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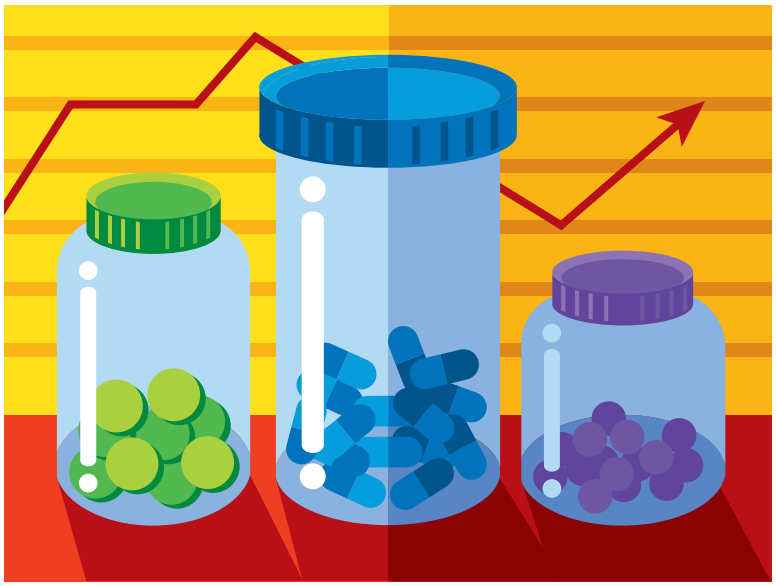

Prescription Drug Management in Workers' Compensation

The Fourteenth Annual Survey Report (2016 data)

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Introduction

Over the last seven years, workers' compensation prescription drug costs have decreased by approximately one billion dollars.

Prescription drugs have long been a critical issue in workers' compensation. Accounting for one of every seven medical dollars, pharmacy's impact on patient recovery, disability duration, return to work, and claim settlement outweighs the benefit's dollar expense. Each year pharmacy is the subject of much research on the part of such august organizations as the California Workers' Compensation Institute (CWCI), National Council on Compensation Insurance (NCCI), the Workers' Compensation Research Institute (WCRI), and others. The purpose of this survey is to add depth to our understanding of the issue, supplementing statistical and systemic research by adding the perspectives and data of state funds, insurers, third-party administrators, and self-insured employers.

This is the 14th year the survey has been conducted. For the first six years Health Strategy Associates, LLC, my consulting firm, was responsible for the survey. I'm also the president of CompPharma, LLC, a workers' compensation pharmacy advocacy and education firm, and the responsibility for the survey was transferred to CompPharma in 2009.

As workers' comp pharmacy management has evolved over the years, so has this survey. While it remains focused on cost trends and drivers, market needs, PBM capabilities and program results along with opinions, perceptions, and attitudes about pharmacy management in workers' compensation, we have added and deleted questions over time. Special attention is paid to emerging issues, management approaches, problems and solutions, along with the evaluation of those solutions.

We wish to express our thanks to the workers' compensation professionals who carefully and thoughtfully responded to the survey. 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.

Interviews were conducted in the summer of 2017, with data on pharmacy spend and other metrics derived from respondents' 2016 results.

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.

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Summary of Results

The structural decline in drug costs we've been seeing for the last seven years accelerated in 2016, as workers' compensation pharmacy costs decreased 11% from 2015 across the 23 payers surveyed.

All but four of the 23 state funds, insurers, third-party administrators (TPAs), and self-insured employers surveyed spent less on drugs in 2016 than the previous year, with seven respondents reporting declines greater than 15%.

Survey results over the last seven years indicate drug costs dropped in five of those seven years; spend today is 22% lower than it was seven years ago. Payers experiencing decreases in drug costs identified lower claim volumes, decreased usage of opioids and compounds, and a variety of clinical management changes as key drivers of lower spending.

Compounds, gaming the system by unscrupulous prescribers and dispensers, drug price inflation, and implementing state formularies were named as the emerging issues of most concern to payers. There was no consensus about the "biggest problem" in workers' comp pharmacy management.

The continued consolidation in the PBM industry was again a topic of this year's survey, with responses all across the board. Respondents' views ranged from "very enthused" about the potential for lower costs and more capabilities to concerns due to fewer competitors fighting for business, a possible reduction in PBM flexibility due to consolidation of merged operations, and loss of key staff after mergers.

