

**managed
care matters**

CHANGING THE LAWS OF SUPPLY AND DEMAND TO CONTROL PRESCRIPTION DRUG COSTS

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Pharmaceuticals are an important element in providing quality health care today. They enable clinicians to treat far more conditions, to help prevent catastrophic health-care events, and to keep people healthier. Ultimately, use of pharmaceuticals controls costs. If not managed properly, however, workers-compensation-related pharmaceutical use can mean runaway claim costs and reduced return-to-work rates.

Managed care programs already address obvious workers compensation cost drivers, such as excessive or inappropriate diagnostic testing. A program that would routinely allow an x-ray for a back injury might require specialized circumstances to approve an MRI. Why not apply a similar program to

pharmaceuticals that will flag a doctor's prescription for OxyContin when Tylenol or acetaminophen with codeine might be just as effective?

Prescription drugs represent a growing percentage of workers compensation medical costs. Pricing is part of the problem, but utilization is by far the larger issue. Pharmacy benefit management programs, which involve switching patients from brand names to generic medications or creating pharmacy formularies, can help control costs. However, to get significant and sustainable results within workers compensation, employers need to target both the supply of and the demand for prescription drugs.

A DIFFICULT PILL TO SWALLOW

The extent of the prescription drug problem has been well documented. According to recent data from the National Council on Compensation Insurance (NCCI), in the five years between 1997 and 2002, prescription drug costs per accident year increased from 10.1 percent to 12.1 percent of total workers compensation medical costs.¹ NCCI predicts that, by 2011, the purchase of prescription drugs will comprise nearly 15 percent of total national health-care spending.² In other words, the trend of rising prescription drug costs in workers compensation is unlikely to turn around in the near future.

According to NCCI data, between 1990 and 2004, the average prescription cost increased from \$17.20 to \$74.94.³ Several factors drive costs. One of these is the emergence of direct-to-consumer marketing by pharmaceutical companies. This strategy drives demand for brand-name drugs over generics by creating the perception of superior quality. Another factor is off-label use, such as prescribing the antiepileptic drug Neurontin to manage pain, Botox injections to numb back spasms, or the narcotic analgesic Actiq, currently labeled for cancer patients with breakthrough malignant pain, to manage non-cancer-related pain. This practice typically requires a brand-specific prescription, as no generic is available for the particular off-label use.

Some frequently prescribed drugs, such as the narcotic analgesics, have the potential to create a range of problems, including dependence, addiction, or other misuse, and even altered ability to perform — any of which could actually hinder productive return to work. And narcotic analgesics aren't the only class of drugs that can cause problems. Even medications that were previously considered benign pain drugs can have undesirable side effects. For example, prescription COX-2 inhibitors had long been the first treatment choice to control pain. However, several of these medications have now been withdrawn from the market because they have been associated with

increased cardiovascular events. Vioxx was voluntarily withdrawn from the market in late 2004, followed by Bextra in April 2005. Celebrex now has a black label warning. The FDA also does not allow COX-2 manufacturers to market directly to consumers because of these concerns.

Other social and economic factors that contribute to increasing workers compensation costs for prescription drugs include an aging workforce that is more likely to become injured, increased availability of medications, and a growing societal mindset that demands a quick fix without much effort. Today's injured employees are more likely to expect — and today's physicians are more likely to prescribe — pain medication as part of the treatment plan. Finally, increased access to prescription medications through insurance coverage has made their large price tag invisible to consumers, reducing any incentive on the part of injured employees to help control drug costs.

LIMITED IMPACT OF TRADITIONAL APPROACHES TO COST CONTROL

In early 2005, Archestral, an Ohio health-care data analysis firm, conducted an audit of 2 million paid workers compensation prescription claims.⁴ It found that 20 percent of prescription drug payments contained at least one error, such as drug purchases that conflicted with the compensable diagnosis, incorrect pricing, or provision of a brand name when a generic was available. Pharmacy benefit management programs can offer drug utilization review to spot such errors and to control other problems such as contraindicated drugs, duplications, and prescriptions that are refilled too soon.

