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Reining in the Costs: Workers' Compensation and Prescription Drug Spending

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Medical services represent the bulk of workers' compensation claims costs — and prescription drugs are a big contributor. Employers can attack drug costs on multiple fronts, including provider behavior, opioid prescriptions, physician dispensing, compounded medications, and vendor selection. At the same time, adopting a more employee-centric model can help keep the focus on the injured worker and provide them the support and information on the road to recovery.

PRESCRIPTION DRUG SPENDING TRENDS

OPIOIDS

Public health agencies have frequently warned of the dangers of opioid use, and have referred to opioid abuse in the US as an epidemic. And current evidence-based medical treatment guidelines do not consider opioids to be appropriate first-line therapy for pain.

Nevertheless, physicians continue to prescribe and dispense opioids, which account for 13 of the 25 most commonly dispensed medications for injured workers, according to Express Scripts. They are also the most expensive therapy class in workers' compensation (see Figure 1) and represent more than 31% of total prescription fills in 20 states.

Several states have introduced new legislation and regulations intended to help control opioid use and abuse. For example:

- In October 2016, the New York State Workers' Compensation Board introduced a new process to determine whether individual claimants should be weaned from opioids or if there is sufficient evidence to continue opioid treatments.
- New Jersey Assembly Bill 3, effective May 2017, imposes a five-day limit on first-time opioid prescriptions and mandates that doctors create and periodically review opioid pain-management treatment plans for their patients, including workers' compensation claimants.
- Effective April 2017, opiate prescriptions for adults in Ohio are limited to seven days and cannot exceed an average of 30 morphine equivalent dosage (MED) per day.

FIGURE 1: 2016 PER USER SPEND BY THERAPY CLASS

SOURCE: EXPRESS SCRIPTS

Although these legislative and regulatory trends are promising, it will take time for doctors to alter their prescribing patterns. The same goes for claimants, who often assume they will be prescribed opioids to manage any form of pain following a workplace injury.

PHYSICIAN DISPENSING

Following a workplace injury, a worker who is prescribed medication by a doctor typically fills the prescription at a retail pharmacy. But over the last decade, some physicians have bypassed pharmacies and instead dispensed medication directly to patients.

Since its emergence in California workers' compensation programs in the early to mid-2000s, physician dispensing has become a regular practice nationally. In 2014, physician-dispensed drugs made up 10% of total workers' compensation prescription drug costs, according to NCCI. And it's carried a high cost: Physician-dispensed drugs cost $109.19 more than drugs dispensed to injured workers by pharmacies in 2016, according to Express Scripts.

Medications dispensed by physicians often cost more because they are typically purchased by repackaging companies that split bulk shipments from drug manufacturers into smaller packages to sell at a higher unit price. Every commercially available drug is classified by its average wholesale price (AWP). When a drug is repackaged, it is assigned 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 AWPs.

Advocates of physician dispensing argue that it increases the likelihood that a patient takes prescribed medication and ensures that treatment begins immediately. But the practice can contribute to poorer workers' compensation claims outcomes.

For example, many injured workers have more than one doctor, and these providers are not always aware of every medication an injured worker may be taking for a work-related injury. That includes those prescriptions filled at pharmacies and other physicians' offices.

Several states have taken action to limit or ban physician dispensing or the markup of repackaged drugs in workers' compensation. For example, in Colorado, effective January 1, 2017, reimbursement for all prescription medications (except topical compounds) is the AWP plus $4. For repackaged drugs, reimbursement is determined based on the original AWP. Other states have taken similar action, including amending fee schedules and formularies to limit physician dispensing or require prior authorization of certain drugs.

The potential long-term effectiveness of these reforms, however, is unclear. For example, in 2011, South Carolina capped prices paid for physician-dispensed repackaged drugs at the original manufacturer's AWP plus a $5.00 dispensing fee; physician-dispensed medications dropped from 23% of all prescriptions in the third quarter of 2011 — prior to passage of the new law — to 7% in the first quarter of 2014, according to the Workers Compensation Research Institute (WCRI). Meanwhile, in 2012, Connecticut limited reimbursement for physician-dispensed repackaged drugs at the original manufacturer's AWP; however, physician-dispensed medications only dropped from 39% of all prescriptions in the second quarter of 2012 to 32% in the first quarter of 2014.