External Factors

Pharmacy management in workers' compensation does not occur in a vacuum. Outside factors profoundly affect pharmacy in workers' compensation, including:

- The ACA's expansion of insurance coverage
- Societal issues, such as the explosive growth in opioid abuse and misuse and the introduction of new brand drugs and patent expiration
- Generic price inflation
- Practice-pattern evolution, and
- Pharmaceutical marketing practices

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Drivers specific to workers' compensation, such as fee schedule changes, implementation of state-regulated formularies, claim frequency, physician dispensing and novel drugs, respondents report that better programs — properly implemented — deliver lower loss costs, which translate to lower combined ratios and costs for work comp insurers and self-insured employers and better care for workers' compensation patients.

Background

Today, total workers' comp annual pharmacy spend is approximately $3.6 to $4.1 billion. After much analysis, we have come to the conclusion that it is not possible to precisely calculate workers' compensation drug spend. There are several reasons for this.

Pharmacy is a component of workers' compensation medical expense, which was approximately $31.6 billion in 2016 (Sources: National Academy of Social Insurance REPORT: Workers' Compensation: Benefits, Coverage and Costs, published October 2016[1], trended forward using NCCI medical inflation rates, which were 1.4% in 2015 and 6% in 2016 from NCCI Annual Issues Symposium State of the Line, May 2017[2]. Other considerations include:

- Different estimates are based on data from different states, and the various estimates use differing methodologies. The methodology used by NCCI is based on an analysis of projected spend for claims occurring in Accident Year using data from NCCI-reporting states. As such, the NCCI estimate is based on the anticipated total spend over the entire life of the claims incurred in a specific year, and not on drug spend in that calendar year. In contrast, anecdotal information from payers indicates drug costs account for 10 to 13% of medical spend
- The basis for determining what products or billing codes are included in drug spend varies among and between payers and jurisdictions
- Drugs are dispensed in a variety of settings and by a variety of providers; therefore some drug costs may be included in other charge categories. For example, specialty drugs may be billed under home health care/durable medical equipment services, while long-term care and hospital-dispensed medications typically are counted as facility expenses. It is unlikely all payers surveyed use the same methodology when calculating drug costs
- Physician-dispensed drugs may or may not be counted towards drug spend, as they can be billed on standard medical billing forms with the cost "rolled-up" under physician costs for reporting purposes.

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Respondents

Respondents were decision makers, clinical personnel, and operations staff in state funds, carriers, self-insured employers, and TPAs with drug expenses ranging from $1.5 million to $200 million+. The 23 respondents' 2016 drug costs totaled $971 million or about 24 to 27% of total workers' compensation drug spend.

Findings

Notes:

- We continue to use both quantitative and qualitative measures in the survey with the questionnaire structured in such a way as to "triangulate" on specific issues and confirm opinions and perspectives, thereby providing readers with confidence in the survey's findings.
- The quantitative questions use 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).
- Not all respondents answered all questions and some respondents provided multiple answers to other questions, thus response rates/numbers will not always correlate with the total number of payers.

Inflation/trend in drug costs

Total drug costs dropped by 11% year over year, and costs are down 22% over the last seven years.

Clearly, the work done by PBMs and payers to attack what was once the fastest-growing component of workers' compensation medical expenses has paid off.

Averaging each respondent's trend results in a decrease of 9.6%, indicating that larger payers saw greater drops in drug spend. Many of the 23 respondents enjoyed double-digit decreases in drug spend, with three seeing declines greater than 20% and six others reducing drug costs by greater than 15% year over year.

Across all respondents' total drug spend, the decrease of 11% resumed what had been a persistent trend of flat or declining spend. (That trend was interrupted in 2014 with a 6.4% increase over 2013's results.) Considering the total change in spend, the decrease marks a resumption in the long-running trend of declining inflation rates, and more recently, declining cost itself as inflation turned negative.

