

If you have seen one PBM you have seen them all....Not: Comparing Work Comp to Group Health

Often it's said "Seen one, seen them all", even in healthcare. Well in the Pharmacy Benefit Management (PBM) arena, that couldn't be farther from the truth. Many ask why the group health pharmacy benefit management model could not be applied in workers' comp prescription management. This speculation is considered in part because the major differences between the two are not well known or understood. While there are similarities, there are more differences. Group health coverage is offered, typically through an employer, as an employee benefit, or is purchased as an independent policy. Workers' comp, on the other hand, does not come into play unless an employee has been injured on the job and is provided for solely by the employer. Both group and comp cover medical care and prescription drugs; however, there are numerous differences in the level of direction of care and how care is managed.

One of the primary differences between health plans and workers' comp is eligibility management. Health plans have specific enrollment periods and rules. This allows providers to determine if the employee is eligible to utilize the provider's services prior to treatment. This is not the case in workers' comp where eligibility is fluid. For instance, just because an employee is injured does not mean their claim is compensable or that the treatment is related to the work-place injury. This creates a certain level of risk since providers may treat the individual and not have the ability to be reimbursed for services provided.

Network utilization is another risk within the workers' comp system. Health plans generally have the ability to direct network utilization through either co-insurance and/or network direction tools. In other words, the patient has choices to make, such as to pay more out-of-pocket for care when selecting non-network providers. Since workers' comp is a no cost program to the injured worker, network management is more difficult. And, many jurisdictions do not allow strict direction of care. While workers' comp does utilize networks and injured employees are requested to use such networks, they are not required to do this (jurisdictionally based). This is also a contributing key element as to why workers' comp programs cannot negotiate the same low rates/discounts as a group health plan. Pharmacies do not have 'guaranteed foot traffic through their stores.

Coupling the challenge of eligibility and network utilization with medication management, there are also some distinct differences in drug utilization between health plans and workers' comp programs. With both group health and workers' comp, pharmacy benefit management programs are used to employ guidelines for prescription use; however, access to medications and their cost vary greatly due to the unique circumstances surrounding them. In workers' comp the management of drug utilization requires interventions that go beyond the typical group health model. Since PBMs are not the final approver or denier of medications, coordination of care includes many individuals: pharmacists, physicians, nurse case managers, claim examiners, and others. In addition, occupational injuries require healthcare providers to approach medicine in different ways than are typically seen in group health. This paper will outline some of the issues faced by workers' comp PBMs and why when you have seen **one** PBM you've seen **one** PBM.

Key Trends

While both group health and workers' comp are affected by common trends within the healthcare industry, they also face pressures unique to their environment. Below are a few of the key areas of impact:

Group Health Challenges¹

- Growing obesity rates continue to increase healthcare costs
- Chronic diseases which make up the majority of healthcare spending
- The impact of the increased use of costly specialty drugs
- The movement of existing drugs from off-label use to expanded label indicators approved by the Food & Drug Administration (FDA) which may have the potential to significantly increase utilization
- Advances in drug development that will create more expensive drugs for the treatment of illnesses such as cancer and central nervous system disorders
- Healthcare reform

Workers' Comp Challenges (in addition to all the above)

- Constant federal and state regulation changes
- Repackaging and physician dispensing of medications
- Combating increasing costs as a claim ages
- Identifying and managing high cost/highly addictive narcotics
- Recapturing out-of-network utilization
- Third-Party Billers (TPBs) who increase costs and create additional administrative issues

Workers' Comp Prescribing Outside of a PBM Program

Payors are not required to contract pharmacy services for workers' comp; however, prescription costs are considerably higher without their oversight. Without PBM monitoring, injured workers have access to a broader range of drugs, and while specific medications should be indicated for the injury, it may be difficult for a claims examiner to know what drugs are beneficial versus not. Preventing group health prescriptions from creeping into a workers' comp claim can be difficult. In workers' comp, claims examiners have responsibility for approving and denying prescriptions and their associated costs. These types of decisions could benefit from the use of a PBM paving the way with input from a pharmacist, nurse, or consulting physician who is knowledgeable about the drugs and their use as it relates to specific injuries.

In addition, many states have pharmacy fee schedules which are typically generous (exceptions are California and New York). Payors not using PBMs will ultimately reimburse providers at a higher cost than would be the case when using a PBM. Also, other than standard point-of-sale protocols, utilization controls are not in place to monitor or review prescription behavior. Injured workers have the ability to request prescription changes through their physician or at the pharmacy which could potentially result in obtaining more expensive drugs. Patients often times will pressure their doctors to provide brand medications they have heard of over less expensive generics. With no out-of-pocket expense for the injured worker and no PBM in place, injured workers and/or their providers can heavily influence the prescription costs associated with their claim. Some states attempt to manage this type of behavior through legislation. However, by using a PBM, rules are applied at the point-of-sale to ensure that unnecessary costs are not passed along to the payor.

Workers' Comp Prescribing within a PBM Program

Today, some PBMs are exclusively servicing the workers' comp industry and others are group health PBMs that have decided to offer their services in the workers' comp sector. Most workers' comp PBM networks operate similarly to group health PBMs in that they recruit pharmacies to participate in their networks and try to drive claimants to in-network pharmacies. Despite this similarity, workers' comp PBMs do not have as much control to direct injured workers to network pharmacies as their counterparts in group health do.

One difference between the two is the level of patient involvement needed in a workers' comp PBM. Injured workers often require a high level of hands-on support. To accommodate this, workers' comp PBM call centers must be manned by highly trained representatives who are knowledgeable about workers' comp and can provide individual assistance to injured workers regarding their work-related injury medications.

Another difference is the level of reporting offered in group health and workers' comp. In the group health environment reporting is offered at a high level and typically consists of summarized reports reflecting the average number of prescriptions and average cost per member per month. In workers' comp highly detailed prescribing information including prescriber, National Drug Code (NDC), quantity, and cost at the claimant level are provided, as well as additional reports covering utilization trends and overall program performance.

