A REPORT TO THE INDUSTRY

Pharmaceutical Cost Management in California Workers' Compensation

NOVEMBER 2002

Foreward

Pharmaceutical costs in the California workers' compensation system have grown rapidly in recent years, more than doubling to well over $200 million between 1995 and 2001 according to the California Workers' Compensation Insurance Rating Bureau. Recognizing the need to control these costs, state lawmakers early this year enacted provisions within AB 749 calling on the Division of Workers' Compensation to promulgate a pharmacy fee schedule by July 2003. At the same time, the legislators authorized workers' compensation payers to contract with pharmacies or pharmacy benefit managers (PBMs) to
provide prescription drugs and supplies to injured workers, following standards developed by the state – the stated goals of which are to reduce costs and assure reasonable pharmaceutical access to injured workers.

This Report to the Industry, prepared by Neil Smithline, MD, FACP, Institute Research Director Alex Swedlow, MHSA, and Nora Blay, MBA, provides background on the issue of pharmaceutical benefit delivery, reimbursement, and management in California workers' compensation. The analysis reviews past studies by CWCI and other research organizations that compare the California system to other programs, examines the current role and potential savings from PBMs, and outlines factors that are likely to affect the cost and delivery of pharmaceuticals to injured workers in the future.

California Workers' Compensation Institute

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About CWCI

The California Workers' Compensation Institute, incorporated in 1964, is a private, non-profit organization of insurers and self-insured employers conducting and communicating research and analyses to improve the California workers' compensation system.

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Background

In recent years, pharmaceutical costs have represented one of the fastest growing medical expenses in California workers' compensation. In 2000, the Commission on Health and Safety and Workers' Compensation (CHSWC) and the California Department of Industrial Relations, working in cooperation with the California Workers' Compensation Institute and other researchers, conducted a study to examine the magnitude and escalation of drug costs, and to estimate potential savings from modifications to California's current approach to regulating workers' compensation pharmaceutical costs.[1]

Under the current system, worker's compensation pharmacy costs are governed by the Official Medical Fee Schedule (OMFS). The schedule allows pharmacies to charge either their customary fees for drugs or the maximum under the OMFS – whichever is less. OMFS maximums for generic medications are 140 percent of the average wholesale price (AWP*) plus a $7.50 dispensing fee, and maximums for brand name drugs are 110 percent of the AWP plus a $4.00 dispensing fee.

CHSWC Findings

In its study, CHSWC used claims data from the Institute's Industry Claims Information System (ICIS) to examine approximately 600,000 pharmacy payment records from 1998 and 1999. These records identified the date of service, billed amount, paid amount, dispensing agent, and drug dispensed. The study confirmed that pharmaceutical costs are higher in California workers' compensation than in other systems, and identified several key cost drivers. Among the principal findings:

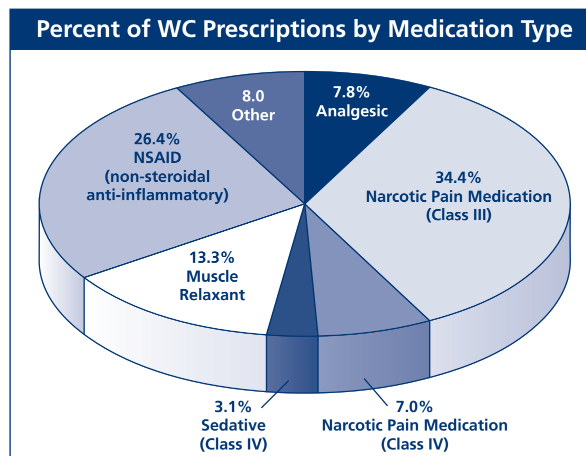
- California workers' compensation pharmaceutical reimbursement rates exceed those of other systems such as Medicaid, Medicare, and general group health.
- Within workers' compensation, California's OMFS pharmaceutical reimbursement rates are 23 percent to 36 percent higher than those allowed by other states or the federal workers' compensation program.
- In 1996, California workers' compensation prescription drug costs totaled $114 million. CHSWC estimated these costs would rise to $212 million per year by 2000 and to $374 million per year by 2005.
- Due to the rapid growth of pharmaceutical costs, prescription drugs increased from 3.8 percent of California workers' compensation medical costs in 1996 to 5.8 percent in 2000. By 2005, the Commission projected that pharmacy costs would comprise 7.3 percent of workers' compensation medical benefit expenditures in California.
- California pays a high premium (the $7.50 dispensing fee) to encourage pharmacists to dispense generic drugs in place of brand name equivalents. Many states avoid this cost by requiring that generics be dispensed unless the doctor specifies "dispense as written" on the prescription.

Potential Savings

The OMFS reimbursement rates in California result in high costs to employers without necessarily offering any benefit to injured workers. In its study, CHSWC found that 92 percent of drugs dispensed in workers' compensation are for pain medication, anti-inflammatories, and muscle relaxants. Chart 1 illustrates the drug distribution from the CHSWC study.

