

BEYOND AVERAGE WHOLESALE PRICE: NEXT- GENERATION PBM ADDRESSES MULTIPLE COST DRIVERS

BETSY ROBINSON

Today's employers, particularly those in the United States, face a number of challenges, including a shortage of skilled, trained employees. Despite the recent economic downturn, unemployment in the United States remains low — at 4.5 percent for June 2007.¹ An attractive benefits package is a key recruitment and retention tool. In light of the growing reality of global competition, however, the need to offer a robust wage and benefits package often puts U.S. employers at a disadvantage. Steadily increasing health-care costs make the discrepancy that much more notable. In recent years, increases in employer health insurance premiums have significantly outpaced the general rate of inflation. On the workers compensation side, indemnity costs are no longer the greatest cost driver. According to the National Council on Compensation Insurance (NCCI),

medical losses have increased from 45 percent of the workers compensation pie in 1986 to 59 percent in 2006.²

The drivers behind increasing medical costs are no secret. Medical technology is advancing at warp speed — but at a cost. As medicine becomes more sophisticated, the costs of equipment, procedures, and pharmaceuticals all increase. At the same time, changing demographics have a huge impact. As the baby boomer bubble ages, a large segment of the work force is in their mid to late 50s. Health-care consumption is growing in both intensity and volume. On top of that, the average health-care consumer is not actively engaged in making health-care decisions. Considering these trends, medical spending is likely to continue to increase unless there is some intervention.

Costs, however, aren't the only factor that the employer needs to consider in the benefits conundrum. In reality, it is in the employer's interest to provide employees with access to quality health care. For one reason, as mentioned above, when good workers are difficult to find, good benefits make an employer more attractive. Second, and equally critical, is the fact that in today's competitive marketplace, employee productivity must be at its maximum, and that does not occur unless employees are at optimum health. Healthy employees are more productive, and they help their employers become more profitable and better able to compete more effectively.

The savvy employer's goal is to find ways to control medical costs without compromising the quality of care. That goal is paramount, regardless of which system — health insurance or workers compensation — pays the bill. Ultimately, it comes out of the same pocket — and a solution benefits the bottom line. It makes sense, then, to look at integrated solutions where common problems exist.

In the face of increasing medical spending, many employers are looking at pharmaceutical benefits managers (PBMs) as a means to control costs. This article will address the role of strategic pharmacy benefit management — managing utilization in addition to negotiating better prices. It will examine the value that employers can derive by applying the richness of clinical management to their workers compensation pharmacy program and will look at how the next generation of PBMs might evolve in the future to achieve their fullest potential.

FOCUSING ON PHARMACY

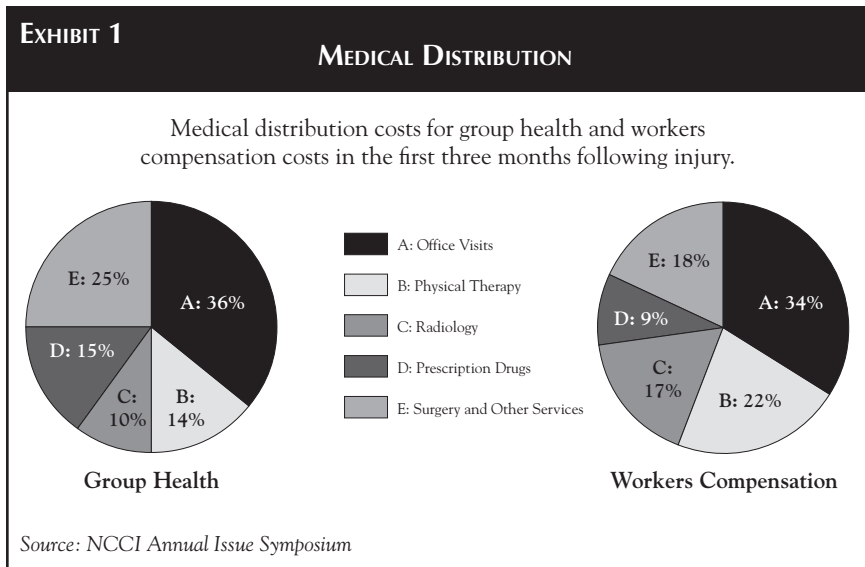
Specialty care, including pharmacy, represents a major cost driver in both health-care and workers compensation medical spending throughout the life of a claim. According to NCCI, in the first three months, specialty

care — physical therapy, radiology, prescription drugs, surgery, and other services — accounts for 64 percent of group health medical costs and 66 percent of workers compensation medical costs.³ (See Exhibit 1.) That makes early intervention critical.