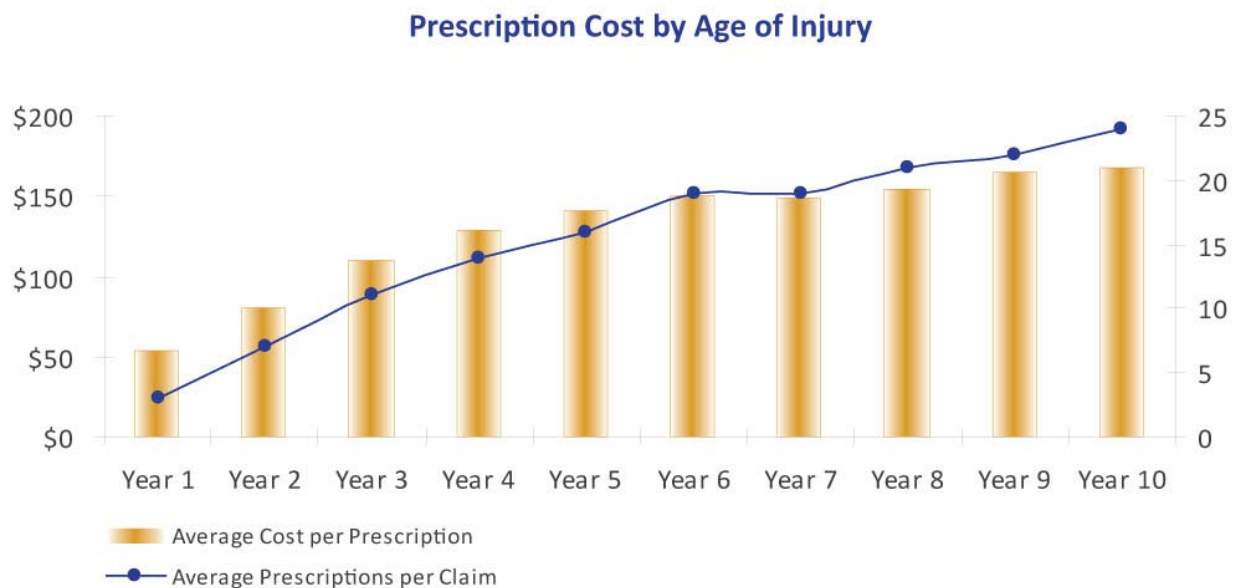
Workers' comp PBMs can also offer payors the benefit of monitored prescription use through point-of-sale drug edits, prior authorizations, retrospective alerts, drug utilization assessments, and peer-to-peer reviews. Workers' comp PBMs reduce drug spend not only through contract rates below fee schedule, but with additional savings achieved through utilization controls. These PBMs typically provide payors with a team of individuals who are knowledgeable about medications, occupational injuries, and state and federal regulatory issues.

Prescription Costs

It is no secret that the cost of prescription drugs is on the rise for both group health and workers' comp. These increases are being driven by the consolidation of drug companies and the narrowing of competition within the market. Below are some statistics that help put this into perspective.

- According to the Centers for Medicare and Medicaid Services (CMS), which analyzes healthcare spending annually, our national healthcare spend grew approximately 5.7% in 2009 to reach \$2.5 trillion.² The CMS projects that by 2018 healthcare spending will reach \$4.3 trillion.³
- Pharmacy spend represents approximately 10% of medical spend nationally.² Workers' comp transactions represent less than 3% of that.⁴
- In a recent study done by Hewitt Associates they predict that total healthcare premium cost will more than double from \$4,083 in 2001 to \$9,821 in 2011 and employee out-of-pocket expenses will more than triple from \$1,229 in 2001 to \$4,386 in 2011.⁵
- The change in utilization and prescription drug costs analyzed from one year to the next demonstrate an increase of 3.7% from 2008 to 2009.¹
- In the workers' comp industry, pharmacy costs represent approximately 19% of total medical costs per claim.⁶ This translates to an estimated \$5 billion in pharmacy drug spend nationwide.
- The average workers' comp medical cost increased 6.6% from 2002 to 2008, and in 2009 the average cost for a lost time claim was \$27.2 thousand.⁷
- Since 2002 the average number of prescriptions per workers' comp claim has increased by nearly 52%, and during that same timeframe the average amount paid per prescription increased by almost 72%.⁸
- Statistics also indicate that medical costs per claim for workers' comp are increasing much more rapidly than medical costs in general.⁹
- For aging workers' comp claims the average prescription cost more than doubles between years one and four (Figure 1).¹⁰

Figure 1.

