

Managing Workers' Compensation Drug Costs

Lessons Learned



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- The Workers' Compensation Primer
 - Why WC is different from group health
 - Why managing WC drug spend is different
- Industry's views on managing drug spend
 - Drivers
 - Solutions
- Where the industry is heading
 - Clinical management
- Results
- One Company's experience
 - JI Companies' Drug Management Program

Summary of workers' compensation insurance

- Mandatory benefit in 49 of 50 states
- Developed in 1913 to end litigation for industrial accidents
- Covers all reasonable and necessary medical expenses and a portion of wage replacement for injuries or illnesses arising out of or during the course of employment
- Total workers' compensation premium and equivalents in 2005 was \$83 billion
- Total medical expenses in 2005 were \$32 billion
 - Rx costs were \$3.5 - \$4 billion
- Medical trend for 2005 was about 9% after three double-digit years
 - Rx trend was 10% in 2005, 12% in 2004, 17% in 2003
- Injury rates are on a steady decline of about 3-5% per year, but that is likely ending
- "Severity" or claims expense is increasing significantly, especially for claims that involve time away from work

- This market is comprised of three segments
 - Large Property & Casualty firms (e.g. Liberty Mutual)
 - Third Party Administrators (TPAs, e.g. Sedgwick)
 - State Funds (e.g. California State Fund)
- Workers' compensation rates/benchmarks and benefits are established at the state level
- State funds usually compete directly with large private workers' compensation insurers
- In four states (North Dakota, Ohio, Washington, and Wisconsin), the state funds are the exclusive providers of workers' compensation insurance (WV is changing)

How workers' comp is different from group health

- The insurer owns the claim forever...
- Coverage is “first dollar, every dollar”
 - No copays
 - No tiers
 - No deductibles
- “Formularies” are controlled by the state and the treating provider
- Mix of injuries and illnesses is different
 - Musculoskeletal/orthopedic
 - Trauma and some cardiovascular
- There is no ERISA exemption
- Typically broad interpretation of “medically necessary”

How workers' comp is different from group health

- Peer Review physicians are focused on treatments more than broad Rx strategies
- Group Health member must have “card” to get a covered script v. injured workers can obtain a “covered” script without...
- States control all aspects of workers' comp
 - Except for federal employees, railroad and harbor workers...
- Some states have strong managed care laws, others don't
 - Networks
 - Employer v. employee choice of provider
 - Presumption laws
 - FL pharma pricing statute
- Approximately half of the states have a state-set fee schedule for medical procedures, including prescription drug
 - Most Rx fee schedules are based on AWP (CA is not)

- Workers' Compensation pays 115% of AWP (national estimate of FS/U&C)
 - Group Health pays 72%
- Half of the states do not allow “direction” to network providers, few mandate generic substitution
- Significant obstacles to altering prescribing behavior
- Claims adjusters are ill-equipped to deal with Rx issues and questions
- Fear of litigation drives adjusters to pay for non-compensable drugs
 - “You buy it once, you own it forever”

- 24 payers, in-depth survey of decision makers and implementers
- Ranged from very large national players to state funds to TPAs to employers
 - Represents 18% of total WC medical expense countrywide
- Focused on
 - assessing awareness and level of concern
 - defining the problem
 - identifying solutions
 - assessing program results

Problem - Rx cost increases averaged 10% over 2004

- Varied from 2% to 35%
 - Lowest increase from large, sophisticated payers
- 2004 increased 12% over prior year, 2003 18% increase
- Inflation attributed to
 - **Higher utilization**
 - Physician behavior
 - Over-use of pain medications e.g. Oxycontin, Actiq
 - Higher unit prices
 - Increased use of compounds

- Considered more important than other medical cost issues (3.8)
 - more so at larger entities
- Senior management is paying attention (92%)
 - more so at larger entities
 - increase over 2003 (81%)
- Projected to become significantly more important over the next 12-24 months (4.0)