Chart 1

Percent of WC Prescriptions by Medication Type



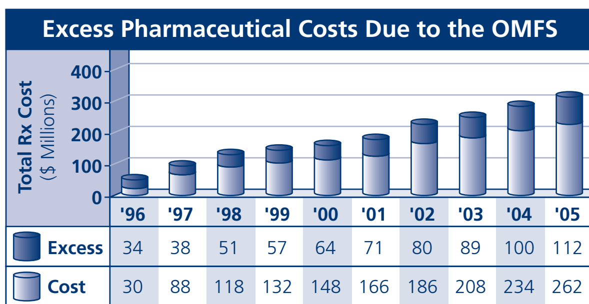
* AWP is an artificial price established by the pharmaceutical industry for each medication and is generally lower than the average wholesale price at which medications are actually purchased.

Several interest groups contend that the high cost of prescription drugs in California workers' compensation is justified because it guarantees access for the injured worker to pharmacists who would otherwise be unwilling to dispense under the OMFS. After extensive analysis, however, the CHSWC study found that the typical injured worker has a choice of five dispensing pharmacies within a 4.5 mile radius of their home address. In addition, there was no reported access problem even in other states that reimbursed workers' compensation prescriptions at significantly lower rates than California.

For its cost analysis, CHSWC compared the California system for reimbursing workers' compensation pharmaceuticals to four other programs: fee schedule systems used by MediCal and the state of Washington, and negotiated rate systems used by Employer Health Benefits and the Washington State Self-Insurance Association.

Among the five systems studied, California currently uses the most generous baseline and pays a premium on top of that. As a result, other workers' compensation systems pay a fraction of the California AWP. Chart 2 shows the Commission's estimates of reasonable pharmaceutical costs for California workers' compensation, as well as the excess costs--the portion of current drug costs that CHSWC says could be saved if the state adopted changes recommended in the study.

Chart 2



	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05
Excess	34	38	51	57	64	71	80	89	100	112
Cost	30	88	118	132	148	166	186	208	234	262

If California reconstructed the OMFS to provide the approximate average of the reimbursement rates accepted by pharmacists in the four other programs — which would mean negotiating contracts at an average of 30 to 40 percent below the OMFS — California employers would pay approximately 70 percent of the current cost. That would save an estimated $64 million on pharmaceuticals in 2000, and a cumulative $516 million by 2005. Under the proposed system, 17 percent of the savings (approximately $11 million in 2000 and a cumulative $88 million by 2005) would result from reduced fees paid as incentives to dispense generics. The remainder would derive from switching from the current AWP.

Recommendations from the CHSWC Study

Based on its findings, CHSWC recommended the following actions:

- Give employers/insurers control over the dispensing of pharmaceuticals for the life of the claim. This involves a commodity transaction that is seamless across all pharmacies. Payers could negotiate group rates with Pharmacy Benefit Managers (PBMs) at substantial discounts from the current rates, eliminating the need for a fee schedule or limiting its use to out-of-state transactions or situations where an injured worker does not have access to a network pharmacy.
- Revise the OMFS to bring it in line with group health plans, Medi-Cal or with other states such as Washington. This would reduce payments for drugs and lower dispensing fees for generics.
- Adopt a rule requiring pharmacists to dispense generics except when the physician specifies "dispense as written." This would eliminate the expensive premium incentive used to encourage the use of generics.
- Create incentives for insurers and employers to approve a limited "first fill" of prescriptions, even if the claim has not been accepted. Adopting such language would protect claims administrators against liability in the event a claim is denied.

What Insurers Are Doing About Drug Costs Today

In June 2002, CWCI surveyed its members regarding current pharmaceutical costs and practices. The Institute obtained responses from 13 members, representing about 70 percent of the California market. According to survey responses:

- About two-thirds of insurers indicated that pharmaceuticals are a major cost driver today.
- Pharmacy costs represented between 4.5 and 11 percent of the respondents' total medical costs in California workers' compensation.
- All respondents actively manage pharmaceutical costs, most with a company-wide program affecting all policies; a few with pilot programs of varying scope.
- About three-quarters of survey participants manage pharmaceutical costs by negotiating rates with a Pharmacy Benefit Manager program, while several do retrospective bill review or use retail drug cards or home delivery programs.
- In general, mail order represents only about one percent of all prescriptions, but when a home drug program is used, 90 percent of the prescriptions are sent via mail order.
- All Pharmacy Benefit Management programs provide some form of discount to the insurer. Typical reductions from the OMFS range from 27 to 40 percent for generic drugs, and 5 to 11 percent for brand name drugs. At best, this brings the price to par with the average wholesale price.
- Handling the first fill does not represent a significant risk for any carrier and is handled in a variety of ways, including:
    - Providing the claimant with a first fill card
    - A phone call from the adjuster to the PBM
    - Sending an overnight data file to the PBM
- While some insurers guarantee the first 10 days of a prescription, others reimburse the claimant only after compensability is determined. A small minority pay the entire first fill in full.