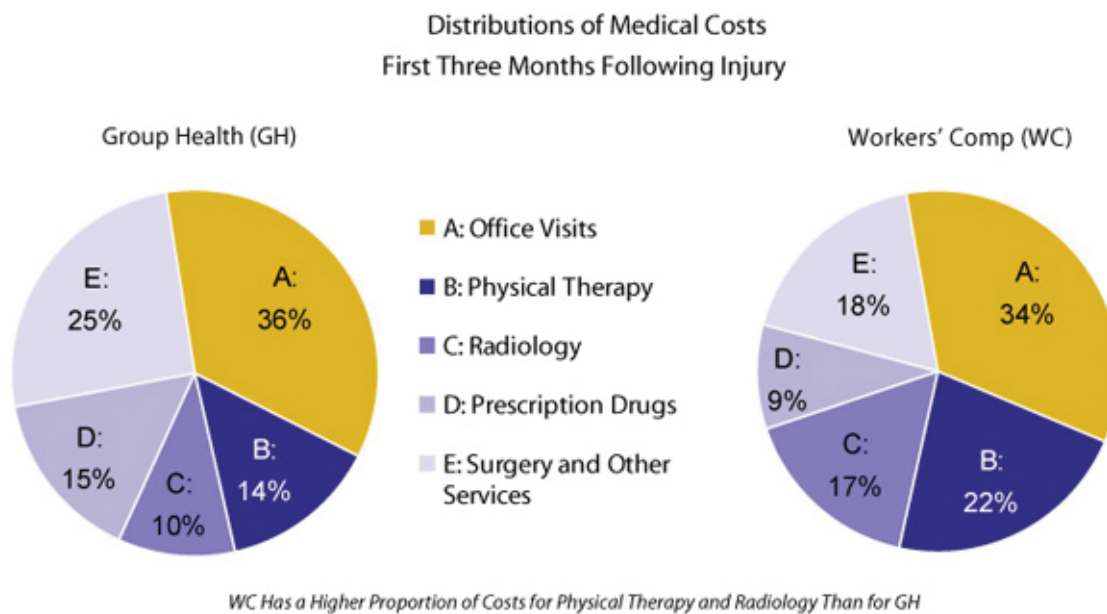


Source: First Script 2009 Drug Trends Report

Medical Benefits Comparison

The cost of medical benefits for similar injuries for workers' comp prove to be considerably higher than the costs for group health. An NCCI Holdings study of service categories based on the first three months of care found that physical therapy and radiology represent a higher percent of the overall workers' comp costs than group health (Figure 2). Medications seem to represent fewer dollars in the first three months of work comp claims, which makes sense when one considers workers' comp's focus on recovery and return-to-work. According to the study, in workers' comp higher physical therapy costs were the result of greater utilization and higher costs for services equally.

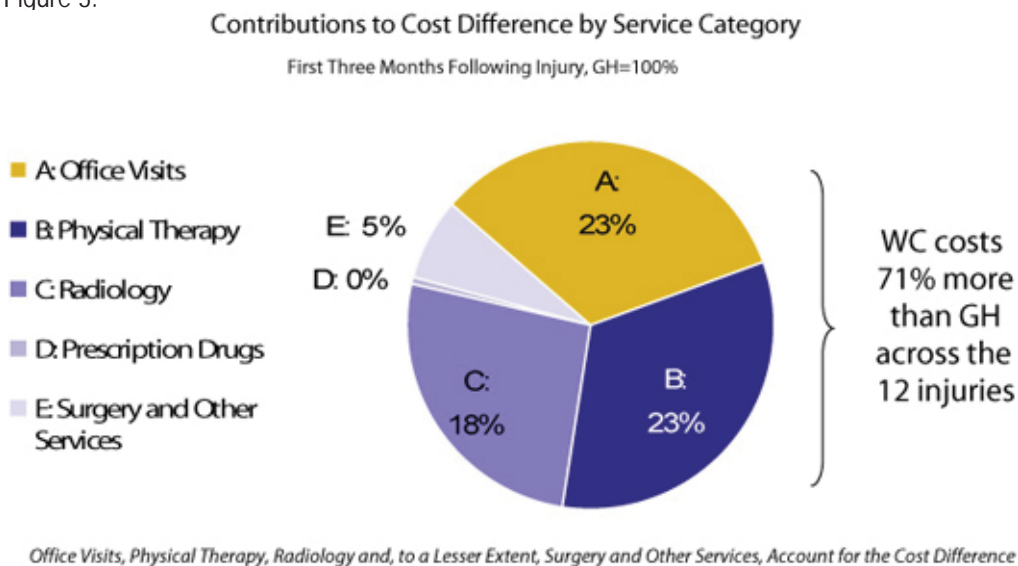
Figure 2.



Source: NCCI

Figure 3 shows cost differences between group health and workers' comp for these services, which are mainly coming from office visits, physical therapy, and radiology. Across twelve injury categories, including chronic and complex and acute and trauma-related medical conditions, workers' comp costs were 71% higher than group health. In these same categories, related to acute and trauma-related injuries, workers' comp was 45% more costly than group health, and for chronic and complex injuries, workers' comp was 104% higher.¹¹

Figure 3.



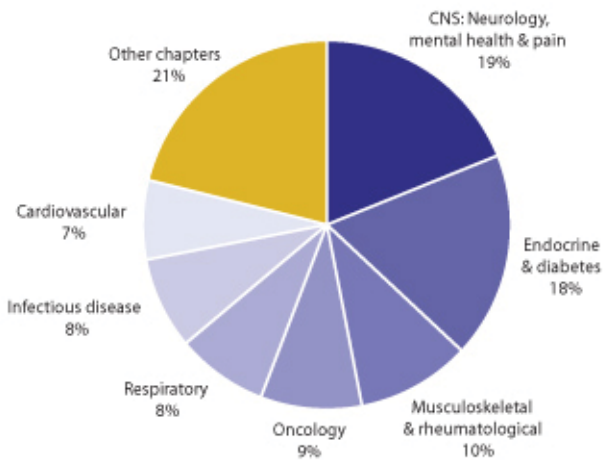
Source: NCCI

Medication Comparison

Medco, a leading pharmacy benefit manager for group health, predicts that in the next three years over 72% of drug costs will be driven by six broad chapters (Figure 4) within their Preferred Prescription® formulary. From these chapters eight drug categories (Figure 5) will make up nearly two-thirds of the ingredient cost growth for the same time period.¹

Figure 4.

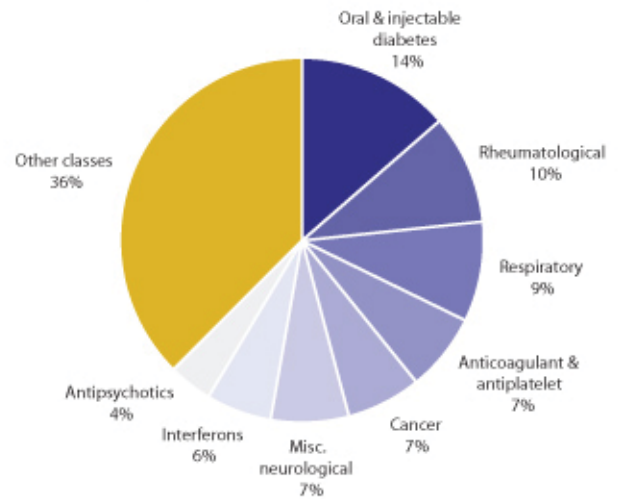
Top Therapeutic Chapters Contributing to Projected Drug Trend (2010–2012)



Source: Medco projection
Data are expressed as a percentage of the total projected increase in plan ingredient cost.

