fact, almost all respondents clearly indicated that senior management is paying attention to drug costs, and drug costs are projected to become slightly more important over the next 12 months. In contrast, policyholders, while still not very concerned about the issue, appear to be more interested than they were in past years.

New news

This year we took a deeper look at generic fill and generic efficiency. For our purposes, 'generic fill' is that percentage of scripts that are filled with generics. "Generic efficiency' is estimated by calculating the percentage of the total number of scripts that could be filled with generics that was actually filled with generics. I would note that different payers use somewhat different definitions and formulas, and therefore these numbers may not be entirely consistent. With that caveat, across all respondents the generic fill rate was 71.7% and the generic efficiency rate averaged 90.6%. (Note – 20% of respondents did not provide their generic fill rate, and 35% did not provide their efficiency rate. It may be safe to assume that the 'actual' industry wide figures are somewhat lower for both indices as those payers that monitor a metric are more likely to be working to affect it.) (Note – my sense is the 'actual' generic efficiency rate may be lower, as some respondents excluded scripts with a 'DAW1' requirement (prescribing physician specifically required dispensing of the brand name drug)).

Evolutionary changes

One of the advantages of conducting a survey over several years is the insight it provides into market evolution. The market has changed considerably over the last five years, and this year is no exception. Key changes include:

- The focus on utilization (addressing the volume and types of drugs used by claimants) is now almost universal, with almost all respondents voicing concern over or discussing programs to address utilization
- Price is less of an issue this year. Respondents, when asked to rate (1-5) the factors that one might consider when selecting a PBM", rated discounts a 3.7, somewhat less than last year's 4.0. Factoring in the external environment (pricing

across the industry is essentially flat as noted above) this result is not surprising. However, the payer community is notoriously price sensitive, with substantial anecdotal evidence indicating price is a, if not the, key issue in vendor selection.

- There is a greater emphasis on using home delivery/mail order, with respondents averaging 4.8% of scripts delivered via this method, an increase of a full percentage point over last year.
- Last year payers were more demanding of their PBMs than ever before, and the pressure continues to ratchet up. Increasingly, payers are asking their PBMs to provide insights and new information about trends in WC Rx, take the lead in dealing with third party billers, and provide more clinical drug management services.

WC drug cost drivers

States without Fee Schedules, per unit price increases, the volume of scripts per visit compared to past trends, compound medications, the lack of real resolution on repackaging issues in California, societal implications not necessarily specific to WC, advertising in specific and pharmaceutical companies in general and the use of - medications to deal with chronic pain and the closely related desire on part of patients to want to feel their best right away were all cited by respondents as directly affecting a payer's total drug costs

The most significant "driver" remains utilization – the sheer number of scripts and the type of scripts dispensed. Continuing a trend from the last two reports, many respondents had a deeper understanding of the underlying forces impacting utilization. Their observations included:

- "generic utilization and MD education about generics is key."

- "prescribing doctors, not just limited to one doc, they [claimants] go to multiple docs that they [the payers] may not know about, different specialists, and scripts from other lines of coverage. Fee Schedule is an issue."

- "increased usage of experimental drugs…there appear to be some efforts on physician side to challenge treatment frequency to address symptomatology will help"

- "certain meds are appropriate for certain conditions; we are looking at clinical approaches to refine our approach to manage costs…[we also] have an active MD committee that was just P&T [pharmacy and therapeutics] and has evolved to cover more topics"

The qualitative responses were consistent with responses to some of the quantitative questions. When asked "who is responsible for drug costs?" Treating physicians received the highest rank at 4.5 (compared to last year's 4.3), and eleven respondents had MDs ranked or tied for first. This was supported by narrative responses throughout the survey.

Drug repackaging and physician dispensing of drugs is a significant issue for some payers, especially those with significant business in California. Fortunately, recent changes in that state's work comp laws have greatly diminished the problem of drug repackagers inflating the price for common meds. (Note that one respondent did not believe the recent change has materially improved the situation in California) However, respondents noted that other repackagers have popped up in other areas, notably the southeast and upper Midwest. Payers should carefully monitor this situation, as California has taught us that physician dispensed drugs can rapidly become a major part of total drug costs.

Respondents noted that they are "on the lookout" for drugs billed on HCFAs and drugs billed with physician TINs.