How Today's Pharmacy Benefit Manager (PBM) Programs Work

Services and Functions of PBMs

Most employers (policyholders and self-insureds) currently contract with Pharmacy Benefit Managers (PBMs) to control pharmacy costs, either directly, or indirectly through their workers' compensation insurer. In addition to cost containment, PBMs generally provide the following functions.

- Pharmacy benefit design
- Automated drug processing, including prior authorization and adjudication
- Pharmacy network management
- Mail-service pharmacy
- Drug formulary management
- Drug Utilization Review (DUR)
- Reporting

Some PBMs also include networks of durable medical equipment suppliers and supply other items such as TENS units, respiratory services, hearing aids, and examinations by Independent Medical Evaluators and Qualified Medical Evaluators.

Formulary management entails both establishing and assuring compliance with a list of generic and brand name medications developed by a managed care organization to reduce unit cost. Formularies include medications purchased at discounted rates or associated with rebates. In group health, the patient's co-payment is generally greater for non-formulary medications. Drug Utilization Review (DUR) is a prospective, concurrent or retrospective process of reviewing actual drug usage against pre-established criteria and standards. These reviews help communicate the latest clinical practice and health economics information for a variety of medical conditions. A DUR may include drug contraindications and offer recommendations on

educational interventions to promote appropriate use of prescriptions drugs. PBM reports include such information as drug utilization, claims activity, savings, DUR, therapeutic class analysis, and distributions of generic versus brand drugs.

As a result of this complex mix of services and information systems, an individual covered by a PBM can walk into almost any pharmacy nationwide and get a prescription filled. The PBM information system allows the pharmacist to electronically transmit the information on the member's identification card to the program's online claims adjudication system, where within seconds, the PBM verifies eligibility, plan design and co-payment information. In addition, the PBM's central database contains information about prescriptions the member is taking that have been filled at other network pharmacies, allowing an in-depth analysis of drug-to-drug interactions.

Contracting with a PBM

Generally, an employer (except for self-insureds) contracts with an insurer for all health care costs, including pharmacy, and the insurer subcontracts or "carves in" the PBM to manage pharmacy costs. The PBMs in turn develop and manage a network of pharmacies, usually numbering between 40,000 and 55,000 nationwide. In addition, some PBMs offer customized or regionalized networks. In California workers' compensation, most pharmacy contracts are between the insurer and the PBM.

Alternatively, there is a "carve-out" model where the policyholder contracts with the insurer for the health care benefit, but not the pharmacy benefit, in effect, "carving-out" the pharmacy benefit. In this model, the policyholder, rather than the insurer, contracts directly with the PBM to provide the pharmacy benefit.

PBM Pricing and Incentives

Forming pharmacy networks involves recruiting and credentialing pharmacies, negotiating discounts on drug prices, monitoring pharmacies for quality and customer satisfaction, auditing to prevent fraud and abuse, and providing technical support and training. PBMs also may provide incentives for network pharmacies to increase the rate of generic drug use, and often provide support in the form of software programs, technical support and customized reports for tracking performance, updating patient profiles and learning about new clinical issues, services and programs.

More sophisticated services offered by PBMs include claims audits that review source documents instead of aggregate data to check the accuracy of pharmacy claims and payments. PBMs are striving to improve customer service, which they routinely measure, and to improve quality control procedures to avoid overbilling, rebilling and dispensing fewer pills than prescribed.

Most PBMs offer refill services by mail order, and are beginning to establish contracts with online pharmacies. All of these companies negotiate with retail pharmacy networks to provide drugs at substantial discounts from the average wholesale price. Discounts are usually greater for generic drugs (where they can be as high as 55 percent[2]) than for brand name drugs. In group health, it is not uncommon to see discounts of 13 percent on name brand drugs and 20 to 25 percent on generic drugs, each with a $2.50 to $3.00 dispensing fee. In workers' compensation, discounts from the average wholesale price usually produce smaller savings, partly due to state-designated, wide-open formularies that leave little room for controlling drug utilization and preclude PBMs from obtaining lucrative rebates from pharmaceutical manufacturers for reaching certain utilization targets. In addition, because allowable pharmaceutical reimbursements under workers' compensation are generally much higher than those under group health, a 2 percent discount from the average wholesale price may generate a 40 percent discount from the workers' compensation fee schedule. This gives the appearance of a "large" discount, even though the allowable fee is still more than what would be paid under group health.