Figure 5.

Top Therapeutic Categories Contributing to Projected Drug Trend (2010–2012)

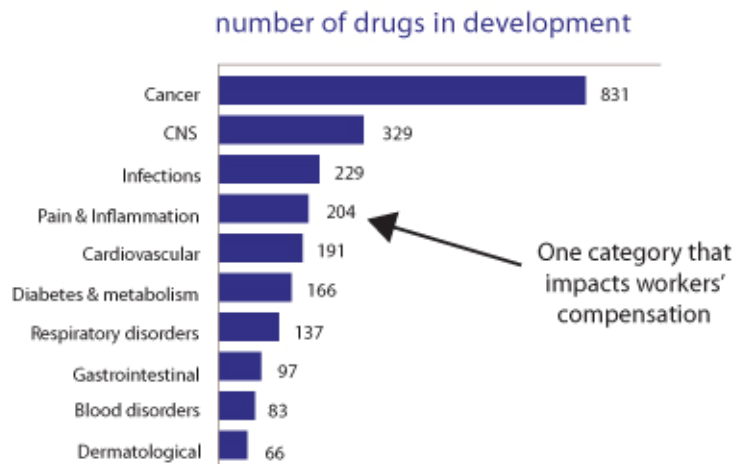


Source: Medco projection
Data are expressed as a percentage of the total projected increase in plan ingredient cost.

There are approximately 2,300 drugs undergoing development that fall within the top ten therapeutic categories.¹ Of these only the pain and inflammation category impacts workers' comp (Figure 6).

Figure 6.

Drugs in Development by Therapeutic Area (2009)



Source: R&D Directions

The figure shows the number of drugs in the pharmaceutical pipeline for the top 10 areas of development, including drugs in Phase I, Phase II, and Phase III, or awaiting FDA approval.

According to a recent First Script (the PBM offered by Coventry Workers' Comp Services) drug trends report, the top ten therapeutic classes in 2009 accounted for over 80% of the total prescriptions dispensed and more than 85% of the total billed amounts for First Script clients (Figure 7).¹⁰

Figure 7.

Top 10 Therapeutic Classes - 2009

Therapeutic Class	Examples	% Total Units	% Total Billed
Narcotic Sustained-Release Medications	OxyContin, Duragesic	5.5%	18.9%
Narcotic Short-Acting Agent	Percocet, Vicodin	31.0%	18.6%
Anticonvulsant Agents	Lyrica, Neurontin	8.5%	11.1%
Muscle Relaxant Agents	Flexeril, Skelaxin	10.5%	8.2%
NSAIDs	Celebrex, Motrin	11.1%	7.9%
Antidepressant Agents, Non-TCA	Cymbalta, Effexor XR	6.1%	6.8%
Anesthetic Agents	Lidoderm patches	1.8%	4.9%
Hypnotic Agents	Ambien, Lunesta	3.6%	3.6%
Ulcer Medications	Prilosec, Nexium	2.6%	3.5%
Antipsychotics	Seroquel, Zyprexa	0.6%	1.8%
Top 10 Total		81.3%	85.3%

Source: First Script 2009 Drug Trends Report

Formulary Versus Drug List

A group health drug formulary is typically a comprehensive drug list that is designed according to each employer's desired benefits. Most formularies have tier levels which drive patient behavior through co-pays and coinsurance. Traditional group health drug formularies are not mandated by state regulation. Members can purchase the drug of their choice; however, the co-pay will vary based on the tiered level. They can also choose less expensive generics with lower co-pays. Drugs not in the formulary can also be purchased, but the employer will push more of the cost to the employee.

In contrast, a workers' comp PBM drug list can be designed to manage the injured worker's access to needed medications while controlling costs for the payor. As the claim ages, tighter drug controls are put in place to the point where an injured worker can have their own unique drug list.

Some workers' comp PBMs initiate potential claims through the use of a first fill drug list that is designed to be broad enough to meet the immediate need of the worker at the point-of-injury. After a short period of time, the injured worker is moved to a more restricted drug list that is typically injury-specific. This allows for the management of drug spend by applying injury-specific drug lists at the claimant level that include the use of NCCI codes, ICD-9/ICD-10, and proprietary injury codes. These codes are pre-mapped to specific drug lists according to location, type, and severity of injury, and point-of-sale transactions can then be edited against the claimant's specific drug list.

It should also be noted that the Work Loss Data Institute recently published a workers' comp drug formulary as part of the Official Disability Guidelines (ODG), further demonstrating the industry's need to adopt this approach. Currently, the State of Texas is moving towards adopting this closed formulary for newly injured workers in January 2011 and for existing injured workers in 2013.

Workers' comp drug lists are based solely on inclusion or exclusion criteria since financial incentives (patient co-pays/deductibles) do not exist. In this instance if an injured worker attempts to fill a prescription outside of the drug list, a prior authorization is triggered and the

PBM will not process the prescription without approval from the claims examiner. In such cases, the PBM's clinical team can be available to provide assistance to the claims examiner in determining the clinical validity of the medication.

Lastly, the range of drugs in workers' comp is considerably narrower than in group health. Drugs prescribed for non-injury related illnesses such as cancer, diabetes, and high blood pressure are excluded, and approximately 80 drugs account for 75% of all prescriptions.¹²

From a Patient Perspective

In group health, an individual either has coverage or they do not, and coverage is easily confirmed. This is not the case in workers' comp where injuries must be reported and compensability must be determined, which can result in a delay between the injury and the approval. Many times this translates into patients receiving care and seeking prescriptions prior to a case being deemed compensable.