From the beginning of a claim, pharmacy medical spending is significant. For group health, prescription drugs represent about 15 percent of costs during the first three months; pharmacy represents 9 percent of costs for workers compensation injuries in the first three months. The percentage of medical spending on prescription drugs becomes larger as the claim matures, usually due to chronic pain management. In the fourth service year following the date of a workers compensation injury, the share of total medical payments allocated to prescription drugs reaches 18 percent; by year five, 23 percent. In the ninth service year, prescription drug payments represent 38 percent of the medical costs.⁴ (See Exhibit 2.)

Chronic conditions are part of the health-care experience as well, with a similar pattern of an increased percentage of spending on prescription drug costs as the claim ages. Regardless of benefit system, long-term pharmacy costs may be particularly high in instances where a case is not managed well initially, where there are no controls in place for the care plan, and where there is no means of price reduction for ongoing prescriptions.

The health-care system has tools in place to manage pharmacy costs. For example, formularies help guide consumers to use equivalent generic drugs



when medically appropriate, rather than using more costly brand-name versions. Also, pharmacy benefit management (PBM) programs negotiate discounts that can help keep costs down. Utilization review assures that the volume, type, strength, duration, and mix of medications prescribed are appropriate. Bill review is designed to address fraud and abuse, among other issues. Why not apply those and other medical management tools in workers compensation?

It can be done — successfully — although the different nature of the systems demands some differences in approach.

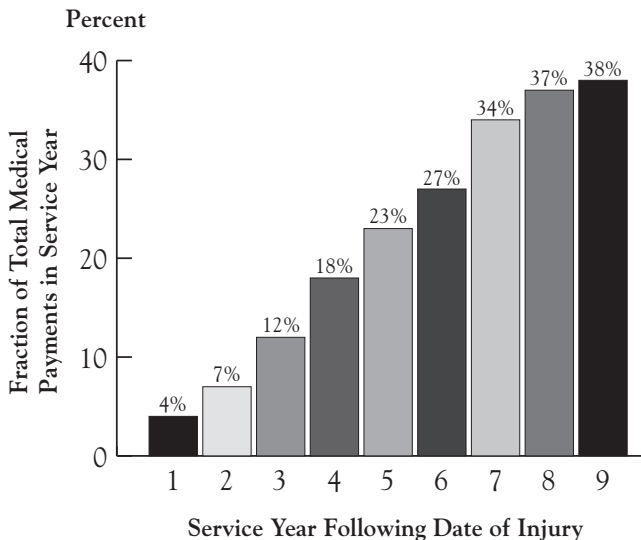
BETTER PRICING IS ONLY A PRELIMINARY STEP

One key issue for workers compensation is the disparity in prescription drug costs when compared to these same costs in group health plans. According to NCCI, it is not unusual to pay 65 percent to 75 percent more for a workers compensation-related prescription than for the same drug in group health.

EXHIBIT 2

PHARMACY COSTS BY AGE OF CLAIM

As a claim ages, pharmacy represents an increasing percentage of medical costs. This chart shows drug costs as a proportion of total workers compensation medical payments. Similar patterns are seen with aging health-care claims.



Source: NCCI Annual Issue Symposium

For example, a national food service distribution company, headquartered in Richmond, Va., was seeing a severe gap in the cost of prescription drug costs between group health and workers compensation. Some workers compensation prescriptions were costing more than two times the prices being charged under group health.

Since implementing a PBM, the company now enjoys the benefit of direct workers-compensation-specific contracts with 45,000 pharmacies across the nation, including both large chains and independent drug stores.

The potential to negotiate better pricing makes utilization of a PBM attractive. However, bear in mind that overall workers compensation pharmacy expenditures are just a small fraction compared to health-care pharmacy spending. On their own, most workers compensation PBMs don't have the buying power necessary to negotiate the deep discounts that health-care PBMs can. Some PBMs rent health-care networks, but don't necessarily pass the savings along to their customers. In order to gain the greatest advantage, employers must seek a PBM that not only has workers compensation expertise, but significant scale on the health-care side, so it can benefit from that buying power. The PBM should have sufficient leverage to deliver discounts below fee schedule in most, if not all, states.

