

**Prescription Drug Management in Workers' Compensation**

**The Fourth Annual Survey Report  
Spring, 2007**

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## **Introduction**

This is the fourth year that Health Strategy Associates, LLC has surveyed executives and senior management in workers comp 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. 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).

This is the second 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.

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  $\text{Cost} = \text{Price} \times \text{Utilization}$ .

## **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 \$35+ billion in 2006. In comparison, workers comp drug costs were about 14.5% of workers comp medical expenses (\$5 billion).

## **Respondents**

Respondents were decision makers and operations staff in carriers, TPAs, and managed care firms, with 2006 drug expenses ranging from \$3 million - \$147 million. Respondents' total Rx expenditure amounted to \$1.02 billion, or about 20% of total estimated workers' compensation drug spend.

## Findings

For the fourth year in a row, respondents reported their pharmacy inflation rate was less than the prior year's trend. Rx cost increases between 2005 and 2006 averaged 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, 2005 drug costs increased 10% over prior year, 2004 12%; and 2003 18%.

Looking deeper, it is clear that it's getting better...for some payers. When examined individually, Rx cost changes ranged from a decrease of 8% to increase of 20%. Unsurprisingly, 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.

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

- Higher utilization
- Physician behavior
- Over-use of pain medications e.g. Oxycontin, Actiq
- Off-label use
- Higher unit prices due to Part D

Despite significant price increases last year, better managed programs actually reduced their drug spend. Most payers experienced a 5% - 8% increase in Average Wholesale Price (AWP) for many drugs after implementation of Medicare's Part D program in January of 2006. And, payers also saw a 100% increase in AWP for Actiq during 2006 (Actiq is consistently among the top four WC drugs in terms of dollars spent). The ability of these programs to actually cut drug costs in the face of industry-wide price increases speaks to the effectiveness of their utilization control efforts.

Clearly, the industry's efforts to better manage drug costs are paying dividends. However, payers are not complacent. In fact, respondents clearly indicated that senior management is paying attention to drug costs, (91%), and drug costs are projected to remain important over the next 12-24 months.

### 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 four years, and this year is no exception. Key changes include:

- The focus on utilization (addressing the volume and types of drugs used by claimants) has increased dramatically
- Data mining, reporting, and analysis efforts are much more sophisticated, driven in large part by payers frustrated by PBMs' inadequate reports

- Payers are more demanding of their PBMs, asking the PBMs to provide insights and new information about trends in WC Rx, strategies for dealing with third party billers, and more innovative drug therapy management.
- Payers' tolerance for third party billers has declined; while TPBs are considered to be a potential part of the 'solution', the frustration with TPB tactics is palpable.

### **WC drug cost drivers**

Price increases are a key contributor to drug cost increases. As noted above, the price increases both across the industry and for Actiq in particular directly affected total costs. However, other factors, including the brand to generic mix, third party billers, physician dispensing/repackaged drugs, patent expiration, revamped fee schedules, renegotiated PBM deals, and new PBM arrangements were also cited as directly affecting a payer's total drug costs.

Perhaps the most significant "driver" remains utilization – the sheer number of scripts and the type of scripts dispensed. However, many respondents had a deeper understanding of the underlying forces impacting utilization. Many respondents had thoughtful and intelligent perspectives on these forces:

When asked "who is responsible for controlling drug costs?" Treating physicians received highest rank (4.3), and eleven respondents had MDs ranked or tied for first. This was consistent with the 2005 survey, and 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.

Third Party Billers are one area where if anything, payers have grown more frustrated than in years past. All but one respondent said they were a problem, albeit at an average rating of 4.0, less of a problem than last year. Consistent with the 2005 survey results, there continues to be some interest in considering TPBs as part of the solution.

