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Remedy for Rising Drug Costs in Workers Compensation Is a Comprehensive Pharmaceutical Management Program

Jim Andrews, R.Ph.

Drug costs in workers compensation are increasing at double-digit rates and restrictive fee schedules seemingly are unable to curb rising rates. Looking behind the scenes reveals what's really influencing drug spending and what's being done to provide solutions.

Drugs are estimated to account for more than 14 percent of total medical costs in workers compensation claims. They are the single largest contributor to workers compensation medical inflation. In 2006, for example, drug costs accounted for an estimated $5 billion of the total $35 billion in medical expenses in workers compensation.[1]

Drug costs for workers compensation claims are high throughout the industry. Workers compensation insurance payers can pay, on average, 125 percent of AWP (average wholesale price) for drugs, based on a national estimate of fee schedule and usual and customary pricing. This compares to the 72 percent average rate paid in the group health markets.[2]

Many factors are raising the drug-spending curve. Injury severity of

older workers is one factor on the rise.[3] Physician prescribing patterns are changing, including a trend to off-label prescribing. A growing number of working-age adults lack health insurance, raising the likelihood uninsured workers will file a workers compensation claim. On some key drugs, the brand license patents are expiring, leading manufacturers to increase costs before generics take away market share. New drugs are continually entering the market, along with direct-to-consumer advertising. As always, the devil is in the details.

The reality is that an increase in injury severity can lead to a greater tendency for drug intervention. In keeping with conservative treatment trends and injured worker choice, physicians are relying more on drug therapy rather than surgical intervention for common workplace injuries.

Direct-to-consumer advertising is clearly on the rise, with drug manufacturers prompting patients to ask their physicians for specific medications regardless of the cost. Since workers compensation patients have no co-pays or deductibles, their incentive to save by using lower-cost drugs is diminished. Likewise, the treating physician, who is paid for service and is rarely measured on outcome, has little motivation to consider cost.

Newer, more expensive drugs, such as the anti-insomnia products promoted on television, help accelerate drug spending. That's because physicians are prescribing sleep aids, often alongside of other medications, to promote rest as part of pain therapy.

Generic Trends

Generics, usually about one-third the cost of equivalent brand drugs, help drive down costs. Many pharmacy benefits managers are capturing these savings on behalf of their clients. Cypress Care, Inc., a pharmacy benefits management company (PBM) that focuses on workers compensation prescription benefits, processes 70 percent of its claims as generic, which compares favorably to the estimated 50 percent to 55 percent generic rate in the group health industry.

Recent regulations have helped curb costs, as many states are mandating generic dispensing and adopting formularies that restrict the types of drugs allowed for workers compensation claims. The state of Washington, for instance, excludes certain brand-name drugs in its formulary for workers compensation claims. Brand manufacturers are countering by increasing branded drug prices before patents expire, opening the door to the generic equivalents.

The dramatic increase in the price of one drug last year explains the impact that the entry of generic equivalents has on brand prices. The manufacturer,

systems development and support with a primary focus on the utilization of pricing, clinical drug data, and managed care claims submission. He has also worked as a member of the pharmacy operations management team with an increasing scope of responsibilities to include district and regional management. He is a member of the Georgia and Florida Pharmacists Associations, the American Pharmacist Association, American Society for Automation in Pharmacy (ASAP), Florida Society of Hospital Pharmacists, National Council of Prescription Drug Programs (NCPDP), and the Academy of Managed Care Pharmacy. Jim has recently been appointed as co-chair for the NCPDP Work Group for Property and Casualty/Workers' Compensation. He is currently licensed to practice pharmacy in Florida and Georgia. In addition, Jim has served as a member of First Databank's User Advisory Board and liaison for all FDB products and services.

Like other regulated, market-driven industries, workers compensation is constantly being influenced by trends and new rules. Developments that should be watched are patient directability; that is, the ability of payers to direct patients to medical providers. Also on the radar are repackaged drugs, a practice where the physician, as the re-seller, can set high prices that drive up the payer's cost.

In the end, given the level of concern over escalating drug costs, payers and other stakeholders are likely to accelerate their interest in finding a new and better solution to the fastest growing component of their medical expenses. PBMs should be at the forefront of these initiatives.

Endnotes

1. This figure is derived by Health Strategy Associates (HSA) from a combination of NCCI statistics trended forward by 10 percent from 2005, an estimate of medical inflation in workers compensation, and HSA client data by Health Strategy Associates.
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3. Restrepo, Tanya, Scott Sobel, and Harry Shuford, "Age as the Driver of Frequency and Severity," NCCI Research brief (December 2006).
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5. Lollipops & Lawsuits, *Newsweek* (May 7, 2007): p. 54.
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9. 2006 Pharmacy Benefits Management in Workers' Compensation Study, Health Strategy Associates.