The benefit of contracts is diluted if employees don't use network pharmacies, so it is important to implement processes that facilitate penetration. For example, if the PBM assumes the risk for first fills and guarantees payment to network pharmacies, injured employees are more likely to receive their medications promptly. Multiple points of channeling, such as a robust communications package, adjuster education, case management, pharmacy cards, etc., all direct the injured worker to network pharmacies. Claimants also have incentives to use network pharmacies because they have no out-of-pocket expense. With this approach, some employers see as much as 90 percent network penetration. If a claimant goes to a non-network pharmacy, the PBM can contact the employee to provide the location of nearby network pharmacies and explain the advantages of using a network pharmacy. Depending on the non-network pharmacy used, the PBM may also take the opportunity to contact the pharmacy to initiate a contract. For savings on long-term claims, a mail order program helps control costs of maintenance prescriptions. The PBM will also reach out to its network pharmacies that have failed to bill through the point-of-sale (POS) system because they did not recognize the injured worker as a PBM patient to make certain that they use the POS on the next fill.

BUILDING WITH HEALTH-CARE TOOLS

Negotiated pricing is just a beginning, however. The understanding

of “savings” in pharmacy management is moving rapidly from a focus on per-script discounts to a more comprehensive perspective. For workers compensation, this means attacking pharmacy costs on multiple fronts, as is done with health care, and integrating clinical programs and other tools to manage utilization. This is facilitated by use of the health-care PBM’s electronic POS system at network pharmacies.

For example, the health-care system regularly uses formularies and drug utilization review (DUR) to control access to medications, decreasing the number of prescriptions that are not indicated and reducing inappropriate prescription drug use. If a prescribed drug is not included in a formulary, it can be flagged at the point of sale, and the prescription can be denied. Systematic review of drug-use patterns and cost data can mitigate health and safety risks and can increase fee schedule savings. DUR can be configured with POS system screens for issues ranging from injured worker eligibility to early refills and days supply compliance, to generic substitutions, to drug interactions and therapeutic duplication, to drug/diagnosis issues, to formulary compliance, to price overrides, and even to specific physician issues.

Tying into the POS system provides workers compensation with a mechanism for identifying a) whether the claimant is eligible and b) whether the medication prescribed is appropriate and related to the injury. The formulary can be customized for workers compensation based on injury and body part. Formulary issues can be addressed immediately with the employer, health-care provider, or injured employee as appropriate. Pharmacists are always instructed to substitute generic drugs when available and appropriate. In the event that a prescription does not match the formulary or is flagged for any other reason, the system will call out to the PBM to get prior authorization or other instructions.

Sophisticated technology supports the flexibility to make immediate formulary changes when the data warrants doing so. Changes can be made at the employer, treating physician, claimant, or state levels, among others. Based on the circumstances of the claim, controls can be configured to require that a claimant must receive prior authorization for each new prescription. For example, this might be the case when a claimant who receives multiple or ongoing prescriptions for narcotic analgesics could potentially be at risk of addiction or inappropriate care. Controls might also be appropriate for off-label prescriptions. When a provider prescribes a medication for a use that the Food and Drug Administration (FDA) has not yet approved, the prescription can be denied or short-filled, and the PBM can request a letter of medical necessity before authorizing or

completing the fill. The letter of medical necessity provides the clinical justification for the off-label prescription. It also informs the patient of the off-label prescription, thereby encouraging a doctor/patient discussion and, ultimately, better health-care consumerism. The formulary can also be customized to meet the regulations of a given state. For example, in states where regulations allow for employer choice, the formulary can be configured to flag prescriptions from unapproved doctors. Ideally, a PBM should be able to provide sufficient customization to whatever level of control the customer requires.

An electronic billing system complements the contracts and formulary program and reduces the time and cost associated with handling paper. Retrospective bill review applies discounts to network pharmacy bills and screens for incorrect pricing. Further, if the PBM receives a paper bill from a network pharmacy, it can contact the pharmacy to alert them that the claimant should be processed through the electronic POS system.

When the national food service distribution company, mentioned earlier, adopted the integrated PBM program, it launched the program for new claims only. Beginning in July 2006, all new workers compensation claims were processed through the new PBM program. By July 2007, the company had achieved a generic fill rate of 89 percent and a 99 percent network penetration rate. Its overall savings for workers compensation pharmacy costs were 22 percent. The next step is retrospective DUR—review of older claims by a clinical pharmacist. Recommendations might include reaching out to a prescribing physician to discuss future pharmaceutical care and/or use of mail order for long-term medications.

