

# TARGETING PRESCRIPTION DRUGS TO DECREASE WORKERS' COMPENSATION COSTS

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Attacking medical costs can be one of the most effective ways to rein in the high price of workers' compensation programs. With medical services representing 60% or more of workers' compensation claims costs, there are several fronts to target. Two of these that relate to prescription drugs are physician dispensing and compounded drugs. Employers should consider working with their insurance brokers, claims administrators, and pharmacy benefit managers (PBMs) to understand the true cost of these practices and to manage their impact on workers' compensation programs.

## ■ PHYSICIAN DISPENSING

Following a workplace injury, a worker who is prescribed medication by a doctor would typically fill the prescription at a retail pharmacy. But over the last decade, some physicians began to bypass pharmacies and dispense medication directly to patients.

"Advocates of physician dispensing argue that it increases the likelihood that a patient takes prescribed medication and ensures that treatment begins immediately because the patient can bypass the pharmacy," says Tom Ryan, Market Research Leader in Marsh's Workers' Compensation Center of Excellence. "But the cost of physician dispensing can be high and the practice can contribute to poorer workers' compensation claims outcomes."

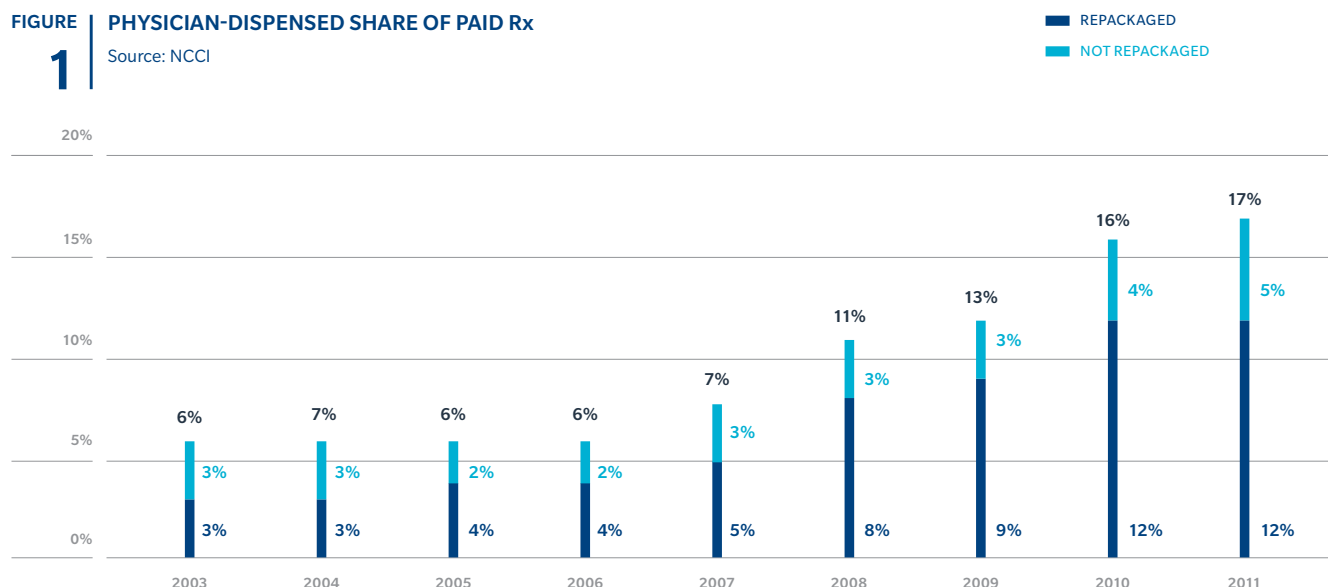
Medications dispensed by physicians are typically purchased by repackaging companies that split bulk shipments from drug manufacturers into smaller packages to sell at a higher unit price. Under the Drug Listing Act of 1972, every commercially available drug is classified by a three-segment number, called its National Drug Code (NDC), which informs its average wholesale price (AWP). When a drug is repackaged, it is assigned a new NDC and a new AWP that is typically several times the price of the same drug in its original packaging. Nearly all workers' compensation state pharmacy fee schedules are based on these AWP.