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raised the price of the drug several times before the drug went off patent, resulting in a total effective price increase of over 40 percent.[4]

The drug grabbed headlines because of its growing popularity for treating breakthrough pain associated with some workplace injuries. Although the drug was developed and FDA-approved only to treat pain specific to cancer, the manufacturer said it could be effective in managing pain from other origins as well. As such, the drug manufacturer wants to expand the FDA's approved use for the drug.[5]

The favored status of this drug likely comes from its rapid delivery of an opioid (fentanyl) to the body's pain centers via absorption through the mouth. While the drug represented less than 1 percent of the prescriptions dispensed by Cypress Care in 2006, its high cost illustrates how a single drug can occupy a disproportionate share of the overall drug spending. Depending on dosage, the industry-wide average monthly cost per patient for the drug exceeds $3,000, based on current First Data Bank AWP pricing.

Physicians Play Key Role

Complicating matters is that many claimants receiving opioids are being treated by primary care physicians, orthopods, and other specialists whose primary expertise is not in pain management. Such physicians, when facing patients complaining of excessive pain, tend to increase dosages, transition patients to more powerful drugs, or combine medications in lieu of offering other available pain management therapies.

Another drug by the same manufacturer expected to gain popularity is a new fentanyl buccal tablet. This drug could become problematic for payers of workers compensation pain treatment because of the potential for abuse and increased cost. The new drug will cost about the same as equivalent doses of generic versions of the older drug, but considerably more than immediate-release morphine or oxycodone. The average wholesale price of the new drug is between $13.08 and $38.53 per tablet, depending on the dose.[6]

The critical point for physicians is to understand that the two drugs are not equivalent. Doses of the newer drug should be lower because fentanyl absorption is higher and faster with this buccal tablet. The manufacturer appears to have learned from its experience with Actiq, as it is attempting to obtain FDA approval for the broader use of Fentora for indications such as treating low back pain, migraines, and other conditions.[7]

Given the physician's key role in helping to control workers compensation costs and the inability of payers to influence drug pricing, payers are turning to strategic solutions as a hedge against rising costs. They want good

field intelligence and strong cost-management practices that can manage utilization and bring physicians into the process in a collegial fashion.

Comprehensive Clinical Pharmaceutical Management

The price of the pill is only one component of the cost of pharmacy to the workers compensation payer. Price can be managed by PBM pricing strategies, which are being implemented across the marketplace. Utilization is the less obvious but more important component of controlling drug costs.[8]

Utilization should be addressed through PBM management of pharmacy spending. PBMs should ask the following questions: Is the medication being prescribed the best medication for the injured worker at this point in the treatment process? Are there equivalent options that are less apt to have untoward side effects or interactions with other parts of the medical regimen? Do the drugs allow the injured worker to progress towards a successful return-to-work (RTW), or do they enable or prolong the disability? How can the PBM work in conjunction with the physician toward promoting the best outcome for the injured worker?

Research tells us that sophisticated payers are holding prescription drug cost increases within the 2 percent to 5 percent range through the use of clinical management programs that incorporate data mining, adjuster training, strong electronic data interchange (EDI) connections, and intelligent third-party biller strategies.[9] The informed payers are learning to focus less on the price of the pill and are starting to understand the need to manage drug costs on a per-claim basis.

A proven approach is one in which the PBM combines three levels of comprehensive clinical pharmaceutical management that address:

1. individual prescriptions;
2. high-cost claimants; and
3. high-cost prescribers.

To be effective, the program must be backed by a sophisticated data mining system capable of analyzing and "red flagging" questionable and high-cost medications. More importantly, the program must be set up to initiate a strategic follow-up action.

Individual Prescriptions

In the case of selected prescriptions, the program should implement a clinical authorization procedure that incorporates a physician reviewer to

examine the drug regimen objectively. The program should provide the claims adjuster with objective clinical recommendations on the medical appropriateness of specific prescriptions. This information helps the adjuster manage the medication aspects of the claim with confidence.

High-Cost Claimants

To deal with the high-cost claimant, the program should initiate a clinical case review where the claimant's pertinent medical record is examined and recommendations are offered on the entire drug treatment program, again backed by professionals with clinical expertise. The clinical review in combination with the complete medical records will then allow the adjuster to determine the appropriate next steps in managing the claim.

Data mining will "red flag" claimants based on monthly drug expenses, allowing a clinical staff to review each of the files and contact treating physicians to identify duplicate therapies, potential harmful drug interactions, possible overdosage, or fraud and abuse. Armed with written recommendations and supporting documentation, the adjuster is in a better position to make an informed decision.

High-Cost Prescribers

Physicians who regularly prescribe brand or dispense as written (DAW) prescriptions can be identified to the payer through good data mining. Once identified, those physicians can be contacted about their prescribing history to determine possible options that are equally effective and potentially more cost-effective. Off-label prescriptions can be managed in a similar fashion. Outcomes can be enhanced by continuing to work collegially with the medical, pharmaceutical, and claims professionals for the best results.

Program Effectiveness

To test the efficacy of its program, Cypress Care performed studies on cases where the average age of injury was five years and the average number of drugs being administered was six. After modifications to the therapy plan, the program successfully achieved an annual savings per case equating to $15,389 per case.

In one such case, which was being reviewed for Medicare set-aside funding, the claimant was taking seven drugs for lumbar back injury and chronic pain. The recommendation led to the termination of one of two similar drugs as duplicative therapies and the reduction of dosage of two others, resulting in a $5,988 savings per year or a total of $35,928 savings to age 65.