Third Party Billers

TPBs still frustrate payers. All but one respondent said they were a problem, and the 4.0 rating (how much of a problem are TPBs?) was consistent with the 2007 study. There has been some decrease in payers' willingness to consider TPBs as 'part of the solution'. Payers' 'flexibility' diminishes rapidly when asked to consider TPBs as potential partners to help manage drug costs. Third Party Solutions garnered a rating of 1.2, with ex-competitor WorkingRx managing only slightly better at a 1.7. Again consistent with last year many respondents outright refused to consider working with third party billers. (Note – Third Party Solutions and WRx have merged, but most respondents were able to differentiate between the two legacy firms.)

Their reasons for not wanting to work with TPBs include:

- Increased administrative hassles and expense, extra work for adjusters
- Loss of control
- Lost savings
- Lost DUR opportunity
- Data capture

Controlling Drug Costs

For the second year we asked respondents what programs they had initiated over the last year, how they were being measured and how they were progressing, and what programs might be on the agenda for 2008.

Several respondents had invested time and resources in upgrading their ability to capture and report information regarding their drug spend. They focused on developing metrics, drill-down capabilities, and the ability to focus in on specific claimants, physicians, and script types in an effort to better understand costs and outcomes, and be in a better position to assess the results of current and new initiatives.

Others spent time reviewing and tightening formularies, with a couple instituting diagnosis- or injury-specific drug lists (note this was done several years ago by at least one major payer).

Both of these foci appeared to be designed to help with the clinical management of drugs. A deeper understanding of the payer's drug spend, coupled with a more robust background in pharmacology, seem to be foundational requirements for effective clinical management. From survey responses, this appears to be the case. Several respondents described specific processes and guidelines used for certain drug/claimant/physician scenarios. It was evident from their descriptions that these payers had invested considerable clinical and operational thinking in devising the best way to apply expertise to discrete situations.

While many of the respondents did have evaluation processes and metrics in place, a disturbingly high percentage did not. This is troubling, as it is difficult to assess the impact of a program (and the payoff as well) if results are not measured.

For 2008 and beyond, step therapy seems to be the hot topic among early adopters. Those payers setting a more deliberate pace will tend to work on adding analytical capabilities and refining formularies (as some of their faster moving competitors did last year).

Back in the present, we asked what payers are doing today to control costs. Respondents are employing multiple tools techniques and approaches to manage the number of scripts and the type of scripts dispensed to claimants. These approaches include:

- "closely monitor utilization and challenge docs who use high cost drugs and drugs off label, we truly monitor provider utilization and challenge them"
- "Formularies, both injury specific and claimant specific"
- "tiering of meds, step therapy, etc"
- "looking at and tracking what drugs [claimants] are using, implementing some step therapy etc. not relying on states to do that, but relying on controls they are implementing"
- "education on all fronts; policyholder, claimant, physician"
- "certain meds appropriate for certain conditions, looking at clinical approaches to refine their approach to manage costs"

Utilization control merits special mention. Again, when asked what needed to be done to manage costs, most respondents mentioned some way to control utilization. One quote reflects the type of deep thinking that is starting to become commonplace among sophisticated payers:

"We have to attack utilization, really get at point where we are doing predictive modeling re which claims and what triggers in claims medication usage, symptoms, etc will trigger [the claimant] going into increased use and cost overall, [we] can flag things but have to understand where they go overall…other piece is we have to have good conversations with claimants re impact of using these meds – using some of these meds does not go without implications and side effects…[we have to think] beyond Actiq to system failure; how do they get to that. There is lots of info re off label usage; are docs heeding those notices and taking [the] best interest of claimants to heart; what is long term plan. Once

they are on the meds it is more than just a program there is [a] mental aspect [that is] is far beyond detox…"

The message here is simple, even if the situation is anything but. To control costs, payers must control drugs, and to control drugs requires a lot more understanding, thought, communication, and work.

Price

The issue of "price," defined as the price per script, is contentious and confusing (and covered in various other sections of this report as well). Despite respondents' oft-repeated concerns about utilization, clinical management, and customer-service and ease-of-use issues, historically price per script, or more accurately discounts (below fee schedule or U&C) were quite important in the selection of PBMs. However, it appears that price is a good deal less important this time around.

When asked the question "do low fee schedules and/or discounts below FS reduce your total drug costs?" 28% of respondents replied in the affirmative, 44% were negative, and 28% believe price is a short term, or partial solution. This is a significant change from last year, where more than twice as many respondents believed low FS and/or discounts reduced drug costs. Similarly, the number of respondents who did not believe low prices reduced costs doubled over the last year.