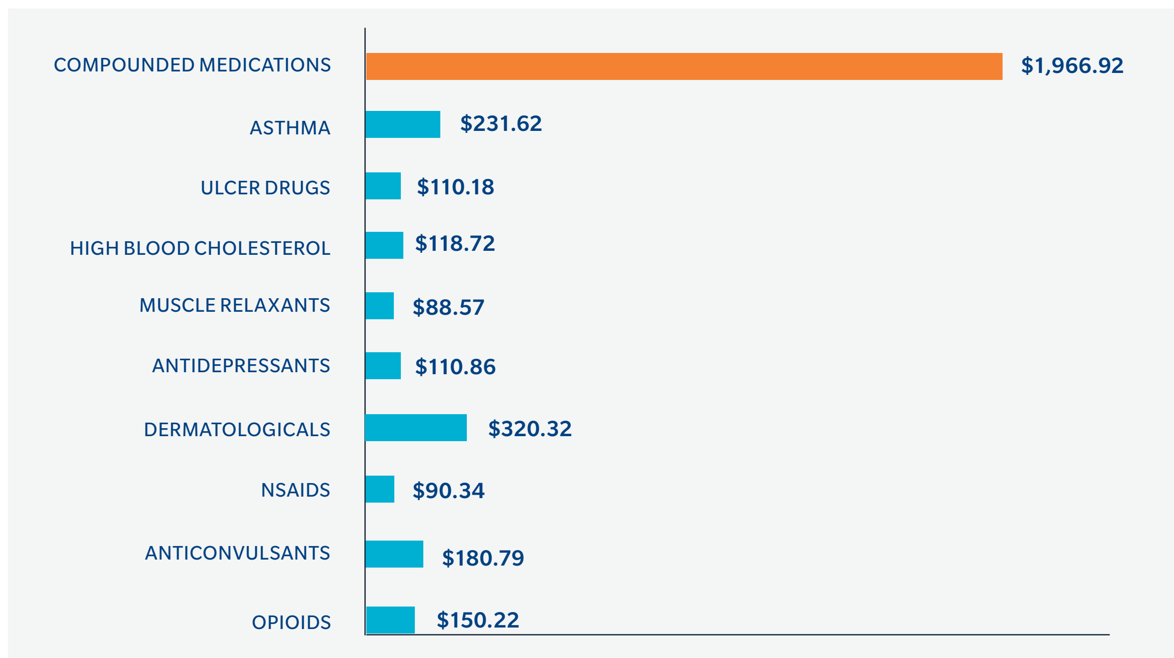
COMPOUNDED MEDICATIONS

Compounding is where a licensed pharmacist or licensed physician combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient. Compounded medications may be deemed medically necessary in some cases to treat some patients — for example, those who are allergic to dyes present in commercially available alternatives. But compounds are not tested and approved by the US Food and Drug Administration (FDA), which has noted that such medications carry potential health risks.

Nevertheless, compounds remain among the top 10 therapy classes in workers' compensation, according to Express Scripts. And although the per user per year cost of these medications dropped significantly — almost 25% — from 2015 to 2016, the cost per prescription is far higher for compounds than for other top therapy classes (see Figure 2).

Many states have taken steps to reduce the cost of compounded medications. 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. Many of these states also require compounds to be billed based on a fee schedule, and several states have put caps on how much compounding pharmacies can charge.

FIGURE 2: 2016 COST PER PRESCRIPTION BY THERAPY CLASS

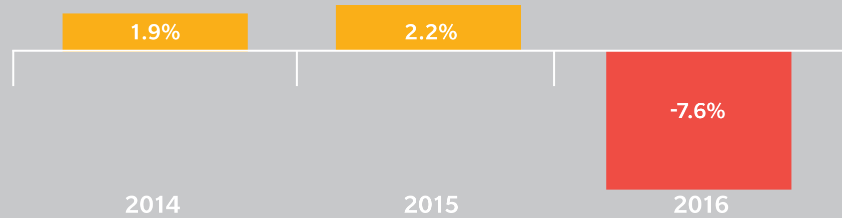


SOURCE: EXPRESS SCRIPTS

MEDICAL AND PRESCRIPTION DRUG COSTS CONTINUE TO INCREASE IN WORKERS' COMPENSATION

ANNUAL CHANGES IN DRUG SPENDING PER INJURED WORKER

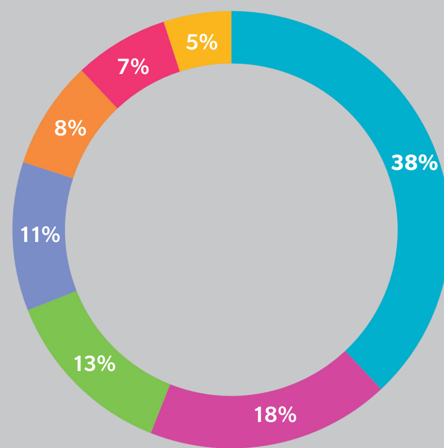
Spending on prescription drugs per injured worker fell in 2016.