Pharmacy benefit management also provides a means to control prescription drug costs through negotiated pricing. Drug reimbursement schedules provide another tool. Currently, 28 states mandate such fee schedules, and some of these states have recently reduced allowable reimbursements. Of the remaining states, more are likely to add drug reimbursement schedules. Despite these differences, most reimbursements are determined by a formula linked to the average wholesale price. According to NCCI, workers compensation pays an average of 125 percent of the average wholesale price; group health pays an average of 72 percent.⁵ Therefore, there are distinct advantages for a workers compensation program to be linked with a pharmacy benefit management program or a health plan.

On the group health side, significant savings may be obtained through use of generic equivalents whenever appropriate. However, this approach is associated with only limited savings for workers compensation. This is mainly due to differences between the systems in the types of drugs being

prescribed. NCCI research shows that more than half (55 percent) of the drugs prescribed in workers-compensation-related care are painkillers, followed by muscle relaxants (20 percent) and antidepressants (14 percent).⁶ This makes the workers compensation system particularly sensitive to trends, such as the introduction of new brand-name blockbusters, in those key categories. In contrast, no single drug category dominates on the group health side. The top category, cardiovascular agents, represents only 18 percent of prescriptions.

A look at data for prescriptions paid by workers compensation shows that of the top ten prescribed drugs, five have no generic equivalent.⁷ These brand-name-only drugs account for more than half of workers compensation pharmaceutical costs. However, more medications are going generic over the next year or two. This may offer some savings opportunities in the not-too-distant future.

The good news: When generics are available, they are prescribed at an increasingly high rate for workers compensation claims — from 79 percent of the time in 2001 to 86 percent of the time in 2002.⁸ The bad news: Workers compensation pharmaceutical costs are still rising despite the relatively high and increasing use of generics. In fact, NCCI estimates that the potential savings from use of available generics is only about 7 percent in the workers compensation market.⁹

If pricing controls don't provide a far-reaching solution, what other tools do employers have? The answer seems to lie with managing both the supply and the demand for medications.

SUPPLY-SIDE ECONOMICS

If there is an upside to the unique nature of prescription drugs in workers compensation care, it is that the possibility exists to make a significant impact on costs by focusing on a handful of drugs. According to the Medical Services Company, of Jacksonville, Florida, 16 to 18 drugs account for approximately 50 percent of workers compensation prescription drug costs, and 80 drugs drive 75 percent of costs.¹⁰ NCCI data drive the point home even harder. In its 2004 Workers Compensation Prescription Drug Study, NCCI listed 10 drugs that accounted for 42 percent of total workers compensation prescriptions paid. Although the specific names on the list may change from year to year, the trend seems to be clear: A few blockbuster drugs drive costs.

While pharmacy benefit management programs offer group-buying power that can result in discounts, effective action must address more than just the price of the drug. The same thought process used in evaluating any other kind of treatment applies to drug management. When a prescription

is written for an expensive brand-name drug, asking whether a different, less costly drug might be equally effective may result in savings. If the more expensive drug helps avoid the need for surgery and a generic drug would not have the same result, the expense may be worth incurring. But if the particular drug is not improving the outcome, the prescription should be questioned. Does the injured employee really need a 30-day supply? In the absence of a pharmacy management or utilization management program, the potential for overprescription and overconsumption can be high. Is the prescribed drug likely to cause other problems — such as unwanted side effects, long-term health risks, or conditions that impair productive return to work? For example, putting a truck driver or heavy machinery operator back on full duty while he or she is taking a drug that may cause drowsiness doesn't make sense.

Not all pharmacy benefit management programs will tackle the supply-side problems giving rise to burdensome prescription costs. The most basic service is a formulary that simply excludes drugs that are not to be used in workers compensation cases as a result of utilization reviews for FDA-approved uses. The more effective programs will offer specific controls beyond merely prohibiting use of certain drugs. For example, a pharmacy benefit management system could be set up to flag OxyContin when it is prescribed for longer than five days or when it is prescribed for nonspecific back pain. To help spot abuse, the system could also flag refills. Flagging contraindications and adverse drug interactions might also make sense. Employers may maximize the benefit of the program by using the same pharmacy benefit management program for group health and workers compensation.

A good occupational health network, composed of physicians who have a solid understanding of the role that different drugs might play in returning an employee to work, also tackles the supply-side problem of overprescription. An experienced occupational physician is more likely to be careful about prescribing a drug that might put an employee at risk in the workplace. Similarly, a case manager with an understanding of both the injured employee's duties and his or her treatment plan is better able than a nonmedical supervisor to identify potential modified-duty tasks that are appropriate to the injured employee's capabilities. The case manager would also be well positioned to spot the red flags of a developing drug dependency.