### **Price**

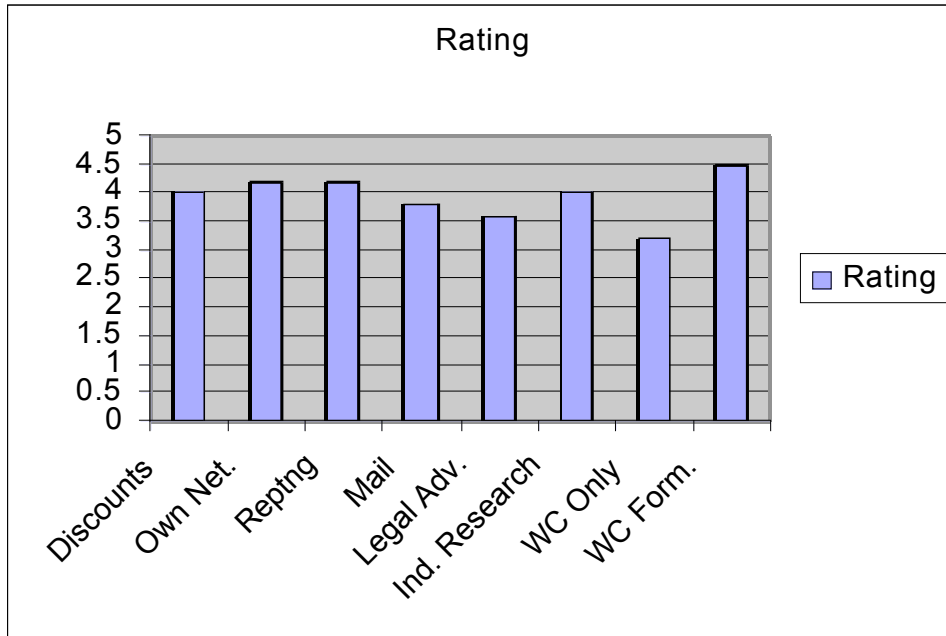
The issue of 'price', defined as the price per script, is contentious and confusing. Despite respondents' oft-repeated concerns about utilization, clinical management, and customer-service and ease-of-use issues, it is clear that price per script, or more accurately discounts (below fee schedule or U&C) remain important in the selection of PBMs. Respondents did not appear to be very enthusiastic about low fee schedules' impact on costs; they clearly are "A part of the solution", not "The solution".

Notably, the payers with the lowest rate of drug cost inflation (most of which 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 last year, all respondents were using PBMs to some extent. And all payers rely on their PBMs for a lot – they are responsible for everything from EDI connections to cost saving reporting (more on that later) to dealing with third party billers to Drug Utilization Review to state reporting. The overwhelming sense is that most payers have ceded responsibility for dealing with the pharmacy ‘benefit’ and all that entails to their PBMs.

**PBM Features**



Payers’ views on PBM skill sets/features/capabilities continue to evolve. A “WC-only” focus is the lowest-rated of the eight PBM features. That said, payers continue to demand their PBMs know, understand, and are conversant with the regulatory, repricing, and jurisdictional nuances of work comp.

Cost saving reporting – Several respondents decried their PBMs’ “creative” cost savings methodologies. There is a lot of skepticism on the part of payers about PBMs’ own savings report, a skepticism that has led several payers to develop their own internal reporting process and methods.

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.

Mail order/home delivery – The average percentage of total pharmacy spend that went for mail order was 3.8% (excluding one payer with a large block of old claims; this payer has 27% mail order). However, median results were somewhat different, with fully half of respondents’ at penetration levels less than two percent. For some reason, respondents view mail order as an important but not critical component of their drug program. Given all the positives associated with and driven by mail order programs, this is puzzling.

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.

Card v. Cardless - In a reversal of prior years’ findings, carded programs are now more popular than cardless programs. (53% v 36%, remainder use both).

### **Best Practices**

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:

- 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
- Cards – carded programs have higher network penetration rates, few paper and third party biller bills, and better data capture.
- 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 demonstrations of interest on the part of senior management, sufficient resources for analysis and reporting, and a commitment from executives to understand drug management issues
- Training for adjusters and clinical staff on drug issues, trends, basic (very basic) pharmacology terms and issues, and higher level clinical support for these staff when they need additional expertise for specific issues/claims
- 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.
- Aggressive pursuit of mail order/home delivery
- Assertive mentality in dealing with third party billers and retail pharmacy store compliance

- All scripts processed by and through the PBM to consolidate data, enhance network steerage and penetration, and identify non-compliant retail stores

While no top-performing payer reported adoption of all these practices, 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 managing utilization have seen their costs decline year over year. They are beginning to strongly promote carded programs. Successful payers have partnered with their PBMs, and in many cases driven 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 new and 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. I would expect that differential to increase in future years, as the aggressive payers continue to outdistance their more complacent competitors.