● The Problem - Utilization

- Too many drugs are being prescribed at physician's offices for
- too many patients for
- too long

● The Solution

- Payers are looking to PBMs to do a better job of managing utilization
- Without adding to adjuster workload

- Predominant model is “generic” DUR comprised of system edits to catch early refills, duplicates, etc.
 - State-specific due to jurisdictional allowances and restrictions
 - Wildly overstated results (illusionary benchmarks)
- Less than 100% of scripts are captured by the system
- Prior Auths are rarely rejected by the adjuster
 - But take a lot of time...
- Potentially problematic claims require physician review
 - Which is rarely done...
- Physician education is just starting
 - And will take careful analysis over a long time

● Three Levels of Clinical Management

1. Individual prescription – Clinical Prior Authorization

- Bringing a physician into the PA process
- Provides adjuster with clinical recommendations on specific prescriptions

2. High cost claimant – Clinical Case Review

- Review of entire medical records by physician
- Provides recommendations on entire drug treatment program

3. High cost prescribers

- Identify prescribers whose prescribing patterns appear to contradict best practices, provide them with their data

● JI Companies

- Administrator of workers comp and group health programs for employers in public and private sector
- In-house Utilization Management & Case Management
- Strengths
 - Quantitatively oriented – clients expect and we document our impact and results
 - Demonstrated expertise in claims and cost management
 - Operationally excellent
 - Utilized a work comp PBM since 2000

Why we're interested in and focused on drug costs

- Client demands
- Need to stay in front of market issues
- Medical expenses are more than 55% of claims costs, and accelerating rapidly
 - Drugs are >16% of total medical cost
 - Drugs are the single largest contributor to work comp medical inflation
- Overuse of drugs complicates return to work
 - Dependency issues
 - Rehab issues
 - “disability mindset”

- Integrated a PBM into our operations and managed care service offerings
 - Worked closely with the PBM to maximize penetration and script capture
- Put in place both a clinical prior auth and a case review program
- Review high prescribers for peer-to-peer consults
 - Add as criteria for newly implemented networks
- Why?
 - Specific issues with too many narcotic fills for too long for specific claimants without any clear path to resolution
 - High cost claimants can be really high cost – 40% of costs for claims more than 4 years old are from drugs
 - 1/3 of claims dollars are for services rendered three or more years after the claim occurs
 - Medicare requires WC payers to set aside funds to pay those bills

- Identified key clients likely to be supportive
- Researched claims data to identify potential problems
- Worked with PBM to develop a program that
 - Works in different jurisdictions
 - Will provide us with solid legal justification for actions
 - Is clinically sound and robust
 - Delivers meaningful results
 - That can be, and are, documented and reported

- First Fill:
 - Cypress Care one time authorization letters are distributed by the employer at the time of injury, resulting in instant enrollment in the Cypress Care pharmacy programs.
 - The First Fill program ensures the fastest possible response to an injured worker's initial medication needs, and vastly reduces the number of paper bills and third party billers.
- Program parameters are customized by the employer to reduce exposure
 - Formulary Restrictions
 - Generic Requirement
 - Dollar and/or Days Supply Limits
- Results:
 - First Fill Clients average 10% higher Pharmacy Network Penetration Rate than non First Fill Clients
 - Average Total Program Savings for First Fill Client is three to five percentage points higher than for clients that do not utilize the program

- PA list is developed by PBM and payer
- Targeted drugs: Initial scripts for client-specified exception drugs are actually filled, but trigger a clinical review; all refills subject to PA
- PA special exception process
 - Script is referred to PBM clinician (pharmacist and/or physician)
 - Clinician obtains medical information, contacts treating provider, obtains additional information and drug treatment plan. If PBM clinician disagrees with drug treatment plan, PBM requests treating provider modify drug therapy
 - If treating provider refuses to comply, PBM documents all activity, and provides a report along with summary recommendation to adjuster.
 - Adjuster reviews recommendation based on objective clinical information
 - Recommend Approval
 - Recommend non-approval with explanation
 - Clinical data is inconclusive
 - With hard alternative strategy, adjuster can move to full Peer Review and formal action