SOURCE: EXPRESS SCRIPTS 2016 DRUG TREND REPORT

DISTRIBUTION OF MEDICAL COSTS, SERVICE YEAR 2015

- Physicians
- Hospital Outpatient
- Hospital Inpatient
- Drugs
- Durable Medical Equipment, Supplies, and Implants
- Ambulatory Surgical Centers
- Other

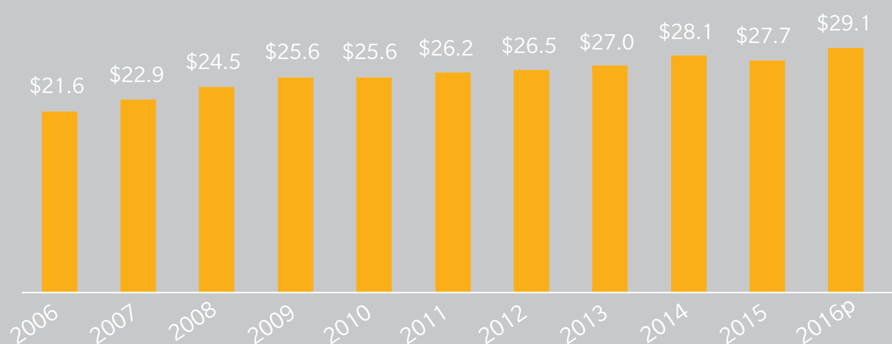


But drug costs still represent a sizable portion of workers' compensation medical costs.

SOURCE: NATIONAL COUNCIL ON COMPENSATION INSURANCE

AVERAGE MEDICAL COST PER LOST-TIME CLAIM (THOUSANDS)

More broadly, medical costs continue to increase, outpacing growth in indemnity costs.



SOURCE: NATIONAL COUNCIL ON COMPENSATION INSURANCE

The bottom line: Employers have an opportunity to better control their prescription drug costs.

CONTROLLING PRESCRIPTION DRUG COSTS

Understanding prescription drug pricing trends, evaluating providers, and addressing employee behavior can help employers to better manage increasing costs.

MANAGING PROVIDER BEHAVIOR

Employers should ensure that their third-party administrators (TPAs), in concert with prescription benefit managers (PBMs), have policies in place to avoid practices that could contribute to higher prescription drug costs. First and foremost, this means ensuring that in-network medical providers follow accepted medical treatment guidelines, including those published by the American College of Occupational and Environmental Medicine (ACOEM) and Centers for Disease Control and Prevention (CDC).

Employers can address provider behavior in several ways:

- Work with PBMs to flag patterns that could indicate misuse or abuse of opioids. PBM solutions can identify risky behaviors at first fill and throughout treatment, so that claims adjusters and clinical staff can engage with injured workers or prescribers to improve treatment outcomes. Automated technology for handling prior authorizations can also provide claims adjusters and nurse case managers with critical information needed to make informed decisions about whether to approve opioid prescriptions that exceed a payer's MED threshold.

- Through TPAs, PBMs, and others, encourage network providers to avoid overreliance on narcotics prescriptions. Providers should instead pursue alternative treatments, including coaching, counseling, and drug-weaning programs when appropriate. This should ultimately help to accelerate recovery of injured workers and reduce overall workers' compensation costs.

- Work with claims specialists to ensure that network providers are not dispensing medications to patients directly. Many PBMs and TPAs offer specialized physician dispensing solutions, including employee and physician outreach, that aim to convert physician-dispensed medications to pharmacy-dispensed. For example, after a physician dispenses medication to an injured worker and a PBM is billed, a PBM can process the prescription against a payer's formulary, plan design, and prescription history. The PBM can then re-price to the state fee schedule and provide payment to the provider as necessary. If the physician dispenses the medication in state where the practice is prohibited, the PBM can recommend no payment and encourage the patient to make future fills using a network pharmacy or home delivery option.

MANAGING SPECIALTY MEDICATION COSTS

Although accounting for less than 1% of the drugs used by injured workers in 2016, specialty medications represented almost 6% of total spend, according to Express Scripts. Specialty drugs treat relatively small groups of patients with complex, chronic conditions. Common workers' compensation examples include arthritis, cancer, hepatitis C, and HIV.

Specialty drugs are often expensive; for example, an antiviral drug used to treat hepatitis C cost $31,389.02 per prescription in 2016. Specialty drugs also typically have special-handling requirements, and patients taking such medications often require ongoing clinical monitoring and more intensive assistance and guidance from pharmacists or other caregivers.