In group health, patients are aware of their insurance provider and their benefit plan before they require medical assistance of any kind. They are also aware of co-pays and deductibles for prescriptions and office visits, and know that in many cases they will be responsible for some out-of-pocket expenses. In workers' comp this is not the case. While employees typically know there are laws that require employers to cover work-related injuries, most have little knowledge of how workers' comp coverage works. In addition, just as most employees do not know who their employer's workers' comp payor or manager is, most would not know there may be a specific workers' comp PBM available to them until after an injury occurs.

In many cases, injured workers can be provided coverage information at the time of injury, but this is not always possible. For example, if an injured worker is hurt away from their office, as with construction workers or truck drivers, they will likely go directly to a hospital or clinic and contact their employer afterward. If medications were prescribed, the injured worker could also potentially visit the pharmacy without any PBM information, which results in filling their prescriptions either through their group health plan, or possibly a Third-Party Biller (TPB) for workers' comp would be engaged by the pharmacy. In either case, additional work will be required on the employer's part.

Additionally, patients have no financial incentive to use an in-network pharmacy or to opt for a generic drug. Workers injured on the job can go to the pharmacy of their choice and opt for a brand drug over a generic. Workers' comp PBMs can assist with this; however, ultimately the approval process lies with claims examiners who typically approve prior authorizations, partially due to concerns regarding litigation.

From an Employer Perspective

Employers or designees (third-party administrators/carriers) using a workers' comp PBM are ultimately responsible for making coverage decisions. The PBM assists with program design during the implementation process; however, once in place, decisions that fall outside of the established program are made by the employer, carrier or Third-Party Administrator (TPA). While PBMs can provide assistance, they cannot make decisions for the payors. Given this, there are many unknowns in the process that create financial risk. For example, the existence of pre-existing illnesses or injuries, injury relatedness to work, and the types of medications included on the drug list are unique to each claim. This is not the case with group health.

There is much more flexibility in group health. Employers can impact employee behavior through contributions, deductibles and co-pays. Employees know co-pays will be lower for generics, for example, and will choose them over brand drugs to reduce their out-of-pocket expense.

From a Physician Perspective

Group health plans typically have a broad network of medical providers that are familiar with the system and have incentives to participate in the network. In workers' comp, healthcare providers must be willing to accept workers' comp insurance. In many parts of the country, there are shortages of physicians who have the necessary experience to deal with the special issues that patients with occupational injuries face. In addition, treating workers' comp claimants requires doctors to accept reimbursements that are often lower than Medicare and require them to deal with increased paperwork. Providers are in some cases refusing to accept workers' comp patients.¹³

From a Pharmacy Perspective

With group health prescriptions, a pharmacy knows how to verify eligibility. Individuals present their benefit card, and prescriptions are typically filled with little effort. Individuals also have a financial incentive to use participating network pharmacies.

This is not always the case in workers' comp where it may require numerous phone calls for eligibility and prior authorizations if the PBM information is unknown. Initial reject rates on workers' comp prescriptions can exceed 45%.⁴ To avoid rejects, pharmacies, who are not required to process through a specified PBM, may elect to use a TPB to reduce the operational challenges and ensure reimbursement. Workers' comp also reflects a very small percent of the prescriptions that pharmacists process on a daily basis, which can impact the way pharmacies choose to process workers' comp prescription billing.

Disease Management Versus Injury Management

Disease management in group health typically refers to concerns around chronic diseases and the management of future complications from an illness. In group health, disease management is critical to controlling drug costs, and is part of the overall philosophy associated with group health. Typically when a patient visits a physician under their group health plan, the physician's emphasis is on the overall health of the patient, even if they are visiting for a specific injury or illness. Given this mindset, the group health industry is battling the pharmaceutical industry over high cost drugs that may increase the lifespan of a terminal patient with very low return on the investment.

In workers' comp, the physician's focus is directed to the treatment of the work-related injury. For this reason, controlling the physician's prescribing behavior becomes increasingly more important in workers' comp. Studies show that injured workers take longer to recover and encounter additional work and life disruptions than in group health. In addition, injured workers tend to have impairments that frequently keep them from returning to work or attaining new employment when medical treatment has ended.¹³

Physician Dispensing

A major issue on the rise in workers' comp is the high cost of physician dispensed drugs. Large workers' comp payors report that over half of their drug costs are coming from physician dispensing. In 2007 physician dispensing was 7.5% and by 2008 it rose to 18%. States with high workers' comp drug utilization also saw large percentages (greater than 15.5%) of physician dispensed prescriptions.¹⁴

This issue is not specific to workers' comp. Congressional investigations are suggesting that TBPs who repackage drugs are having an impact on price increases for 416 brand name drugs. According to a Government Accountability Office (GAO) report, more than half of the price increases come from suppliers that include Health Maintenance Organizations (HMOs), pharmacies, and stand alone companies.¹⁵

Workers' comp PBMs are not opposed to physicians dispensing medications, and despite the increased cost, proponents of repackaging feel that doctor dispensing offers a convenience to patients and reduces medical error.¹⁵ To help mitigate repackaging costs PBMs can collaborate with bill review engines and partner with occupational clinics. Additionally, in states such as Florida workers' comp PBMs can identify these prescriptions on medical bills and reduce their cost to a fair and reasonable amount.

Regulatory Compliance

Employers are required by law to provide workers' comp benefits for work-related injury claims that are determined to be compensable. This type of mandate is not practiced with group health coverage, and employer requirements outlining who should provide coverage and how those benefits should be provided varies. Since group health coverage is an employee benefit there are many more options for coverage than are available through workers' comp. This creates a very different focus on prescription drug management and its regulation.