- 41 cases to date
- 66% impact rate
 - Future meds were denied due to no medical necessity or
 - Prescribing physician agreed to discontinue
- Savings to clients of \$7,333 per claim (annual)
- Total client savings of \$198,000 (annual) on investment of \$25,000
- Total Program ROI 8:1 (annual)

- Claimant suffering lower back injury 10/05, presently on several pain meds
 - Fentanyl, Topamax, Lidoderm, Lortab
- New script for Actiq 600mcg x 2
- Result of Clinical Prior Auth
 - Treating physician withdrew script for Actiq
 - Alternate treatment with increased dosages of current meds
- Savings of \$9,300 annually

- Old case (16 years) long term treatment with compound med (ketoprofen)
- Results of Clinical Prior Auth
 - Treating physician agreed to stop ketoprofen, replace with oral NSAID (e.g. Naproxyn)
- Savings of \$10,500 annually

Addressing high cost claimants - Clinical Case Review Process

- Data mining identifies “red flag” claimants based on total dollars/month on prescribed drugs
- PBM’s clinical staff reviews each file to identify duplicate therapies, potential harmful drug interactions, possible over dosage and/or fraud and abuse
- PBM staff contacts adjuster re following up with the treating provider
- Adjuster gives OK
- PBM physician contacts treating provider to discuss patient’s history and treatment plan, provide information about possible alternative therapies, and attempt to obtain treating provider’s commitment to modify drug treatment.
- If successful, letter sent out to provider documenting agreement
- If unsuccessful, PBM physician documents conversation and provides recommendation to adjuster for adjuster’s further action.

- Ultimately...It’s always up to the adjuster.

- 40 cases reviewed, average injury age of 6.8 years
- Average of 7.9 drugs per claimant
- 46% impact rate (actual contact with and agreement by treating provider)
- \$10,559 annual savings per case
- \$256,000 savings over the life of the case
- Total Program ROI 8:1 (annual)

Old case, chronic shoulder injury, patient has seen
11 physicians

- Patient currently taking 9 drugs

- Lexapro, Soma, Xanax, Zoloft, Valium, Flexeril, Elavil, Oxycontin, Roxycodone

- Process - Three attempts to contact treating physician, medical records reviewed

- Results –

- Recommend generic substitution for OxyContin
- Wean off Soma
- Discontinue Xanax, Lexapro
- Alter usage of Valium and Flexeril to as-needed only

- Savings

- \$1,728 per year

Older case, lumbar back injury, chronic pain

- Patient currently taking 7 drugs

- Keppra, Duragesic, Topamax, Sonata, Mobic, Lexapro, Percocet

- Process – medical records reviewed for MSA

- Results

- Recommend terminating Keppra or Topamax (duplicative therapies)
- Recommend halving Mobic and Percocet usage

- Savings

- \$5,988 per year
- \$35,928 total savings (to age 65)

- Utilize data mining to identify specific providers who
 - Prescribe compound medications more than once
 - Consistently prescribe medications for non-indicated conditions (off-label)
 - Consistently prescribe brand drugs when generics are available
- Send letters with supporting documentation detailing findings
 - Not judgmental or accusatory
 - Comparison-based
 - Enable feedback from specific providers to PBM
- Track future prescribing activity to evaluate results
- Waiting on results...

- It's hard to manage drug spend in workers comp
- Medical costs in workers' compensation are rising rapidly
- Prescription drug costs are the fastest growing component of medical expense in workers' comp
- Effective tools do exist to mitigate cost increases
- Applying clinical expertise to drug management delivers tangible, quantifiable results

Thank you.



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