Qualitative comments regarding pricing were significantly more common this year than in the early years of the survey (way back in 2003). One of the more intriguing thoughts was from a large payer who had been thinking a good deal about pricing. This respondent said "somehow we have to get towards a group health pricing model, or a variation of the group price model as true group model won't work due to state specific nature [of workers comp]." When further pressed, the respondent clarified that the idea of true transparency was starting to gain some traction at their organization, partly in response to customer demand.

Other comments from respondents also emphasized price, but reflected a deeper understanding of the metric (not just a discount below AWP orientation). When asked what were some of the cost drivers, respondents' comments about price included: "States without Fee Schedules [drive up costs]"; "per unit price increases"; "utilization followed by price"; and "never ending price increases."

This deeper understanding, at least among the respondents with long-term experience dealing with Rx management is a likely contributor to the lack of enthusiasm for or faith in the ability of low prices to reduce expenses over the long haul.

Consistent with last year, the payers with the lowest rate of drug cost inflation (most of whom saw their costs decrease) were much more focused on and astute about utilization control. These payers all but dismissed price, noting that real cost control only occurred after they implemented programs targeting utilization.

PBMs - perceptions and functions

Similar to the last two years, all respondents were using PBMs. While last year the overwhelming sense was that most payers had ceded responsibility for dealing with the pharmacy 'benefit' and all that entails to their PBMs, there is a sense that payers are now taking back some of that power and authority from PBMs.

PBM Features

Payers' views on PBM skill sets/features/capabilities continue to evolve, with payers placing less importance on a PBM owning its network this year (down a full half-point) and discounts below FS/U&C (down three-tenths of a point) while placing greater importance in PBMs' providing independent research and analysis on cost drivers in workers comp (up four-tenths). Payers are also looking for more legal and regulatory assistance from PBMs, with that category moving up slightly from a 3.6 to a 3.8.

Other areas were essentially unchanged from last year's data. Payers continue to demand their PBMs know, understand, and are conversant with the regulatory, repricing, and jurisdictional nuances of work comp.

Cost saving reporting – Reporting continues to be valued, yet respondents continue to voice skepticism about their PBMs' "creative" cost savings reports. This skepticism has led several payers to develop their own internal reporting process and methods. It is apparent that PBMs' all-too common practice of touting big savings based in large part on scripts not filled, early fills disallowed, quantity reductions, and prior authorization denials has led many payers to all but disregard any and all PBM-generated savings reports. In fact many payers choose to run their own calculations to verify actual results.

Retail Pharmacy Network - Bigger is better, and biggest is best. At a 4.6 rating (question was separate from the feature question used to construct the chart above), payers clearly want PBMs to have as many pharmacies as possible in their networks. In part this is likely due to payers' desire to increase network penetration.

Network penetration - While respondents (on average) considered a network penetration rate of 83% to be "reasonable", the actual (average claimed) penetration rate is 76%. Readers should view these numbers with a skeptical eye, as my experience is that very few, if any, payers actually capture 76% of all scripts in their PBM network. My sense is that this number is based on any script that is filled at a network pharmacy, even if that script comes in as a paper bill via a TPB.

When one considers that the average first fill rate is about 25%, and first fills account for almost 40% of all scripts, it is clear that most payers' actual network penetration rate is likely considerably less than 76%.

Bill processing - PBMs typically process all bills (2/3 of payers have PBMs do all bills), including paper bills. This enables the PBM to aggregate data, providing a complete picture of a claimant's drug history and utilization profile. Capturing paper bills also helps the PBM identify retail pharmacies that are not complying with their PBM contract and identify non-par pharmacies for recruitment. Of note, few PBMs are processing bills for physician-dispensed scripts.

First fill capture - Capturing the initial script was considered to be very important – rated a 4.1. Respondents noted that when the initial script is captured within the network, the

payer gets the discount, TPB involvement is dramatically reduced, and clinical management/DUR processes are started promptly. As important as first fill is, there are essentially no new ideas or real ways to do this. And few respondents had any solid notion of their actual first fill capture rate (average appears to be in the 20% - 30% range) In fact, when asked "what is the best way to increase your first fill capture rate?", respondents came up with the same answers they've been giving the last three years - temporary cards, employer and supervisor education, streamlined data feeds to pharmacies, and using a carded program.

How about those PBMs?
For the fifth year, respondents were kind enough to rate their own PBM as well as other PBMs. This is one area where there has been little change over the past five years.