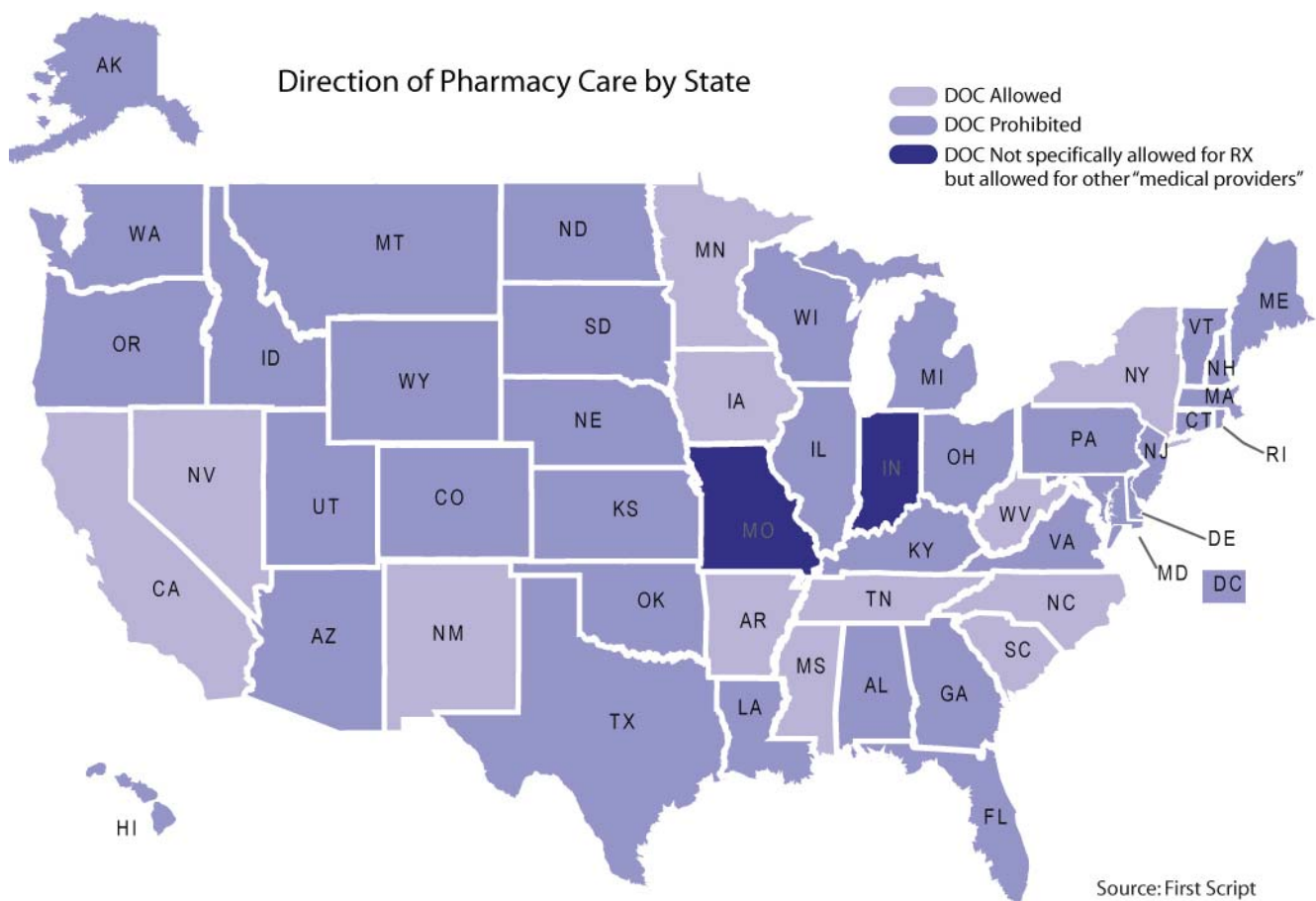
Group health insurance providers are regulated by both state and federal agencies. States play the primary role in regulating healthcare. However, there are many federal laws impacting the states' ability to do so. The Employee Retirement Act (ERISA) regulates essentially all private employer benefit plans. In addition, federal laws also affect state practices. For example, the Health Insurance Portability and Accountability Act (HIPAA) establishes minimum federal standards for state regulated insurance markets.¹⁶

To make matters more complicated, workers' comp has its own set of regulations. In fact, each state has its own set of regulations that include requirements associated with workers' comp medical treatment guidelines, state fee schedules, formulary guidelines, brand/generic rules, state reporting, and direction of care.

Direction of Care (DOC)

In group health, the payor and/or provider has the ability to direct care to a preferred provider for medical or pharmaceutical services. This is not always the case in workers' comp. Direction of care is prohibited in many states, and mail order and retail pharmacy rules may differ within a state. In addition, direction of care itself can vary from state to state. For example, a state may allow direction of care for the first 30 days, may allow direction of care to the initial physician only, or may possibly allow direction to a specific network.¹⁷ PBMs must recognize the manner in which each state operates to remain compliant with regulations impacting their pharmacy program. The map below (Figure 8) illustrates how each state currently handles direction of pharmacy care.

Figure 8.



Generic Substitution

On average generic drugs may cost less than a third of like brand name medications and play a significant role in reducing overall drug costs.¹⁸ As previously discussed, generic substitution is more prevalent in group health due to financial incentives, which do not exist in workers' comp. To combat the use of higher cost brand drugs in workers' comp, 34 states (Figure 9) mandate generic substitution when available. Some states also permit co-pays to be charged to injured workers requesting brand name drugs when generics are available. Workers' comp PBMs can also manage generic substitution to improve generic utilization, and have seen generic efficiency rates, which refer to the number of generics filled out of the total number that could have been dispensed as generic, of 92%.¹⁰

Over-the-Counter (OTC) Medications

Moving forward, the industry will begin to see more drugs being classified for over-the-counter use. This becomes problematic for utilization review and possible drug interaction issues. This is an issue faced by both group health and workers' comp, as OTC medications do not process through the pharmacy system like prescriptions do and point-of-sale edits are not applied.