NARCOTIC ANALGESICS: A POTENTIALLY PAINFUL PROGRAM

Pain management is more often than not a key factor in workers compensation cases, so it makes sense to take a close look at narcotic analgesics and their impact on costs and productivity. In the United States, prescription drugs account for 25 percent to 30 percent of all drug abuse, and 31 million Americans take painkillers without a medical need.⁵ According to statistics from the National Institute on Drug Abuse, employed drug abusers cost employers twice as much in medical and workers compensation claims as their drug-free co-workers. Absenteeism among drug abusers is 66 percent higher, health-benefit utilization is 84 percent greater, and disciplinary actions are 90 percent higher.⁶ Clearly, not all use of narcotic analgesics leads to abuse. On the other hand, 71 percent of all illicit drug users aged 18 and older — 7.4 million adults — are employed, and most of them full-time.⁷ What's more, drug abusers could have a negative impact on productivity.

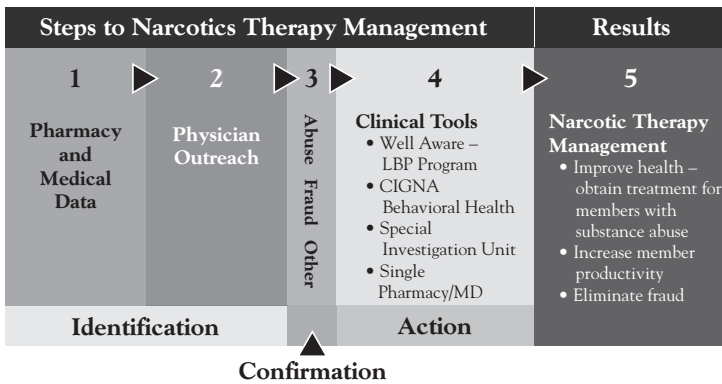
All of this makes narcotics worth a special focus, particularly early in the life of the claim, so potential problems and appropriate interventions can be identified. It also makes narcotic therapy management an ideal area for integration of group health and workers compensation data.

A proactive narcotic therapy management program can help reduce overutilization of narcotic analgesics, identify possible fraud and abuse, and help treating physicians align appropriate clinical care. (See Exhibit 3.) An analysis of historic data on events where narcotics were a dominant issue reveals a clear pattern of events in the early part of a claim that can predict future problems. Prompt identification of these potentially problematic claims can help mitigate the financial impact and support a more positive clinical outcome.

A recent study by The National Center on Addiction and Substance Abuse found that 40 percent of providers do not ask about prescription drug abuse when taking a patient’s health history, and 33 percent do not regularly call or obtain records from the patient’s previous physician before prescribing a controlled substance.⁸ Analysis of claims data identifies employees who may be abusing painkillers, so they can be directed toward

EXHIBIT 3 NARCOTICS THERAPY MANAGEMENT PROGRAM OVERVIEW

Prescription drugs account for between 25% – 30% of all drug abuse in the U.S. and an estimated 31 million Americans have used painkillers without a medical need.¹



1. Reigier, D.A., W.E. Narrow, D.S. Rae, et al., "The de facto U.S. mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services," *Archives of General Psychiatry* 50, no. 2 (February 1993): 85 – 94.

much-needed treatment. In one case, in just three months, an individual obtained 43 narcotic prescriptions from 8 different pharmacies, prescribed by 23 different medical providers. Within a six-month period, the same individual incurred \$54,935 in medical costs, with 46 emergency room visits, 7 MRIs, and 17 office visits. For individuals such as these, interventions could include case management, referrals to behavioral health services, and admission into methadone or buprenorphine management programs. Other options include locking the individual into a single pharmacy or a pain management single provider. Depending on the claim, referral to a disease management program, such as a program for low back pain, might also be appropriate.

A Special Investigative Unit addresses potential instances of diversion, fraud, or abuse and other indicators of multiple problems with narcotic care — for example, filling frequent high-dosage narcotic prescriptions from a single provider, dosages not being tapered off over time, or fraudulent written prescriptions.

The program flags individuals who, within a three-month period, receive multiple prescriptions for controlled substances, including at least one narcotic prescription with fills at multiple pharmacies, prescriptions from multiple providers, or very large quantities of a single controlled substance. To ensure that patients who have a legitimate need for these pain medications have access to them, the program excludes patients diagnosed with cancer, HIV, end-stage renal disease, or sickle cell anemia, and those in hospice care.