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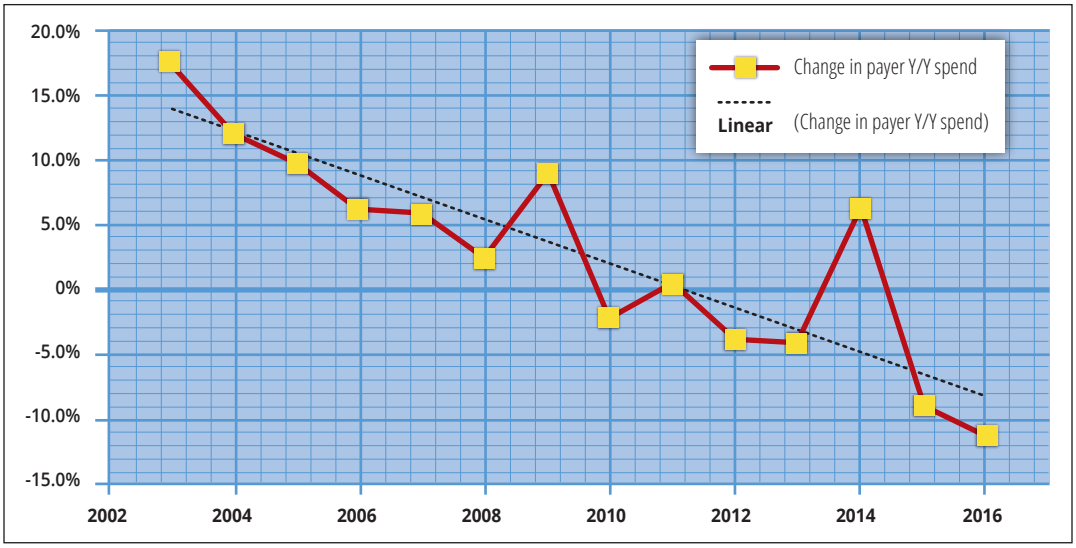
Thirteen respondents cited reduced claim counts as a driver, however several had only slight claim count declines, while others noted decreases in total inventory resulting from more aggressive efforts to close older claims. Other reasons for decreased spend included tighter management of the prior authorization process, increased involvement of clinical staff in drug approval, increased vigilance regarding compounded drugs, and higher generic dispensing rates.

In contrast, 12 respondents credited clinical programs as a key reason costs declined.

PBMs have been very successful at reducing their own revenues. PBMs' clinical programs in particular have dramatically reduced the use of opioids and other very expensive drugs, many of which are used for months if not years.

Drug cost inflation trend



Over the 14 years the survey has been conducted, the pharmacy cost inflation rate decreased by 28.8 points. More significantly, over the last seven years, workers' compensation drug spend has dropped by around a billion dollars.

The workers' compensation pharmacy benefit management (PBM) industry came into its own about 15 years ago. While PBMs such as PMSI (now part of OptumRx) had long been active in the space, until drug costs exploded, many — if not most — payers did not utilize PBMs. Those that did often did so on a file-by-file basis. With the dramatic increases in drug costs in the early part of the last decade, payers hurried to contract with PBMs and integrate them into their service offerings.

From reviewing all survey responses and paying particular attention to new cost management programs and results thereof, it appears that while payers worry about the lack of regulatory authority to address problematic prescribing and prescribers, opioids, physician dispensing, compounds, and other factors, they believe their firms — and their PBMs — will be able to mitigate the impact of these drivers.

Cost drivers

The survey's final question asks respondents to identify the single biggest problem in workers' compensation pharmacy. Similar to 2016's report, this year the answers were diverse indeed. A plurality of respondents mentioned issues related to PBMs, the evolution of the industry and the role of PBMs and other entities in managing pharmacy. While at first blush these may seem disconnected, upon closer inspection it is apparent many respondents are thinking about where PBMs sit in the clinical management/operational work flow and value chain, implications related to that position, and how it is evolving.

This is a critical issue in what is a very mature, consolidating industry. The role of PBMs, the market's perception of PBMs' role and value, and how that will evolve over the near term should be top-of-mind for PBMs and payers. If ignored, PBMs will lose the ability to remain the or "a" leader in pharmacy management in workers' comp.

Opioid spend among respondents dropped precipitously last year; all respondents but one reported lower spend than in 2015. Averaging all respondents' results, opioid spend decreased 13.3%. When totaling all respondents' changes from 2015 to 2016, opioid spend dropped 16.1%.