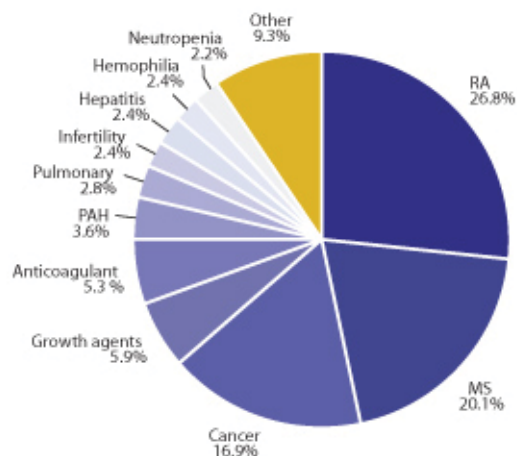
In terms of coverage, group health plans do not typically cover OTC medications; however, health plans may reimburse employees for some OTC medications through a Flexible Spending Arrangement (FSA) or a Health Reimbursement Account (HRA) regardless of the injury or illness. Workers' comp benefits may not cover OTC medications depending on the client drug list specifications.

Specialty Drugs

Both the group health and workers' comp industries are challenged with the management of specialty drugs, which are used to treat rare or complex chronic conditions; however, the use of these drugs within each program varies widely. Rheumatoid arthritis (RA), multiple sclerosis (MS), and cancer are the three largest contributors to specialty trends in group health (Figure 10).

Figure 10.

Contribution to Net Plan Specialty Costs by Category



Source: Medco data

RA = rheumatoid arthritis and includes other immune disorders; MS = multiple sclerosis; PAH = pulmonary arterial hypertension. Other = all categories contributing $\leq 2.2\%$ to net plan specialty costs: anemia, HIV, immune deficiency, metabolic disorders, ophthalmics, osteoarthritis, osteoporosis, respiratory syncytial virus. Percentages are rounded and may not add up to 100%.

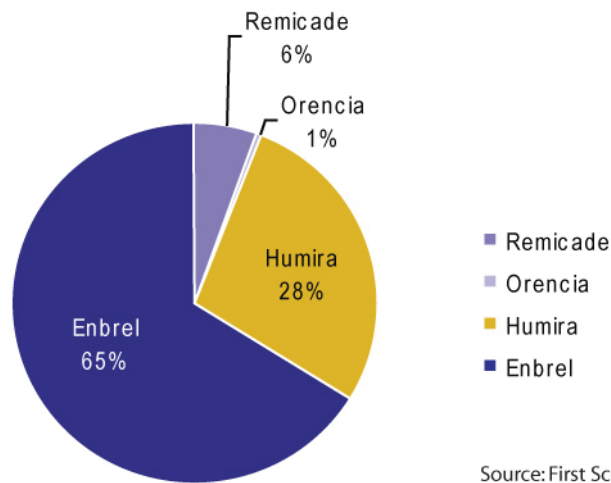
Expensive cancer remedies force payors to make hard choices regarding the value of the additional life these drugs provide to patients despite the fact that their success varies widely from patient to patient. In addition, these cancer remedies may be purchased by clinics from drug makers and then resold to patients, which may further increase their cost.²⁰

In a study published in the *Journal of the National Cancer Institute*, public data revealed that for the treatment of a lung cancer patient with Eribitux, which costs \$80,000 for an 18 week supply, the treatment added only an additional 1.2 months of life. Researchers then took the data and extrapolated it out and determined that to extend the 550,000 annual cancer deaths nationally for one year would cost \$440 billion.²¹

In workers' comp the most expensive categories of specialty drugs, based on billed amounts, in 2009 were for the treatment of blood disorders, followed by rheumatoid arthritis, and then by osteoarthritis. Rheumatoid arthritis treatments are in the top three for both group health and workers' comp, and similar specialty drugs are seen in both groups. The specialty drugs used for rheumatoid arthritis listed in Figure 11 are classified as biologic Disease-Modifying Anti-Rheumatic Drugs (DMARDs).²²

Figure 11.

Rheumatoid Arthritis Spend (2009)



Most new specialty claims require follow-up, intervention, or coordination of services prior to use. To process specialty drugs, PBMs have had to develop unified processing and reporting platforms that enable them to manage pricing and clinical utilization through measurable rules that provide a comprehensive picture.

Non-Adherence Versus Abuse

While both the group health and workers' comp industries face issues of non-adherence and abuse, each has a greater focus on one versus the other. In group health, non-adherence can increase the overall costs associated with additional needs for care, and makes it difficult for physicians to treat the overall health of a patient. Adherence quite often relates to prescription use, as patients with financial issues may not take medications as prescribed, may not fill medications prescribed, or may try to stretch doses. Other issues such as side effects may also encourage non-adherence. Non-adherence contributes greatly to overall healthcare costs as demonstrated below.²³

- Total cost of non-adherence is estimated to be \$290 billion a year to the U.S. Healthcare System
 - 13% of total healthcare expenditures
- 10% of hospitalizations and 23% of nursing-home admissions are due to medication non-adherence
- \$2,000 per patient per year is spent in additional medical costs for non-compliant patients
- Rapid onset of disease, increased costs, higher healthcare utilization, poor outcomes, higher hospitalization rates, and lost productivity are common in situations of non-compliance
- 20-25% of employers' healthcare expenses are a direct consequence of medication non-adherence
 - \$50 billion in lost productivity

In workers' comp, where injured workers do not pay for their medications, adherence to treatment is not as much of an issue and in some cases leads to overuse or misuse of prescriptions. Workers' comp injuries often require narcotic pain medications, many of which can be highly addictive. To combat overuse, PBMs need to apply strict point-of-sale drug edits, require prior authorization for drugs outside of the drug list, and utilize retrospective alerts that notify claims examiners to potential abuse. In addition, for cases that warrant additional review, a drug utilization assessment may be warranted. In such instances a clinical pharmacist will review medication regimens and medical records related to the work-related injury. Additionally, a peer-to-peer service can be initiated to effectively influence the pharmacological regimen for an existing claim.