This means that repackaged drugs dispensed by physicians can cost employers exorbitant sums. For example:

- The average paid medical benefits for claims with at least one physician-dispensed repackaged drug were almost 17% higher than for claims without such prescriptions, according to a 2013 California Workers' Compensation Institute (CWCI) study of claims between January 2002 and December 2011. That study also questioned the common arguments in favor of physician dispensing, noting that the average injured worker in California has a choice of up to five pharmacies within 2.2 miles of a dispensing physician's office.
- Drugs commonly dispensed by physicians cost 60% to 300% more than those dispensed at retail pharmacies, according to a 2012 Workers' Compensation Research Institute (WCRI) study of claims from 2007 to 2011.
- In Illinois workers' compensation claims involving physician-dispensed opioids, medical costs were almost 80% higher, indemnity costs were more than 50% higher, and the number of days off work were 85% higher, according to a 2014 study by workers' compensation insurer Accident Fund Holdings and the Johns Hopkins University School of Medicine.

**FIGURE 1** | PHYSICIAN-DISPENSED SHARE OF PAID Rx

Source: NCCI



Note: Some figures above are rounded.

Since its emergence in relation to California workers' compensation programs in the early to mid-2000s, physician dispensing has become a regular practice across several states, spurred in part by the monetary benefit to physicians in dispensing medications directly to patients.<sup>1</sup> In 2011, physician dispensing represented 17% of total workers' compensation drug costs, according to a 2013 report published by NCCI, up from 6% in 2003 (see **FIGURE 1**). Over that time, the cost of physician dispensing per claim more than tripled, from \$19 to \$60, according to the report.

There's also a danger to workers in relying too heavily on physician-dispensed medications. "Many injured workers have more than one doctor, and these providers may not always be aware of every medication an injured worker may be taking for a work-related injury," says Jennifer Kaburick, Senior Vice President for Workers' Compensation Product, Compliance, and Strategic Initiatives at Express Scripts. "That includes those prescriptions filled at pharmacies and other physicians' offices."

As of February 2015, more than 20 states had taken action to limit or ban physician dispensing or the markup of repackaged drugs in workers' compensation, according to CompPharma, a consortium of workers' compensation pharmacy benefit managers. Recently, Pennsylvania House Bill 1846, signed into law in October 2014, capped reimbursement of repackaged drugs at 110% of the original manufacturer's AWP. The law also prohibits Pennsylvania physicians from dispensing more than a 30-day supply of medications, and imposes other restrictions on dispensation of Schedule II and III controlled substances.

But the potential long-term effectiveness of these reforms is unclear. For example, physician dispensing in South Carolina — which introduced reforms in 2011 — dropped from 24% of all prescriptions in 2011 to 10% in the first quarter of 2013, according to a 2014 WCRI report. But a separate report published by WCRI in 2014 found that physician dispensing only decreased slightly in Connecticut, from 39% to 36%, after reforms in that state took effect in 2012.

<sup>1</sup> American Academy of Urgent Care Medicine. Physician Dispensing a Key in Reducing Billions to US Healthcare Costs. Available at <http://aaucm.org/About/News/NewsDetail.aspx?a=5622>

## I COMPOUNDED DRUGS

Compounded drug prescriptions have also driven workers' compensation costs up. Compounding, as defined by the US Food and Drug Administration (FDA), is the practice by which a licensed pharmacist, licensed physician, or a person under the supervision of a licensed pharmacist combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient.

"Compounded drugs may be deemed as medically necessary in some cases to treat some patients — for example, some patients who are allergic to dyes present in commercially available alternatives," said David Dross, the Managed Pharmacy Practice Leader at Mercer. "But compounded drugs are not tested and approved by the FDA. And the agency has noted health risks that could be associated with compounded solutions."