EVOLVING TOWARD OPTIMAL OUTCOMES

Today, most PBM activity in workers compensation is focused on processing and discounting. Adding analytical capability and predictive modeling brings it to the next level. Using pharmacy data to trigger medical management interventions in workers compensation cases makes sense, and not just in instances of drug abuse. Pharmacy data can often serve as the proverbial “canary in the coal mine,” pointing toward a treatment plan that is not optimal. In such a case, a peer-to-peer discussion might be in the employee’s best interest. The key to applying these health-care tools and clinical expertise to risk management lies in creating interventions that make sense in the workers compensation arena.

The next logical step is to integrate both health-care and workers compensation data to get the complete plan of care for the employee as well as the complete pharmaceutical experience for the employer. The benefits of tools such as DUR could be maximized by housing both workers

compensation and group health DUR in the same system. Having access to pharmacy data on both sides of the house serves as a safety measure, because it makes it possible to flag a wider range of potential problems. For example, an integrated pharmacy system could spot therapeutic duplications or potentially dangerous drug interactions that might occur when one provider prescribes a potent painkiller for an injured employee who is already taking a sleep agent from another prescriber. In such a case, the pharmacy data could trigger a medical management intervention, such as letters to both providers making them aware of the situation. In another case, an injured employee might not receive any pain medication from the workers compensation physician that would interfere with the employee's ability to run machinery. But if that same employee is receiving a sleep agent from a family doctor, it might influence how the employee is managed back to work. Having full access to the data could make a big difference.

Too often, an injured employee is seen as a pulled muscle, a slipped disk, or a broken leg when, in fact, he or she is an individual with a past and current medical history — multiple issues that could impact the outcome of the injury. The body doesn't know or care which benefit line is paying for treatment. The traditional bifurcated approach, which segregates people into "injured employees" and "health-plan members" does a disservice by ignoring the big picture. Too often, the result is less-than-optimal outcomes and excessive and unnecessary costs. All of this is not to say that moving toward integration is not without its challenges. Some controls that are inherent in a health plan do not readily translate in the workers compensation arena. Case management, peer-to-peer discussions, and other techniques are more appropriate. It will also be necessary to determine where in the process any outreach should occur for maximum impact. Most important, it will be critical to establish protocols that ensure the privacy of each individual's information and that comply with the Health Insurance Portability and Accountability Act (HIPPA) and other relevant regulations. There are also technological issues associated with integrating data. For this reason, it is likely to be difficult for two companies to partner on an integrated system. A single entity may be able to integrate data more quickly and easily.

ANY BEGINNING IS A STEP FORWARD

For most employers, a completely integrated health-care and workers compensation system is years away, if it's on the horizon at all. Perhaps the best approach is to evolve toward it, implementing integrated solutions in areas, such as pharmacy benefits, where common problems exist. To

that end, it is important to recognize that today's PBM programs can do more than merely deliver discounts. If the PBM is based on robust clinical competencies and programs to manage pharmaceutical care, as well as discreet competencies in workers compensation and in health care, the program can not only save direct pharmacy costs, but can support better outcomes and promote a healthier and more productive work force. The more closely the workers compensation PBM is integrated with the corresponding health-care PBM, the greater the focus on the employee as a whole person rather than as a cluster of injuries or symptoms, and the greater the benefit to the individual employee, the work force as a whole, and, ultimately, to the employer.

ENDNOTES

1. U.S. Bureau of Labor Statistics, July 2007.
2. National Council on Compensation Insurance, Annual Insurance Symposium 2007.
3. Id.
4. Id.
5. Reigier, D.A., W.E. Narrow, D.S. Rae, et al., "The de facto U.S. mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services," *Archives of General Psychiatry* 50, no. 2 (February 1993): 85-94.
6. National Institute on Drug Abuse, *Research on Drugs and the Workplace: NIDA Capsule 24* (Rockville, Md.: U.S. Department of Health and Human Services, 1990).
7. Id.
8. National Center on Addiction and Substance Abuse.

Betsy Robinson is assistant vice president of product management and development at Intracorp, a Philadelphia-based provider of disability management solutions that prevent injuries and illnesses, ensure appropriate care, and reduce unnecessary medical and lost-time costs. She develops solutions for employers who are seeking occupational and nonoccupational lost-time management solutions, ranging from total absence management to benefit-specific interventions. She also has experience as a vocational case manager and rehabilitation supervisor. Robinson holds a bachelor's degree from Temple University and a master's degree in counseling from Villanova University.

Reprinted with permission from The Journal of Workers Compensation
Volume 17, Number 1; Fall 2007.

Copyright 2007, Standard Publishing Corp., Boston, MA.

All rights reserved.

www.spcpub.com