Perry Cohen, CEO of The Pharmacy Group, has noted changes in the primary functions of pharmacy benefit managers since the 1990s.[3] In the '90s, PBMs reduced administrative costs by providing automated claim submissions, then produced further savings by reducing the unit costs of drugs – initially by obtaining discounts from retail pharmacies, and more recently by increasing the use of generics, formularies and rebates on brand name

drugs, which also helped cut down on the use of inappropriate drugs. However, by the mid-90's, when employers were regularly carving out pharmacy benefits for their employees, the large PBMs inappropriately convinced payers that reduced administrative costs and pharmacy network discounts offered the biggest opportunity for savings. These discounts, however, represented only 2 to 3 percent of the workers' compensation pharmaceutical budget. The big dollars were in over-utilization.

The PBMs have been effective at ratcheting down drug prices, but at the cost of decreasing compensation for pharmacists and increasing administrative work for physicians who must deal with rigid formulary requirements. In addition, higher co-payments and three-tier co-payments* have shifted more of the costs to the consumer, except in workers' compensation, where there are no co-payments.

With pharmacy benefits rising to 25 percent of the health care dollar by 2010, Cohen forecasts that PBMs will need new products and services to meet client needs. Information technology and disease management will be a key part of this. The initial foray into electronic or e-prescribing, offered as stand-alone software for a handheld device, has not been widely adopted,[4] but, a number of Web-based prescribing programs are gaining traction for use with desktop or laptop computers in the office. In addition, with the push from the Leapfrog Group** for Computerized Physician Order Entry, more institutions are installing these systems.

Disease management, a specialized form of utilization management that involves protocols for physicians and care managers, now plays a major role on the group health side, with payers carving out care for such diverse conditions as asthma, heart disease, cancer and kidney failure. In addition to the disease management programs offered by some of the large pharmaceutical manufacturers, which generally center on their product line of medications, there are many independent organizations offering disease management services. Some PBMs also are entering this arena. To date, however, the PBMs have not incorporated disease management concepts into the programs they offer in the workers' compensation market, nor have most of the other vendors concentrated on this area.

PBMs and Workers' Compensation

Despite the consolidation of the Pharmaceutical Benefit Management industry in recent years (the top three companies, MerckMedco, AdvancePCS and Express Scripts, now account for 75 percent of PBM enrollment) there are many PBMs competing for the business of workers' compensation insurers. Most have networks comprising 40,000 or more of the nation's 56,000 retail pharmacy outlets. Generally, payers update their compensable claim files daily and send the PBMs electronic file transfers in a standard format developed by the National Council for Prescription Drug Programs (NCPDP). The PBMs in turn update their systems so that all network pharmacies have a reasonably current list of compensable claims. Once a claimant is listed in the system, he or she can fill or refill a workers' compensation prescription at any network pharmacy. This data will constitute "protected health information" under privacy regulations promulgated under the federal Health Insurance Portability and Affordability Act (HIPAA).***

However, injured workers often fill the first prescription ("the first fill") before the insurer has determined compensability. Generally there are two ways that injured workers can obtain a first fill.

1. **ID Card:** Payers often provide emergency packets to employers that are given to the injured worker by the manager at the time of injury. These packets include a list of network pharmacies and a pharmacy ID card that the claimant presents to the network pharmacy. With some PBMs, the cards are valid for a fixed period, usually 30 to 90 days. In other networks the card is merely used as a form of identification, and all eligibility information is updated and stored in the network computer.

   Alternatively, the adjuster may inform the PBM of a new compensable claim by phone, or the payer may send a nightly download of compensable claims to the PBM. Once the PBM receives notification of the claim, it mails the ID card to the claimant. In some instances, the PBM will phone the authorization number to the adjuster or directly to the pharmacist.

* Tier I: Generic drugs with the lowest co-payment. Tier II: Preferred Brand has a slightly higher co-payment. Tier III: Non-Preferred Brand: highest co-payment. In addition, some plans now call for a pharmacy deductible, a so-called fourth tier.

** The Leapfrog Group is an organization of Fortune 500 companies that works with medical experts throughout the U.S. to identify problems and propose solutions to improve hospital systems. It represents more than 31 million health care consumers in all 50 states.

*** HIPAA privacy regs take effect April 14, 2003. Although certain workers' comp data is excluded, so that employers can still know about their employees' injuries, pharmacists would be precluded from releasing protected health information to other third parties without patient consent.

2. **Go Bare:** The claimant also may go to the pharmacy with no information, informing the pharmacy that this is a workers' compensation claim. In this case, the pharmacy has two choices:

    a. It can send the bill to a "third party biller," a company that factors account receivables for pharmacies. These companies buy the workers' compensation claim from the pharmacy, find the correct payer, and submit the claim to them. The third-party biller keeps the difference between the state fee schedule and what they pay the pharmacy.

    b. Alternatively, some pharmacies may keep the bill until they learn which PBM is adjudicating the claim, then send the bill to that PBM. In the small likelihood that a claim is not compensable (about 2 percent of the claims), many PBMs will pay the bill anyway.