Through their PBMs and TPAs, employers should closely monitor specialty drug expenses. PBM and TPAs should alert employers of upticks in spending and ensure that specialty medications are delivered via the correct dispensing channel. They can also ensure that patients understand the complexity of these drugs and counseling options available to them.

- Ensure that compound prescriptions are subject to point of sale authorizations, 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 confirm that a legitimate medical rationale exists for the use of a compound rather than a commercially available alternative. Claims administrators should also ensure that quantity limits for compounds are in place to discourage costly and often unnecessary refills being sent to injured workers.

REPORTING AND AUDITING

TPAs and PBMs should provide employers with robust data review and analysis capabilities, including the ability to track pharmacy spending through risk management information systems (RMIS) or other reporting tools. Employers should also work with their TPAs and PBMs to conduct regular audits — quarterly or more frequently — to ensure that providers are following best practices.

Employers should consider placing on probation any providers and pharmacies that engage in problematic behavior, including physician dispensing and frequent prescriptions of opioids and compounds. Terminating contracts may also be an appropriate option in some cases, but should be considered carefully by organizations, including with their legal advisors.

EMPLOYEE OUTREACH

To manage their workers' compensation programs, employers have typically focused mainly on cost reduction methods, such as reducing the number of days that injured workers are away from the job. But an employee-centric claims advocacy model that focuses on caring for employees can contribute to better claims outcomes. Such outcomes are typically characterized by shorter recovery times for employees and lower prescription drug costs for employers.

Successful claims advocacy programs typically focus on communication, education, and transparency. To manage prescription drug costs specifically, employers should consider the following steps (among others):

- Have written substance abuse policies that spell out rules and expectations about prescriptions and over-the-counter medications. Injured employees should understand their responsibilities with respect to prescription drugs, including confirming with their physicians and pharmacists that any medications they are prescribed will not jeopardize them and their co-workers.
- Communicate directly with injured workers upon their first opioid fill. Employers — either directly or through their TPAs or PBMs — can educate these workers about potential side effects, addiction risks, and treatment options.
- Train supervisors on employee assistance programs (EAPs), workplace safety policies, and drug-free workplace policies. TPAs and others can also help to educate supervisors on signs of drug overdose and risk factors for abuse.
- Build robust return-to-work programs. Generally, returning an employee to work more quickly — even if in a part-time capacity — will reduce the duration of the claim and number of prescription drugs assigned to the employee. Where appropriate, these programs should make modified and temporary transitional duty available to injured workers.

Outreach to employees can also help to discourage specific practices such as physician dispensing. This often occurs early in workers' compensation claims 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 try 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.

BUILDING A PHARMACY BENEFIT MANAGEMENT PROGRAM

When selecting new TPAs 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 in their pharmacy benefit management programs, employers should consider including:

- 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 medication.
- Generic conversion programs. PBMs should provide information to physicians and pharmacists regarding generic alternatives 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.

SELECTING EFFECTIVE CLAIMS AND MEDICAL MANAGEMENT VENDORS

Employers often select TPAs 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, according to Marsh analysis. 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.

As they evaluate competing claims administrators, employers should also consider the quality of their people. Claims adjusters and nurse case managers can greatly influence how quickly an employee returns to work following an injury, which is a significant factor in overall workers' compensation claims costs. Employer should strive to select providers that share their approach to claims management and offer competent and efficient teams.

When building pharmacy benefit management programs, employers should ensure that several key features are included (see sidebar). Employers should receive regular performance reviews and utilization reports 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, compound prescriptions, duplicate prescriptions, and opioids dispensed, and the network's mix of brand name and generic drugs.

ACHIEVING BETTER WORKERS' COMPENSATION OUTCOMES

Prescription drugs are a necessary component of any workers' compensation program. By closely monitoring and managing provider behavior, educating and collaborating with employees, and making strong decisions about their TPAs and PBMs, employers can help to control those costs and drive better overall workers' compensation claims outcomes.

ABOUT THIS REPORT

This report was prepared by Marsh's Workers' Compensation Center of Excellence, with contributions from Express Scripts and Liberty Mutual Insurance.

MPACT® is Marsh's approach to helping clients assess and manage the five key elements of their total cost of casualty risk — retained losses, claim management, risk transfer premium, collateral, and implied risk charge — and through which we provide an array of solutions to control and reduce them. This approach gives clients confidence that they have a strategy to achieve the most optimal results for their casualty programs. MPACT® incorporates proprietary offerings from Marsh's Casualty and Claims Practices, Marsh Risk Consulting, and Marsh Global Analytics.

ADDITIONAL RESOURCES

- Listen to the replay of our Workers' Compensation Center of Excellence webcast, Strategies for Containing Your Pharmacy Costs.
- Read the Express Scripts 2016 Drug Trend Report.

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