In contrast, Quintiles IMS[3] reported total use of all pain medications across all payers fell by 1% last year.

The industry cut one out of every six dollars spent on opioids, a truly remarkable result. While it is important to note that total drug spending also decreased significantly, in most instances opioid spend dropped more than did overall spend (see graph below).

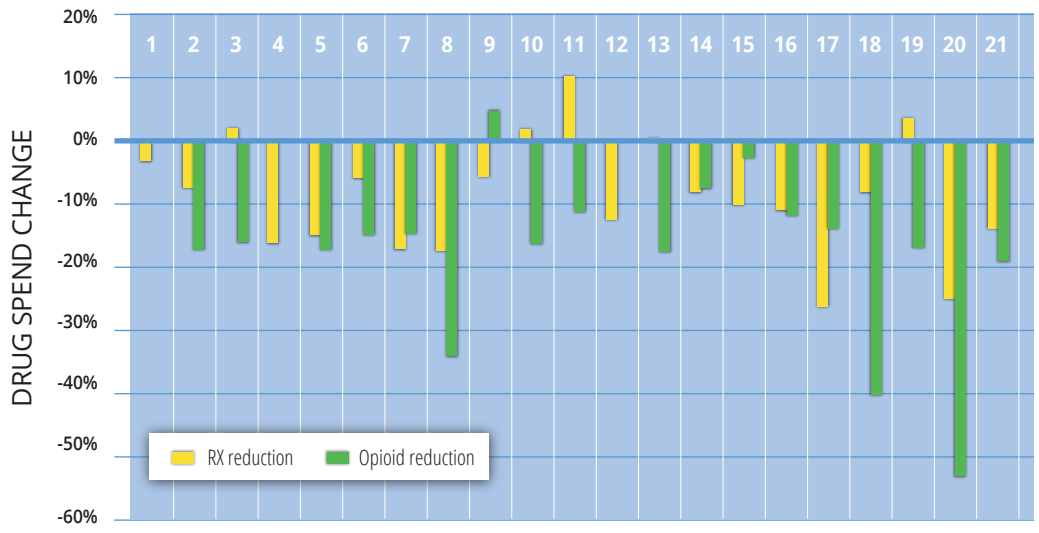
This came about due to multiple major efforts at each payer, efforts described in this and past reports, and thousands of individual actions by claims adjusters, case managers, prescribing physicians, pharmacists, regulators, legislators, and patients. Letters to prescribers, pharmacist calls to prescribers, patients requesting non-opioid pain relievers, physicians denying requests for opioids, adjusters referring potentially troubling prescribing

issues to in-house clinicians, and many more actions, insights, efforts, and programs are behind this improvement.

This year all respondents except one reported their total opioid spend. Opioids accounted for 26.8% of total pharmacy spend, a figure that is just slightly below last year's 28% and similar to other national statistics (NCCI – 29%, Express Scripts 2016 Workers' Compensation Drug Trend Report – 26.5%).

While there was some consistency across all respondents as can be seen in the graph below, opioid spend varied significantly in some instances due to geographic differences in prescribing patterns and/or regulatory controls over prescribing.

Comparing total drug spend decrease and opioid spend decrease



The numbers 1-21 indicate individual payer respondents who provided both total spend and opioid spend data.

Lest any readers take comfort in their "averageness," recall that industry consensus holds we spend far too much on opioids, thus maintaining the status quo is far from acceptable performance. While spend continues to be far too high, the progress being made by most respondents does give hope that we are starting to gain some measure of control. With that said, it is important to remember that many payers report around half of all lost-time claimants have been prescribed opioids, a statistic that reflects rampant over-prescribing.

One of the advantages of conducting a survey over a dozen plus years is the insight it provides into market evolution. While program managers and work comp executives have long known about the relatively high usage of narcotics in work comp, the depth and breadth of understanding of the issue and the implementation of measures necessary to address it continue to increase. Throughout the survey, respondents mentioned narcotics, opioids, addiction, specific drugs, dependency, overdose medications, and treatment even when responding to other questions.

High among respondents' concerns was the risk of addiction or dependency for claimants taking opioids; respondents said they were "very concerned" (4.6 essentially identical to prior years' ratings). The consistently high level of concern is a strong indicator of the industry's awareness of the impact of addiction.