In still other situations, the payer may guarantee the "first fill" to the pharmacy, then bill the PBM when the claim is deemed compensable. In the event the claim is not compensable, the payer will either seek payment from the group health carrier or assume liability for that payment.

Fees and Discounts

Table 1 shows the pharmaceutical reimbursement formulas from the current California fee schedule.

Table 1

California OMFS for Pharmaceuticals		
Type of Drug	**AWP plus**	**Dispensing Fee**
Generic drugs	40%	$7.50
Brand name drugs	10%	$4.00

PBMs currently offer discounts from the OMFS that bring the cost of generics close to the average wholesale price for generics and brand name drugs, with dispensing fees in the $3.50 to $4.00 range for all drugs. Discounts can be up to twice as much for home delivery. All PBMs negotiate discounts with their network pharmacies. Some pass the entire discount on to the payer, some pass on only a portion of it. The discounts are universally greater for generics than brand name medications.

Formulary Management

Formulary management is becoming more common as well. The formularies that PBMs have created for workers' compensation are mainly pain management formularies. Formulary compliance and Drug Utilization Review approaches vary from the very simple, "if it's not a pain medication we deny it," to the more sophisticated, where there is screening for multiple concurrent drugs of the same class, narcotics filled at multiple pharmacies, etc. However, workers' compensation regulations like those in California that allow almost all drugs and devices make it difficult to manage this aspect of pharmaceutical care. In addition, labor and other groups oppose closed formularies.

Mail Order

While all PBMs provide for mail order and online pharmacy, most limit this to a very small portion (often in the range of 1 percent) of their total workers' compensation business. Almost all mail order business in workers' compensation is for chronic cases. Discounts from AWP are always greater for mail order since the PBMs do not have to pay any fees to the retail pharmacy. PBMs are in a difficult position, however, because they can negotiate larger discounts if they provide greater volume to the retail pharmacies, which may be why mail order accounts for such a small percentage of the business. In addition, mail order takes greater coordination by the PBM. On the other hand, some workers' compensation PBMs do a majority of their business as mail order, dispensing 90-day supplies at once via the mail.

Occupational Medicine Clinics

Occupational medicine clinics provide an interesting dichotomy. Some dispense drugs directly, charging the fee schedule plus the dispensing fee, and therefore do not work closely with the PBMs. These clinics directly dispense the vast majority of workers' compensation prescriptions for their clientele since most workers' compensation prescriptions (estimated at 80 to 90 percent) are one-time fills. These clinics also may do the refill if the claimant returns to the clinic for follow up.

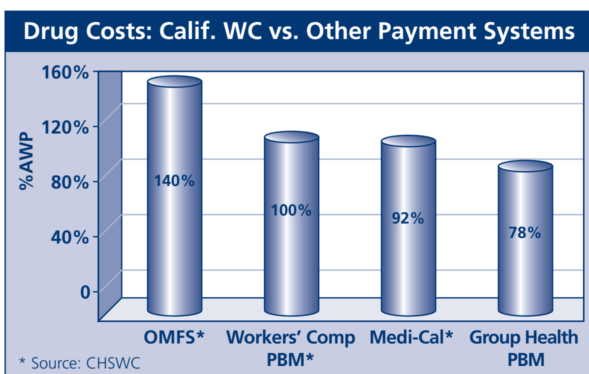
Other occupational medicine clinics work closely with PBMs. One of the "big three" PBMs is

currently running a pilot, installing free e-prescribing software in some of these clinics. It is likely that the physician's office staff rather than the physician will interact with this software. Even so, PBMs argue that on-line ordering of drugs by the clinics will simplify formulary adherence and allow better and faster tracking of both medication usage and physician prescribing patterns.

Workers' Compensation PBM Cost Differential

Despite PBMs, the cost of drugs in the California workers' compensation system remains substantially higher than in group health and federal workers' compensation programs. As shown in Chart 3, even with the use of PBMs, drug costs in workers' compensation often exceed drug costs in group health by 20 percentage points or more. Why is this?

Chart 3



Four factors are commonly cited as reasons for higher drug costs in workers' compensation, though none seems justified:

1) *Workers' compensation involves an additional administrative burden.* However, when using a PBM, pharmacy processes are the same as in group health, with retail pharmacies interacting with the PBMs just as in group health.

2) *In workers' compensation, pharmacies are at risk for the cost of the first fill.* But, as indicated previously, a variety of arrangements protect the pharmacies against this loss.

3) *Fewer pharmacies are willing to fill workers' compensation prescriptions.* In reality, the contrary is true. Most PBMs participating in workers' compensation have large national pharmacy networks that generally include more than 90 percent of retail pharmacy outlets (just as in group health).

