In 2006, drug costs accounted for an estimated $5 billion of the total $35 billion in medical expenses in workers’ compensation. In fact, drug costs represent the single largest contributor to workers’ compensation medical inflation, according to Health Strategy Associates (HSA), a national consulting firm specializing in managed care for workers’ compensation.

Workers’ compensation insurance payers can pay on average 125% of AWP (Average Wholesale Price), based on a national estimate of Fee Schedule and Usual & Customary pricing. This compares to the 72% average rate paid in the Group Health markets, according to a 2006 Workers’ Compensation Research Institute (WCRI) report.

A range of factors is influencing the drug spending curve in workers’ compensation. Here are some examples:

- Injury severity of older workers’ is rising, which can lead to a greater tendency for drug intervention.
- More of the working population is without health insurance, which can influence claim-filing.
- Physician prescribing patterns are changing, including a shift to off-label prescribing which adds expense.
- Brand license patents on some major drugs are expiring, which can lead to a hike in prices just prior to the expiration date.
- New drugs are constantly entering the market, accompanied by the cost of marketing the brand.
- Workers’ compensation patients have no co-pays or deductibles, diminishing the incentive to save.
- The treating physician, who is paid for service and rarely measured on outcome, has little motivation to consider cost.

Role of generic drugs
The use of generics, which is about one third the cost of their equivalent brand drugs, helps reduce costs, and many pharmacy benefits managers are capturing these savings on behalf of their clients. Cypress Care, Inc., a pharmacy benefits management company (PBM) that focuses on workers’ compensation prescription benefits, processes over 70% of its claims as generic, which compares favorably to the estimated 50-55% generic rate in the group health industry.

Many states are implementing regulations to help curb costs. Some states, for
example, are mandating generic dispensing of drugs, and PBMs are taking advantage. Many claimants receiving these types of drugs, or other opioids, are being treated by primary care physicians, orthopedists, and other specialists whose primary expertise is not in pain management. When their patients complain of excessive pain or other associated symptoms, these physicians may increase dosages or shift patients to more powerful, or other medications instead of offering other available pain management therapies.

Because the physician plays an important role in helping control workers’ compensation costs and patients lacking of ability to influence drug pricing, payers want strategic solutions to address rising costs. They are turning to strong cost management practices to direct utilization, including integrating the physician into the process in a manner that is mutually respectful.

Price of the pill vs. utilization

It is important to recognize that the price of the pill is only one part of the cost of a drug to the workers or compensable injuries. The price can be managed by PBMs pricing strategies, and PBMs are doing so across the marketplace. Utilization, however, is the less obvious and more important component of controlling drug costs, as pointed out in a report by the National Council on Comprehensive Insurance (NCCI).

Through proper PBM management, utilization can be addressed. PBMs, for example, should be monitoring utilization as a key part of their management process and implementing triggers that indicate the following:

- Is the medication being prescribed the best medication for the injured worker at this point in the treatment process?
- Are there equivalent options that are less apt to have untoward side effects or interactions with other parts of the medical regimen?
- Do the drugs allow the injured worker to progress towards a successful return-to-work (RTW), or do they enable or prolong the disability?

A clinical authorization process that engages a physician reviewer to objectively examine the drug regimen.

In the case of high cost claims, the program should initiate a clinical case review where the claimant’s pertinent medical record is examined and recommendations are provided on the entire drug treatment program backed up by professionals with clinical expertise.

Good data mining should be able to “red flag” claimants based on monthly drug usage. A clinical staff can cross-reference pertinent files, contact treating physicians, and other stakeholders are seeking new and better solutions to the fastest component of their medical expenses. It is important for PBMs to lead these initiatives.

Jim Andreuzzi, R.Ph., is the Vice President of Pharmacy Operations for Cypress Care. He received his pharmacy degree from the University of Georgia and has over 25 years experience in retail chain pharmacy. His responsibilities include accountability for pharmacy systems development and support with a primary focus on the utilization of pricing, clinical drug data and managed care claims submission.

Jim is a member of the Georgia and Florida Pharmacists Associations, the American Pharmacist Association, American Society for Automation in Pharmacy (ASAP), Florida Society of Hospital Pharmacists, National Council of Prescription Drug Programs (NCPDP) and the Academy of Managed Care Pharmacy. He is currently licensed to practice pharmacy in Florida and Georgia. In addition, Jim has served as a member of First Databank’s User Advisory Board and liaison for all FDB products and services.

How Frequently are Generic Drugs Used?

<table>
<thead>
<tr>
<th>Year</th>
<th>Brand</th>
<th>Generics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984</td>
<td>86.0%</td>
<td>14.0%</td>
</tr>
<tr>
<td>2006</td>
<td>86.0%</td>
<td>46.0%</td>
</tr>
</tbody>
</table>