Physician dispensing

While there is considerable variation in the level of concern over physician dispensing, this year's overall average of 4.0 marks a rating return within the historical range of 3.6 – 4.0 (very concerned), up from last year's 3.2 (concerned). Three respondents, operating in regions where physician dispensing is essentially banned, were not at all concerned.

A broad array of respondents including national TPAs and insurers, rated their concern with physician dispensing a 5 (extremely concerned) or 4 (very concerned). Research conducted by CWCI, Johns Hopkins University and Accident Fund Holdings, Inc., NCCI, and WCRI quantifying the significant cost added to the system by physician dispensing have presented compelling evidence that the practice delivers no benefits to patients.

Physician dispensing also drastically and artificially inflates overall workers' compensation pharmacy costs. Physician-dispensed prescriptions typically cost three to ten times the amount of the same prescription filled by a retail pharmacy.

Recent studies (Johns Hopkins University/Accident Fund and CWCI) point to longer claim duration, more claimants prescribed opioids for longer periods, higher overall medical costs, higher indemnity expense, and poorer outcomes associated with claims with physician-dispensed drugs compared to similar claims without physician-dispensed drugs.

In addition to poorer claim outcomes, there are several further concerns with physician-dispensed drugs. Physician dispensing unnecessarily creates a health and safety risk for the workers' compensation patients receiving these prescriptions. In addition to

their non-occupational health physicians, workers' compensation patients often see multiple physicians for their work-related injuries, each of whom may prescribe multiple medications. These independent doctors often do not know the prescribing patterns of his/her peers or all of the other drugs the workers' compensation patient is taking. Nor do they usually know the patient's entire medical history.

New and emerging issues

In general, the most-often cited concern (12 respondents) pertained to different ways unscrupulous prescribers and dispensers are tweaking their business and billing models to maximize reimbursement. There wasn't one specific issue, rather an understanding that profiteering now takes many forms and appears in many ways.

One common concern involved the regulatory environment, with respondents expressing concerns over formularies and the implementation and "enforcement" thereof. One respondent voiced it well: "Combination therapy [is an emerging issue] — one of the biggest challenges is those states without formal utilization review or treatment guidelines... we have RNs that do informal UR, but we may not be able to do much to address out-of-guideline treatment. [We are] monitoring physician practice in two states (Illinois and Massachusetts) to validate [care delivered] outside practice standards and report to medical board... there's UR in IL but we can't deny pharmacy that's recommended by IL."

Drug testing

This was the seventh year we asked respondents if they were using a urine drug testing (UDT) program. Six years ago, half of all respondents utilized a "formal" UDT program to monitor claimant compliance; today two-thirds of respondents do.

That finding is also appreciably higher than last year's when half of respondents implemented a formal UDT program. Most payers do support UDT, however some do not have directly contracted vendors in place and/or leave that decision to the prescribing physician. This represents an opportunity, as the literature is replete with evidence that there is far too little drug testing of a majority of opioid-prescribed patients, and far too much testing of a relatively small subset. The latter is likely due to the profits generated by drug testing for physicians that own or have a financial stake in a lab.

As states adopt guidelines addressing opioids, we can expect more payers will have to comply by demonstrating their programs are consistent with those guidelines.

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Compound medications

There has been a dramatic reduction in compound usage among respondents. Of the respondents who provide figures for 2015 and 2016, slightly more than half saw a reduction in total compounds reimbursed. However, most respondents reporting an increase indicated the increase was negligible to slight.

Overall, compound usage dropped 40%. Thus, last year's significant increase over 2014 might well be seen as an aberration, or perhaps more accurately, a reflection of the quick and decisive actions regulators and payers took to address the issue.

PBM Performance

Asked to rate their current PBMs' customer service, the average response was 4.3, almost a full point higher than last year's 3.4, indicating payers are somewhere between "very satisfied" and "extremely satisfied." This is — by far — the highest customer service rating we've seen in 14 years.

Over the 14 years this survey has been conducted, the pharmacy cost inflation rate decreased by 28.8 points.

The PBM's business model is based on its ability to win new business to compensate for excellent performance in managing current clients' drug programs, a model that has significantly benefited patients and payers alike. With that said, there are multiple opportunities for PBMs to make improvements.