REINING IN DEMAND

The pharmaceutical industry spends billions of dollars each year on marketing and advertising, including direct-to-consumer ads. These efforts

may influence both what drugs physicians prescribe and what employees ask to have prescribed. In the case of employees, advertising by pharmaceutical companies may be the most visible and readily available source of information about any given drug.

To balance the effect advertising has on demand, employers should borrow from group health, where employers and insurers try to make employees more informed health-care consumers by providing information (often online) regarding alternative medications and their costs. Even though the lack of a copay with workers compensation leaves little incentive for employees to request a less expensive drug, employees can still be motivated to assess their own health and productivity risks before requesting or filling a prescription. For instance, educational materials can be used to point out the risks associated with the long-term use of drugs such as OxyContin, particularly for those whose pain has become chronic, and to suggest that many nonsteroidal antiinflammatory drugs may be just as effective. Other educational material could provide injured employees whose pain has become chronic with advice about alternatives to using drugs to manage that pain, such as acupuncture.

Another option for controlling costs is disease management. On the group health side, employers and employees alike often benefit from disease management programs designed to reduce the number of hospitalizations from chronic health issues such as cardiovascular conditions. Similarly, a disease management program for employees with back injuries could help employees manage chronic pain and prevent reinjury. Because back pain is the number-one problem in workers compensation, a program designed to reduce the frequency and severity of back problems could be a powerful tool in the quest to reduce the need for pain medication and to minimize lost time.

“Just-in-time” ergonomics can also be used to prevent reinjury (and thus to prevent even greater prescription costs) by evaluating injured employees in the workplace and recommending lifting aids or other worksite modifications.

Another part of undermining demand may be analyzing and acting upon group health data, particularly in the case of back pain. For example, the onset or precipitating cause of a back injury is often difficult, if not impossible, to determine, and employers can probably assume that there is some degree of cost-shifting from group health to workers compensation, particularly if the workers compensation benefits are more generous. An analysis of group health claims — specifically, of use of pain medications — might point to the beginnings of a back problem that could benefit from case management

intervention. Of course, this approach assumes that the employer's benefit teams are working collaboratively. A common pharmacy benefit program for group health and workers compensation would make it possible to flag certain medications on the group health side that may alert employers to trends that might indicate the beginnings of future workers compensation claims. In such cases, initiatives that traditionally fall under the umbrella of group health — such as weight management — might minimize the risk of back injury and, therefore, benefit the workers compensation program.

The ultimate way to reduce the demand for expensive medications is to eliminate the need for them altogether through effective safety programs and perhaps an ergonomic analysis to correct environmental factors that have caused injuries in the past.

LOOK AT ALL PARTS OF THE BIG PICTURE

If left unmanaged, the problem of rising prescription drug costs in workers compensation is not going to improve. Price reductions and availability of generics alone won't fix it. As today's brand-name favorites lose patent protection, they are sure to be replaced by new, heavily promoted drugs that carry a premium price tag. To keep the supply in line, employers need pharmacy benefit management programs that have more sophisticated tools than the standard program for drug utilization review and management. In addition, use of an occupational health network can help ensure that treating physicians understand how medications influence an employee's ability to return to productive work. To manage demand, employers need to educate employees about workplace safety and responsible prescription drug use, seek an ergonomic analysis of the workplace, identify early signs of work-related injuries through group health data, and utilize case and disease management. Managing the demand and the supply across all benefit areas is most likely to attain the best results.

ENDNOTES

1. NCCI, *Workers Compensation Prescription Drug Study — 2004 Update* (2004): 1.
2. NCCI, *Prescription Drugs: Comparison of Drug Costs and Patterns of Use in Workers Compensation and Group Health Plans* (2003): 1.
3. Medical Services Company, 2005 proprietary data.
4. Rousmaniere, P., "Prescription for Inflation," *Human Resource Executive Magazine* (Aug. 18, 2005).
5. NCCI, *supra* note 1, at 2.
6. *Id.*
7. *Id.*

8. *Id.*
9. *Id.*
10. Medical Services Company, *supra* note 3.

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