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PHARMACY BEST PRACTICES

Workers' comp drug benefit offers fewer levers for cost control

Utilization review and influence on physician prescribing habits remain the best bet to manage spiraling costs

BY MARI EDLIN

If you thought expenditures for pharmaceuticals were growing rapidly, take a look at prescription drug costs for workers' compensation; they rose from 6.5% in 1997 to 9.6% in 2001, according to the National Council on Compensation Insurance (NCCI). In 2003, these drugs consumed an estimated 10% of total medical costs and registered $2.5 billion on the cost meter. Unfortunately, workers' compensation pharmacy expenditures are a different beast than what you find in group health.

"In workers' compensation, we pay for first dollar and every dollar related to a condition," says Joseph Paduda, principal at HealthStrategy Associates in Madison, Conn. "Unlike group health, you can't utilize a tiered copayment arrangement, require the use of generics or in some states, mandate where patients fill their prescriptions."

"Insurers don't even know who the workers' compensation population is," adds Ruth Estrich, director of networks for MedRisk, a workers' compensation claims management firm based in King of Prussia, Pa. "There are no eligibility lists; workers' compensation is just not employee-driven."

To assess the climate of drug cost management in workers' compensation, last year Paduda conducted a telephonic prescription drug management survey of 21 decision-makers at workers' compensation payer organizations, representing drug spends from $2 million to $170 million. The survey was commissioned by St. Louis-based pharmacy benefits manager (PBM) Express Scripts.

UTILIZATION: KEY TO CONTROLLING COSTS

The survey indicates that 80% of respondents say that drug costs are grabbing the attention of senior management. When asked which methods are used to control costs, respondents, who were clearly more concerned about the volume of prescriptions used, preferred utilization-based rather than price-related techniques. These include changes in formulary to restrict refills, tighter medical management, such as changing prescribing physician behavior, and patient-specific utilization management processes.

Paduda's survey also shows that the majority of respondents cite PBMs and their networks and drug utilization tools, along with treating physicians as "levers" for controlling costs.

Phil Walls, vice president of pharmacy services for PMSI-Tmesys in Tampa, Fla., a PBM featuring a nationwide network of pharmacies, favors both prospective drug utilization review (DUR), which highlights contraindicated drugs, duplications and prescriptions that are being refilled too soon, and retrospective DUR. Tmesys generates intervention letters for physicians, providing patient-specific drug profiles to ensure that therapy is working effectively and is being taken appropriately

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based on medical literature. Walls is not concerned if savings don't accrue as long as the right things are being done clinically.

Although Walls recognizes that the AWP for drugs is increasing 12% to 15% a year, he points to over-utilization of such expensive drugs as Celebrex and Oxycontin for pain and Vioxx as an anti-inflammatory—the top three drugs prescribed under workers' compensation—as lying at the crux of cost increases.

Workers' comp pays 74% more than group health for the same drugs, due to lack of control over AWP and limited purchasing power.

Not only have the popular brand drugs sent costs spiraling, but so has the introduction of costly biologics. The new lollipop narcotic, Actiq, prescribed for breakthrough pain for cancer patients, is sneaking onto physicians' prescription pads as a remedy for chronic pain.

George Furlong, vice president of provider and payment services for CHOICE Medical Management Services in Tampa, agrees that managing utilization is key to controlling costs and places the onus on physicians. "Since no copayment exists in workers' compensation, there is no incentive for the patient to ask for a less expensive drug—a non-steroidal, anti-inflammatory drug instead of a COX-2 inhibitor, for example, so you have to educate the physician," he says.

CHOICE sponsors education seminars for physicians to try to encourage certain prescribing habits and to keep them abreast of current pharmaceutical legislation. CHOICE has experienced 28% lower pharmacy costs per claim in 2003 for all claims with incurred pharmacy expenses.

An NCCI study, comparing prescription drug costs in workers' compensation and group health, attributes an increase in utilization to greater availability of and dependence on medications for treatment, aggressive marketing, an aging work force and increased access through coverage.

ROLE OF FORMULARIES

Although most injury-related drugs are covered under workers' compensation, formulary and generics have an effect. CHOICE's pharmacy program, which is aligned with Express Scripts, uses a workers' compensation formulary and medical guidelines to ensure medications are appropriate for treating work-related injuries and enables physicians to control the authorization of non-formulary drugs. The formulary focuses on classes of drugs most used by injured workers—painkillers, muscle relaxants and antidepressants—and covers the majority of drugs in those categories.

Formularies in workers' compensation, Walls says, are unique for each employee based on his or her specific injury rather than global as found in group health. If a worker is burned, for instance, drugs addressing the injury become part of the employee's formulary. Any medications outside the formulary require prior authorization.

Although programs are in place to determine which medical and pharmaceutical services are compensable, Walls says there are a few gray areas—antidepressants, for example. An employee may become depressed after an accident or injury and be prescribed an antidepressant, but what if the worker was depressed before the injury, should the drug be covered? Walls asks. As an injury moves from the acute to the chronic stage, gray areas also intercede, raising the dilemma of how long an employee should remain on a specific drug.

Generics are key to controlling costs in group health, but present less potential in savings in workers' compensation because many of the commonly used prescriptions are already generic, NCCI says. Drugs without generic equivalents account for 56% of drug costs in workers' compensation, resulting in generics savings opportunities of only 8% of total drug costs.

Discounts, another important factor in-group health, often do not play a role in workers' compensation since there is a lack of control over the average wholesale price and limited purchasing power to negotiate discounts. Workers' compensation pays 74% more than group health for the same drugs and on average, 125% of the AWP compared with 72% in group health, according to NCCI.

As increased utilization and the introduction of higher cost drugs put pressure on the workers' compensation system, NCCI is looking at cost offset—whether the drugs prescribed under workers' compensation add to total healthcare costs or replace more expensive treatments, including surgery and hospitalization.

The Prescription Drug Management Survey also asked workers' compensation payers to rate PBMs' success in controlling costs. Ease of use tied to customer service for claimants, adjusters and employers ranked number one among respondents, with others acknowledging PBMs' ability to achieve savings and negotiate discounts, followed by the size of and their relationship to their networks.

Kathy Bonnell, national sales director at Express Scripts, says that workers' comp should be carved out and addressed more aggressively. She says the PBM is valuable in facilitating first fill so that initial prescriptions can be filled even before employers are notified; "soft" channeling employees to network providers to assure no out-of-pocket expenses; and eliminating the need for third-party billers, who may charge more than the fee schedule for drugs.

Estrich recommends that employers/carriers establish relationships with PBMs, who can offer many of the same services delivered in group health and who are at risk if claims turn out to be non-compensable. Generally, less than 2% of prescriptions are deemed non-compensable. **MHE**

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