Many payers have yet to take full advantage of the services PBMs can provide. For example, several payers still have not integrated their paper bill processes into their PBM data flow, while others allow adjusters to routinely and easily override prior authorization denials. This impairs clinical management efforts, makes it harder to capture those scripts in-network for faster, much-less-cumbersome adjudication, reduces the hassle factor for the patient and claims adjuster, and results in higher per-script costs. Paper bill solutions have been in existence longer than CompPharma (more than a decade); payers not yet taking advantage of this service would be well-served to do so.

The biggest problem in worker's compensation pharmacy management

We ask this question each year, and tracking responses over time has helped us identify trends and track the industry's evolution over the last 14 years. This year, the dominant concern is not readily quantifiable, but it is obvious.

It's complexity. The complexity of regulations and changes thereto, of integrating data, bill, and transaction flows, of getting the exactly correct, pertinent information to the exact person who needs it at the moment they need to make a decision, of working with pharmacy and other medical data to gain a complete picture of the patient, of pricing, transparency, and how prices are calculated.

Payers have gained enough knowledge that they now realize that they don't know nearly enough. I'd liken this to we humans. When we were teenagers we knew everything, now that we (more accurately me) are well into middle age, we understand how little we really know.

Conclusions

Similar to the long-term trend in reduced workers' compensation claim frequency, the annual decrease in workers' comp drug spend may now be structural.

While declining claim frequency is certainly a significant influence, clinical management programs, integration of PBM and payer systems and data flows, streamlined operations and script capture efforts, prescriber intervention and specific targeting of patients at high risk have significantly reduced drug spend and opioid usage.

PBMs and payers have made remarkable progress reducing the use of unnecessary, expensive, often dangerous, and highly problematic medications. Opioid spend is down, compound usage is being controlled, and employers' and taxpayers' costs are declining.

Notably, this is being driven in large part by PBMs, the very same entities that are losing revenues by delivering these programs. While far from perfect, and needing significant changes in terms of utilization review processes, clinical guideline enforcement, and direction of care, patient care is improving and the damage done by overprescribing of opioids is being addressed.

That said, payers are far from complacent. The continued and seemingly intractable problem of long-term use of opioids, the jumble of state regulations and rules dealing with workers' compensation pharmacy, and the very real challenges facing adjusters due to high claims loads and training and IT deficits make it easy to understand why respondents continue to lose more sleep over pharmacy than other medical cost issues.

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Pharmacy management in workers' comp has evolved dramatically over the 14 years we've been conducting the survey. From a focus on the price of the pill and the size of the retail pharmacy network in 2003 to today's concern about opioids, compound drugs, physician dispensing, data and reporting, there has been a remarkable increase in sophistication and understanding.

Yet, despite all the attention and resources dedicated to this issue, payers' levels of concern about pharmacy management remain surprisingly high. Perhaps it is more accurate to say "because" of all the attention paid to the issue, payers' levels of concern are quite high. The hard-won insight into the myriad issues inherent in pharmacy management, coupled with a deep understanding of the long-term implications of poorly-managed drug regimens plus the susceptibility of work comp pharmacy to bad actors makes it a "soft target" indeed.

Finally, as the respondents noted, we would be remiss if we didn't acknowledge the significant impact of external factors on workers' compensation pharmacy, chief among them the nation's growing addiction to prescription pain medications. This is a societal issue, but one that has a deep and damaging impact on comp, driving up costs, prolonging disability and killing patients.

CompPharma is a consortium of workers' compensation pharmacy benefit managers (PBMs) that identifies industry wide problems and develops and delivers solutions. CompPharma's member PBMs are:

Coventry Workers' Comp Services/First Script
Mitchell Pharmacy Solutions
myMatrixx, an Express Scripts Company
Optum Rx

Endnotes

[1] https://www.nasi.org/research/2016/workers-compensation-benefits-coverage-costs

[2] https://www.ncci.com/Articles/Documents/II_AIS-2017-SOL-Presentation.pdf

[3] Medicines Use and Spending in the U.S. A Review of 2016 and Outlook to 2021; Quintiles IMS, May 2017. http://www.imshealth.com/en/thought-leadership/quintilesims-institute/reports/medicines-use-and-spending-in-the-us-review-of-2016-outlook-to-2021