According to the FDA, "Compounded drugs made using poor quality practices may be sub- or super-potent, contaminated, or otherwise adulterated. Additional health risks include the possibility that patients will use

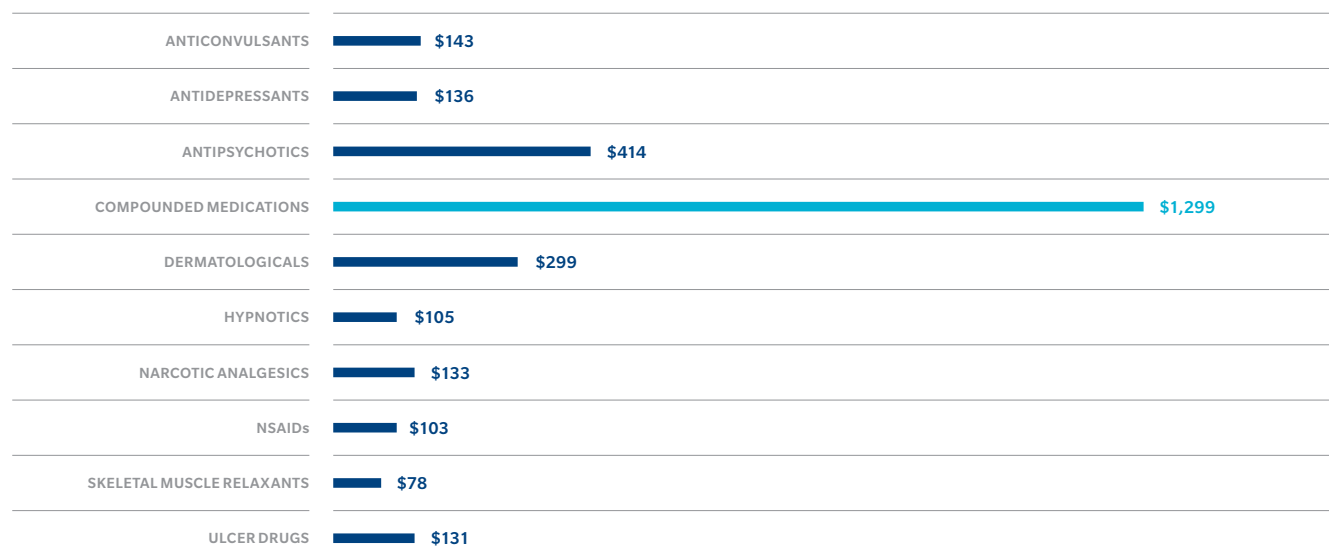
ineffective compounded drugs instead of FDA-approved drugs that have been shown to be safe and effective."<sup>2</sup>

Nevertheless, compounding has become more commonplace in workers' compensation and the broader commercial health insurance marketplace, and has added to medical expenses. Compounding pharmacies generally inflate the price of individual ingredients included in their solutions. For example, the average cost per prescription for compounded versions of diclofenac — an anti-inflammatory drug that is commonly used in compounded solutions — was \$770, compared to just \$46 for the commercially available alternative of the drug, according to Express Scripts' Workers' Compensation 2013 Drug Trend Report. The study also reported that compounded solutions were among the top 10 workers' compensation therapy classes for the first time in 2013, with the per-user per-year cost increasing more than 125% from 2012 to 2013. The cost per compounded prescription in 2013 was nearly \$1,300 — far higher than the cost per prescription for other top therapy classes (see **FIGURE 2**).

<sup>2</sup> Compounding and the FDA: Questions and Answers. Available at <http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/ucm339764.htm>.