4) *A portion of the savings that PBMs provide to insurers is based on formulary management and compliance.* It should be noted, however, that formulary savings are usually in addition to savings obtained from discounts. Formularies limit the number of similar agents that a plan offers, thereby allowing the payer and/or PBM to negotiate volume-contingent discounts or rebates from the pharmaceutical manufacturer. For example, a group health formulary might include only one of the two new COX-2 Non-Steroidal Anti-Inflammatory Drugs (Vioxx® and Celebrex®), but not both. The wide-open formulary mandated for California workers' compensation does not currently allow this type of restriction. With the advent of AB 749, a more restrictive formulary may be possible.

In summary, none of the four explanations typically cited as reasons for higher prescription drug costs in California workers' compensation stand up to close scrutiny. It may simply be that the 20 percent cost differential between group health and workers' compensation reflects the greatly reduced purchasing power of workers' compensation payers compared to group health payers.

The Future

A number of factors will impact the delivery of pharmaceutical drugs in the California workers' compensation system over the next several years. Important trends are developing in five areas:

- New medications
- New regulations
- Technical advances
- Direct-to-consumer and direct-to-physician advertising
- Next-generation medication management

New Medications

Drug companies are developing and testing new and expensive medications at a rapid rate. Most are

genetically designed drugs that treat specific conditions that are not relevant to workers' compensation. On the other hand, new formulations of old medications, such as sustained release oxycodone (Oxycontin®) have already had a major impact on workers' compensation pharmaceutical costs, with this one medication representing up to 10 percent of total medication costs in some areas of the country. Among the new drugs, COX-2 selective NSAIDs such as Vioxx® and Celebrex® have become significant cost drivers, accounting for 2 percent of all prescriptions and 3.7 percent of pharmaceutical costs in the CHSWC study. More are on the way, as two similar medications slated to be released in the near future will likely replace some of the older, non-specific NSAIDs that have a high frequency of gastrointestinal disturbances. Furthermore, new and expensive brand-name medications such as Neurontin are being prescribed for off-label use. Approved for control of seizures, Neurontin is being used for pain control, anxiety, and insomnia, and accounts for about 1 percent of prescriptions and 3 percent of cost. Given that 85 percent of medication costs in the CHSWC study were for pain and musculoskeletal ailments, newer agents will be major cost drivers for the foreseeable future.

New Regulations

Assembly Bill 749 was signed into law in February 2002, with many provisions becoming effective as early as January 1, 2003. Under this legislation pharmacies (but not doctor's offices, clinics, or hospitals) will be required to dispense a generic equivalent where available unless the prescribing doctor states otherwise in writing.

The law requires the Administrative Director of the Division of Workers' Compensation to adopt an official fee schedule for pharmaceuticals by July 1, 2003. The schedule is to establish a maximum for pharmaceuticals and supplies, include a single dispensing fee, and provide access to a pharmacy within a reasonable distance from the worker's home. However, the Division's budgetary constraints may forestall this.

Assembly Bill 749 also authorizes employers and insurers to contract with pharmacies or PBMs to provide medicines and supplies to injured workers. These contracts must comply with standards adopted by the Administrative Director, the goal of which is to reduce pharmacy costs and assure reasonable access for injured workers. The thrust of Labor Code Section 4602, contained in AB 749, is that prescriptions can be filled in this manner "notwithstanding Labor Code Section 4600," so claims organizations should only be liable for the pharmacy network or contract rates for any covered cost, regardless of whether or not the prescription is dispensed by a network entity.

Technical Advances

Technical advances will occur on three fronts: some advances will affect the physician, others will affect the pharmacist, and still others will affect the consumer/claimant.

Physicians: Medical providers are slowly adopting electronic medical records and stand-alone prescription systems for their desktop and handheld computers. This trend will likely accelerate due to two factors:

1) The force with which the Leapfrog Group and others have championed an Institute of Medicine study that postulated that there are 44,000 preventable deaths annually[5] due to medication errors. This will drive the use of Computerized Physician Order Entry in hospitals. As an offshoot, as physicians become accustomed to using this technology, they will be more likely to adopt similar order entry or e-prescribing systems in their offices.

2) Both group health plans and workers' compensation organizations are beginning to provide e-prescribing and other clinical tools in physician offices. To the extent that payers or the government subsidizes these tools, the rate of adoption will increase.

The most important factor in the use of e-prescribing by the physician is the ability of the computer (smart system) to interact with the physician when he or she is actually prescribing the medication. For example, if a physician is prescribing an expensive pain medication and a less expensive formulation is available, the computer can prompt the physician instantaneously. Similar prompts are available to avoid drug-drug interactions and allergic reactions, both of which are costly to the

patient and the system. Furthermore, as physicians move to using an integrated Electronic Medical Record (EMR), they will be able to access information that enables them to manage chronic diseases with more efficiency and better results.[6] This will apply to conditions like asthma and diabetes on the group health side, and back and repetitive stress injuries on the workers' compensation side. Understanding how these advances affect physician prescribing behavior will be critical to controlling drug costs in the future.