In what might be best-described as a wake-up call for workers comp PBMs, no PBM was rated higher than a 3.2. On the 'positive' side, none was rated lower than a 2.3. Notably the third party billers were both rated below the lowest PBM (all ratings on a five-point scale).

Fully seven of the PBMs were within 10% of each other in terms of scoring.

Clearly there is a significant opportunity for PBMs to differentiate in this market. No PBM is so far behind, and none are so far ahead, as to make it difficult, or even expensive, for one to break away from the pack.

This leads to perhaps the most interesting data, at least from the point of view of those PBMs seeking to differentiate. One of the key questions was a rather simple one: "What makes a vendor successful in managing drug costs?"

Here are a few perhaps not-so-simple answers.

- [a] PBM is a PBM; difference is level of involvement they have w clients, added value programs they have w clients; education of clients on costs and trends, what is happening not only within their clients but statistical analysis of the industry and what is happening in drug industry as a whole…[this is required in order] to be proactive in terms of planning…it helps when there is really good infrastructure, with good systems in place to be able to handle a large organization
- have to be willing to help customers pay less and really manage utilization piece, [the PBM has to] help figure it out although they [the PBM] want the money to come in. [This is] counter intuitive but have to better manage spend even if it is against their best interest – what should the treatment plan be.
- just like anything it is communication w/ them or adjusters or w/ their network and pharmacies, making sure they know when payments are paid, who gets paid when, are their docs overutilizing, what management tools can you get from that PBM
- [PBM should be] proactive and not wait for customer to id issues, competitive pricing, not complacent because they have your business

- being able to have data to monitor and trend to see early indicators of issues, be more progressive and upfront in working w carrier on those issues, having a sophisticated ability in system to flag meds, doc hopping, along with over utilization edits and controls…another requirement is good strong relationships with pharmacy network, so they follow rules and processes

Best Practices

Again this year we were able to identify certain practices that appeared to be linked with dramatically better results than those obtained by payers not employing those practices. These practices include:

- A proactive, assertive approach that recognizes improvements and results will not come from external forces, but rather must be driven by the payer.
- Very strong clinical orientation, using medical advisors (internal or externally staffed) to address problematic scripts, high dollar claimants, and individual prescriber behavior that appears to be outside the norms
- Strong emphasis on generic conversion and generic efficiency
- Strong, consistent and prominent support from senior management - not just a memo from the exec, but incorporation of metrics in staff and office evaluation, ongoing demonstration of interest on the part of senior management, sufficient resources for analysis and reporting, and a commitment from executives to understand drug management issues
- Willingness to listen to their PBMs, take their counsel, and look for ways to do things, not obstacles to accomplishing results. There are always reasons things can't happen, the payers with better results seem to ask what can we do with what we have?
- Information derived from the payer's own internal analysis and reporting infrastructure on utilization, red flag reporting, penetration, and trends by area, provider, drug type, claim office, etc. is used to validate and in some cases replace PBM data and reporting
- Aggressive pursuit of mail order/home delivery is paying dividends
- An assertive mentality in dealing with third party billers and retail pharmacy store compliance is reducing paper bill issues
- All scripts processed by and through the PBM to consolidate data, enhance network steerage and penetration, and identify non-compliant retail stores

No top-performing payer reported adoption of all these practices, but the best performers were doing more than the others and were in the process of implementing additional "best practices".

Conclusions

Payers who have committed to thoroughly understanding their drug spend and the relationship between medications, medical costs, and claims costs are making significant progress. Thos payers committed to doing what they can, not lamenting what they can't, are seeing the best results. This involves understanding and managing utilization.

Successful payers have partnered with their PBMs, and continue to drive their PBMs hard to develop better cost savings reports, more effective data capture, stronger clinical programs, and better communication with adjusters. Significant opportunities exist to improve first fill capture rates and conversion to mail order.

Third party billers remain a problem, and few payers are willing to partner with these firms. Physician dispensing/repackaging is a potentially significant problem that is only beginning to emerge in certain jurisdictions and payers would do well to monitor it carefully.

By comparing payers' results and their programs, a clear picture is emerging of the processes and practices that deliver best-in-class results. Moreover, the difference in results between the best programs and those on the other end of the spectrum is growing larger.

We predicted last year that we would see a continued split, a growing gap in results between those payers with effective programs and those without. This survey proves we were right.

Finally, expect that differential to increase in future years, as the aggressive payers continue to outdistance their more complacent competitors.

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