**FIGURE 2** COST PER PRESCRIPTION FOR TOP 10 WORKERS' COMPENSATION THERAPY CLASSES, 2013

Source: Express Scripts





Several states have taken steps to reduce the cost of compounded drugs. For example, California, Colorado, Delaware, Idaho, Mississippi, New York, Oklahoma, South Carolina, Tennessee, Texas, Washington, and Wyoming require that compounds be billed at the ingredient level, which theoretically lowers costs by eliminating overcharging, according to a 2014 report published by CompPharma. Many of these states also require compounded drugs to be billed based on a fee schedule, and several states have put caps on how much compounding pharmacies can charge.

But as with reforms intended to curb physician dispensing, it's unclear how effective these measures will be in reducing costs. For example, California Assembly Bill 378 took effect in January 2012 with the intent of controlling compounded drug costs and prescriptions. However, according to a 2013 CWCI report, from the first half of 2011 to the first half of 2012:

- ▶ Compounded drugs dropped from 3.1% of workers' comp prescriptions to 2%.
- ▶ Reimbursements increased from 11.6% to 12.6%.
- ▶ The average amount paid per compounded drug prescription increased by more than two-thirds, from \$460 to \$774.
- ▶ The average amount paid per non-compounded drug prescriptions fell slightly, from \$113 to \$108.

## BUILDING AN EFFECTIVE PHARMACY BENEFIT MANAGEMENT PROGRAM

When selecting new claims administrators or PBMs or reviewing existing relationships, employers should ensure that their vendors can deliver a variety of value-added services that can help to control prescription drug costs. Among other features, employers should consider including the following components in their pharmacy benefit management programs:

- **Retail and mail-order options for prescriptions.** These options can help employers control pharmacy costs while providing a convenient method for injured workers to receive prescribed medications at their homes.
- **Generic conversion programs.** PBMs should provide information to physicians and pharmacists regarding generic alternatives

## MANAGING PRESCRIPTION DRUG COSTS

"The high costs associated with physician dispensing and compounded drugs should be a cause for concern for any employer," says Christopher Flatt, Marsh's Workers' Compensation Center of Excellence Leader. "But by working with their claims administrators and pharmacy benefit managers, employers can take several steps to limit the effects of physician dispensing and compounded drugs, and better control overall prescription drug costs."

## ENSURING NETWORK COMPLIANCE

Employers should ensure that their third-party administrators (TPAs) or other claims administrator, in concert with PBMs, have specific policies in place to limit both physician dispensing and prescriptions involving compounded drugs. For example, a PBM should require that compounded drug prescriptions be subject to prior authorization reviews, which should be routed to specialized teams of nurses or other well-trained claims management staff.

"These specialists should verify the compounding pharmacy's credentials and ensure that there is a legitimate medical rationale for a compound to be used rather than a commercially available alternative," says Mercer's Dross. "Claims administrators should also ensure that quantity limits for compounds are in place to

available at a lower cost than brand-name drugs. This process can help employers realize significant cost savings.

- **Clinical management and oversight.** This includes medication reviews performed by pharmacists and outreach to prescribers to ensure that prescribed medications are necessary, are not duplicative, and do not present potentially harmful interaction effects.
- **Workers' compensation specific formularies.** PBMs can modify their formularies at the employer level to address unique needs of certain classes of work, and can even create injury-specific formularies that exclude inappropriate therapy classes.
- **Utilization management techniques.** This includes methods to analyze program trends, critical claims, and prescribing patterns of physicians.
- **Fraud, waste, and abuse detection units.** Your PBM should be able to use analytics to identify and thoroughly investigate cases of fraud, waste, and abuse.

discourage costly and often unnecessary refills being sent to injured workers.”

Meanwhile, employers should work with their claims specialists to ensure that network providers are not dispensing medications to patients — and more importantly, not over-relying on narcotics prescriptions of any type. Network providers should be encouraged to pursue alternative treatments, including coaching, counseling, and drug-cessation programs when appropriate. This should ultimately help to accelerate recovery of injured workers and control overall workers’ compensation costs.