Pharmacies. Retail pharmacies in the US are already automated and use the NCPDP standard to transmit data. Through their PBMs, they know immediately about drug interactions and allergies, whether a medication is on the formulary or part of a disease management protocol, and the amount of the co-pay. The next step will be to tie the pharmacist to the physician's office so the physician can benefit from current medications that the PBM and pharmacy know about, but which may be unknown to the physician. In addition, the physician's computer will talk to the pharmacist's computer to immediately learn if a prescribed medication is currently in stock at the pharmacy. These and other technological advances will make medications more convenient, safer and less expensive.

Patients/Consumers. Many patients now keep their own version of an electronic medical record. Furthermore, studies in group health show that up to half of all patients now seek health-related information on the Internet. How these advances will translate to the workers' compensation environment remains to be seen.

Improved Benefit Management

PBMs, to the extent they have been used, have begun to lower administrative and unit costs, increase generic substitution, and decrease drug abuse. But workers' compensation will require new approaches if PBMs are to substantially lower drug costs. The general approach of the PBM is to modify the behavior of the physician, the pharmacist or the patient. In workers' compensation, there is little that can be done to modify the behavior of the patient because the primary motivators available in group health — co-pays and deductibles — are absent. The California workers' compensation fee schedule currently pays about $3.50 more for the dispensing of a generic drug than is paid in most other states and in the group health system. Most insurers that have negotiated arrangements with PBMs in California have eliminated a good portion of this generic dispensing premium.

On the group health side, disease management approaches have proved highly effective in lowering both drug costs and the total cost of care. Some PBMs and a number of large pharmaceutical manufacturers and independent companies regularly offer disease management programs for group health. These may hold similar promise for reducing workers' compensation costs, especially for back injuries and chronic pain management.

Advertising to Increase Demand

Each year drug companies spend billions of dollars trying to gain physician "mind-share." Pharmaceutical detail representatives are common figures in hospitals and physicians' offices. They provide extremely effective five-minute communications designed to influence the physician to prescribe their drugs over the competitor's. The newest generation of detailing is known as e-detailing and allows the physician to interact real time over the Internet with a detail rep, instead of the rep coming to the office. Whether this trend will prove effective is unknown at this time.

In recent years, pharmaceutical manufacturers also have greatly increased "direct-to-consumer" advertising, creating patient demand for medications that may not be necessary, or may not be the most cost-effective treatment. On the other hand, it is highly effective: more than half of all patients who ask their physician for a specific medication appropriate for their condition receive it. PBMs and other Managed Care Organizations are countering direct-to-consumer advertising with targeted patient communications. While most of the heavily advertised drugs play only a small role in workers' compensation, some, such as Vioxx® and Celebrex®, now constitute a significant share of workers' compensation prescriptions and pharmaceutical costs.

Disease and Pain Management

The disease management movement in group health has grown rapidly among managed care payers, where it is saving millions of dollars annually. Disease management (DM) is a system that supports both the physician and patient by providing coordinated healthcare communications and interventions that rely substantially on self-care efforts to treat conditions. DM programs have not been widely used in workers' compensation, in part because the financial incentives have not been aligned. However, there are important aspects of disease and pain management programs that have the potential to produce tremendous cost savings in workers' compensation — most notably in the treatment of back injuries and chronic pain.

It is easy to quantify the number of back injuries in workers' compensation: they represent about 25 percent of all claims. On the other hand, ongoing pain is more difficult to quantify. Injuries of all types that do not heal quickly may lead to chronic pain. Since the primary diagonostic code (ICD-9) in workers' compensation databases reflects the original injury, and chronic pain codes are rarely used, most workers' compensation databases cannot identify chronic pain patients. Yet data from the CHSWC study is clear: almost 80 percent of medications prescribed in workers' compensation are for pain. In some parts of the country, a single brand-name opioid (a type of narcotic), OxyContin, accounts for nearly 10 percent of workers' compensation pharmaceutical costs. Table 2 lists 24 of the most common drugs used in