Most opioids are Drug Enforcement Administration (DEA) controlled-substances due to their abuse potential. In the 1990s drugs such as methadone, OxyContin®, and Vicodin® were increasingly prescribed for chronic pain. More than 20,000 people die each year from drug overdoses, and opioids are the most common type of drug to cause overdose. Deaths due to methadone overdose increased 468% between 1999 and 2005.²⁴

The potential for serious health risks, litigation, rising costs, and increases in lost time are all concerns in workers' comp claims that include narcotics. These concerns have not gone unnoticed and the Food and Drug Administration (FDA) has taken steps to more closely monitor narcotic use. One such response is the Risk Evaluation and Mitigation Strategy (REMS) program that is designed to request narcotic manufacturers to complete the REMS to determine if benefits outweigh risks.¹⁸

Group Health or Workers' Comp Claim

The line between group health and workers' comp can be blurred by many factors. A University of California study suggests that between \$8 and \$23 billion is spent annually by private health plans, Medicare, Medicaid, the Veterans Administration, and other health related systems on occupational diseases.²⁵

Workers' comp injuries are complex, and a simple injury can spiral into related illnesses and injuries that must potentially be considered as part of each case. A simple knee injury that conceivably contributes to back pain, followed by weight gain, and potentially diabetes complicates case management not only for prescription medications, but for overall recovery. Without strict controls, group health prescriptions can bleed into workers' comp and vice versa.

A growing number of Americans are also working from home, which poses unique challenges to workers' comp. Employees working from home receive the same workers' comp coverage, and must meet the same claim qualifications, as those working from an office. In addition to the existence of external exposures not associated with an office environment, it can be difficult to evaluate the relatedness of the injury to employment.

Return-to-Work

Approximately one in every four to five work-related injuries will require time away from work, with most requiring only a few days.²⁶ Return-to-work programs are imperative in workers' comp, more so than in group health, and essentially fall on the employer to enforce. The longer it takes to return to work the longer the workers' comp claim will remain open. However, getting injured workers back to work can be difficult, as they are receiving disability payments while off work, and may prefer to avoid returning to work due to job dissatisfaction or malingering.²⁷

The estimated annual spend for unscheduled work absences is approximately \$660 per employee.²⁸ When employees get hurt on the job and must be away from their place of employment, the employer has to pay both their workers' comp benefit as well as the costs of covering their responsibilities through overtime or temporary workers. In group health, employers still face absentee issues, but do not incur the workers' comp indemnity costs as employees in most positions have a specific amount of sick leave to cover their time away from work. Once all paid leave is used, the employee is no longer paid unless they are deemed disabled. Nevertheless, the employer has a much smaller responsibility in this situation.

The type of injury and type of employment are also important factors in return-to-work programs. For example, a simple fracture may require six to eight weeks, whereas a compound fracture can take between eight and sixteen weeks to heal.²⁹ While injury recovery will vary by individual, claims managers may need to evaluate whether an injured worker's recovery is within a reasonable timeframe. A nurse case manager may need to be engaged to evaluate the worker and possibly request an independent medical examination. In addition, the time for recovery and the injured worker's time to return-to-work will not necessarily be the same. Through return-to-work programs, employees may return to modified work or transitional duties, allowing the injured worker to receive partial or full pay prior to their full recovery.

While most on the job injuries are minor, allowing employees to return-to-work and resume normal activities within a short period of time, approximately 1% of injuries are catastrophic, and can account for 30% of the total medical dollars paid.²⁶

Healthcare Reform

Public funds currently account for 48.6% of national healthcare expenditure, and that figure is expected to rise to 52% by 2019.² Healthcare reform, which was designed to make health insurance more accessible and affordable, is expected to cover 30 million uninsured Americans by 2019.³⁰ Reform is expected to expand Medicaid by requiring states to cover all individuals with incomes below 133% of the poverty level. Today there are approximately 40 million people enrolled. This will increase to 51 million by 2019 with reform.³⁰ The creation of insurance exchanges also remains somewhat unclear as to how the states will approach them, as well as what will be the role of federal versus state government.

It is not yet clear what impact healthcare reform will have on workers' comp, in particular in relation to PBMs and prescription drugs. Workers' comp makes up only 2% of the total medical expenditure, so it is not expected to be the main focus for policy makers as they roll out President Obama's reform package.²⁷ Some suggest the new healthcare reform may promote a healthier work force and decrease an employee's incentive to try to acquire workers' comp benefits for injuries that are not actually related to a workplace injury. In addition, it may also create administrative problems for employers, insurers, and state administrators, and federal mandates may conflict with state run workers' comp systems.²⁷

Conclusion

Today group health has the benefit of having a broader picture of an individual's overall prescription utilization history, and the view for the payor is very different between group health and workers' comp. Workers' comp PBMs are striving to gain similar visibility through bill review data, out-of-network initiatives, and tighter integration. Successful workers' comp PBMs have the capability to see an individual's full medical and prescription history, which allows them to ensure the medications prescribed are appropriate and necessary to treat the injury, assist in evaluating whether an injured worker is able to return-to-work, and promote the best possible outcome for injured workers.

While it is evident that there are differences between group health and workers' comp, impending changes to both industries are bringing them closer together. Reform promises many challenges to healthcare that will likely have an impact on workers' comp. The debate is still open regarding the federalization of workers' comp to alleviate the complexity of individual state run programs. In addition, states are closing the gap by changing regulations to permit direction of care, formularies, and co-pays. Innovations in medicine as well as technology also promise new opportunities for advancement in workers' comp pharmacy management.

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