Employers should work with their TPAs and PBMs to conduct regular audits — quarterly or more frequently — to ensure that these procedures are being followed. Employers should consider placing on probation any providers and pharmacies that are engaging in problematic behavior, including physician dispensing and frequent compound prescriptions. Terminating contracts may also be an appropriate option in some cases, but should be considered carefully by organizations, including with their legal advisors.

## INTERNAL EDUCATION

Physician dispensing often occurs early in a workers’ compensation claim by providers outside of an employer’s network — for example, personal physicians and doctors at hospital emergency rooms or local clinics that injured workers seek out for initial treatment. Employers should seek to limit such treatments outside of their networks by training supervisors and managers, human resources personnel, and environmental, health, and safety professionals to encourage injured workers to visit in-network providers only. Employers can help facilitate this by providing injured workers first-fill forms or cards that they can present to pharmacists to receive initial prescriptions at no cost.

Employers may be able to further discourage physician dispensing by educating employees about the cost and potential dangers of the practice. “Although workers’ compensation treatments are paid for by employers, behavioral research has demonstrated that injured workers care about the cost of the treatments they receive, including physician-dispensed medication,” says Kaburick of Express Scripts.

## EVALUATING YOUR PBM AND CLAIMS ADMINISTRATOR OR TPA

Employers often select a claims administrator based solely on fixed or upfront costs. But variable costs — including medical and indemnity payments — can represent as much as 90% of total workers’ compensation program costs. So it’s important for employers to select providers with which they can build strong relationships with a shared focus on driving better claims outcomes.

Despite its importance, employers that are evaluating competing claims administrators often overlook the quality of their people. “Claims adjusters and nurse case managers can determine how quickly an employee returns to work following an injury, and thus can greatly influence overall workers’ compensation claims costs,” says Ryan of Marsh’s Workers’ Compensation Center of Excellence. “An employer should strive to select a provider with a competent and efficient team, and one that shares its approach to claims management. And when building a pharmacy benefit management program, employers should ensure that several key features are included.”

The evaluation process does not end after contracts are signed. Employers should receive regular performance reviews from their providers, including quarterly and annual updates about pharmacy network performance from their PBMs (via their claims administrators). These reports should include custom metrics that are important to the employer — for example, the frequency of physician dispensing, compounded prescriptions, and duplicate prescriptions, and the network’s mix of brand-name and generic drugs.

## ACHIEVING BETTER WORKERS’ COMPENSATION OUTCOMES

Prescription drug costs will likely continue to escalate for the foreseeable future. But by making strong decisions about their claims administrators and PBMs and ensuring that networks comply with policies governing physician dispensing and compounded drug prescriptions, employers can help to control those costs and drive better overall workers’ compensation claims outcomes.

## ■ ABOUT THIS BRIEFING

This briefing was prepared by Marsh's Workers' Compensation Center of Excellence (COE), with contributions from Mercer, Express Scripts, and Comcast/NBCUniversal. Marsh's Workers' Compensation COE helps employers gain a competitive advantage through an integrated approach to workers' compensation programs. Marsh can also help employers conduct customized audits of their claims administrators and pharmacy benefit managers to confirm they have in place innovative tools, programs, and system triggers to drive favorable claims outcomes and costs savings.

### **Marsh's Variable Cost of Risk Evaluator (VCORE)**

Among Marsh's exclusive analytical solutions is our Variable Cost of Risk Evaluator (VCORE), which can help employers compare claims outcomes based on administrators' performance in containing medical costs and the fees they charge. This can help organizations identify which workers' compensation vendors can best help them improve their financial outcomes.

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## ■ ADDITIONAL RESOURCES

For more on this topic:

- Listen to the replay of our webcast, [Workers' Compensation 2015: Reining in Prescription Drug Costs](#).
- Read [Five Strategies for Reining in Workers' Compensation Prescription Drug Costs](#).



MPACT<sup>SM</sup> is Marsh's integrated approach to reducing all elements of casualty total cost of risk (TCOR). Through MPACT<sup>SM</sup>, we can help employers identify and prioritize cost reduction opportunities and optimize their casualty insurance programs.

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