Table 2

Representative Cost Distribution of Common Drugs Used in Workers' Compensation*

Drug Name	% of 2001 Drug Cost	Pain Med (N=narcotic)	Muscle Relaxant	Other
Oxycontin (Hydrocodone, extended release)	9.7%	N		
Celebrex (NSAID)	7.9%	+		
Vioxx (NSAID)	6.5%	+		
Neurontin	5.8%	+		(Anti-seizure)
Hydrocodone/acetominiphen	4.5%	N		
Ultram (tramadol)	3.3%	+		
Soma (Carisoprodol)	2.8%		+	
Duragesic (Fentanyl)	2.0%	N		
Flexeril (Cyclobenzaprine)	1.8%		+	
Ambien (Zolpidem)	1.6%			Sedative
Darvocet (Propoxyphene/acetominiphen)	1.5%	N		
Prozac	1.4%			Anti-depressant
Prilosec	1.3%			Anti-ulcer
Zanaflex (Tizanidine)	1.3%		+	
Skelaxin (Metaxalone)	1.2%		+	
MS contin (Morphine, extended release)	1.0%	N		
Zoloft	1.0%			Anti-depressant
Paxil	1.0%			Anti-depressant
Naprosyn (Naproxen) (NSAID)	1.0%	+		
Effexor	0.9%			Anti-depressant
Percocet	0.8%	N		
Relafen (Nabumetone) (NSAID)	0.7%	+		
Alprazolam (Xanax)	0.7%			Tranquilizer
Prevacid	0.6%			Anti-ulcer
Total	60.3%	44.7%	7.1%	8.5%

* Proprietary source, national workers' compensation insurers. Drugs constituting 60% of workers' compensation pharmaceutical cost for 2001.

workers' compensation cases nationwide. These 24 drugs represent 60 percent of workers' compensation pharmaceutical costs, and the 12 that are used to treat pain (including six narcotic medications) account for 45 percent of costs. Another 6.5 percent of the costs are from anti-depressants, tranquilizers, or other drugs affecting the central nervous system.

Anecdotal evidence suggests a large portion of tranquilizer usage is for ongoing pain, although the exact percent is unknown. According to Fred Uehlein, Chairman of Insurance Recovery Group of Natick, Massachussetts, chronic pain exists in over half of the long-term disability claims and workers' compensation permanent disability awards in which his firm is involved.[7] Other industry estimates indicate that more than 10 percent of workers with soft tissue injuries resulting in at least six months of disability may be on opioids for extended periods of time.[7] More data on the true cost of ongoing pain in workers' compensation is needed to determine the most effective approaches to treatment.

Two Options

There are two options available to workers' compensation insurers to reduce pharmaceutical costs:

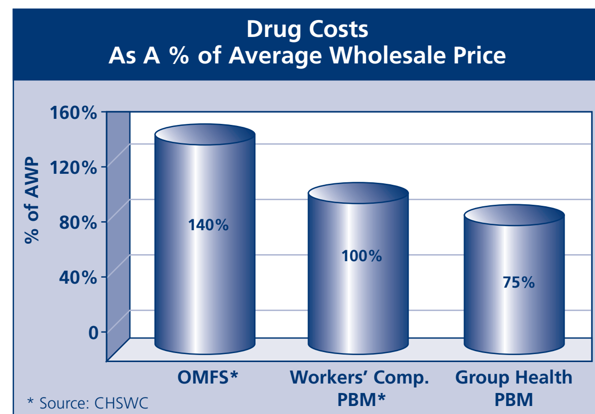
1) Work to pass new legislation reducing pharmaceutical fees under the OMFS so reimbursement rates in California are in concert with other payer groups (group health, managed care) in the state.

Assembly Bill 749 takes effect January 1, 2003, and will permit insurers to collectively purchase pharmacy benefits. It took almost 10 years from the last workers' compensation reform legislation to the passage of AB 749. The political reality is that it will be difficult to pass additional pharmaceutical legislation until the industry has had at least a year to experience the effects of AB 749. With this time lag, pharmaceutical costs will continue to rise. To complicate matters, the DWC is experiencing budget problems and already has a very crowded docket. Thus, it is unlikely that a new legislative solution will be available before 2004 or later.

2) Develop a purchasing coalition of California insurers to contract for improved PBM services at greater discounts.

As documented in CWCI's May 2002 survey of pharmacy costs and practices, most California workers' compensation insurers now use a PBM to manage pharmacy claims and costs. The discounts from the fee schedule that PBMs typically provide significantly reduce workers' compensation pharmacy costs (Chart 4, first and second bars), as PBM reimbursement levels generally fall within a few percentage points of the average wholesale price.

Chart 4



However, these rates are still considerably higher than those paid by group health insurers (third bar).* Based on CHSWC cost projections, this differential will cost California workers' compensation payers $75 million annually by 2005. By combining purchasing power, payers should be able to achieve two important objectives: reduced price and improved performance.

While forming a purchasing coalition would improve the odds that insurers can reduce drug costs, developing such a coalition might prove difficult. Insurers have differing interests, and such a coalition might require some national insurers to contract with one PBM for California claims and a different one for the rest of the country.

Insurers would need to select a vendor that is able to work with a diverse group of California payers to "carve out" the pharmacy benefit. This model has worked very effectively in purchasing coalitions on the group health side. By negotiating specific contracts that include more robust discounts, as well as more customized services such as e-prescribing, enhanced reporting, compliance and Drug Utilization Review benefits, payers would greatly expand their ability to address pharmaceutical and medical supply costs through market forces.

* In group health, discounted prices are typically 5 to 20 percent less than the AWP, with formulary discounts saving another 15% beyond that.

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