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Dialogue

The Pharmaceutical Paradox

Pharmaceuticals remain a large component of the total medical cost in treating workers' compensation injuries and illnesses with both positives and negatives contributing to this fact.

On the positive side, the use of pharmaceuticals may decrease demand on other health resources, improve health outcomes and treatment safety, all enabling people to return to work. From a claims cost perspective, the positives are lower medical treatment costs and lower costs for lost time away from work.

There are a number of negatives that contribute to the cost of treating with pharmaceuticals such as the price of medications. Pharmaceutical pricing in the United States is unregulated, which as with all free markets allows the consumer to establish the price for a product by either choosing to buy or seeking an alternative. However, competitive pricing generally commences once a medication is no longer under patent protection and/or exclusivity marketing rights.

Capturing the National Drug Code ("NDC") is the key to controlling pharmaceutical costs.

Pharmaceuticals are manufactured through two sources, (1) the originator of the medication and (2) the generic manufacturer. The originator markets the medication through a brand or trademark name and has sole marketing rights for a period of time covered under patent protection and/or exclusivity marketing rights. This protection period varies from country to country, but the norm is from 5 to 10 years. On expiration of this protection period, generic pharmaceutical manufacturers are allowed to produce the medication and introduce price competition into the market. Pharmaceutical Research and Manufacturers of America (PhRMA) report that generic medications account for 80 percent of dispensed medications in the United States.

In an effort to control pharmaceutical pricing in California workers' compensation, a number of legislative changes were introduced commencing in 2002 with allowing claims administrators to utilize Pharmacy Benefit Managers (PBMs) and Pharmacy Benefit Networks (PBNs) to establish contract prices for a supplier's medication below the mandated maximum price enacted by legislature and to also allow closer scrutiny of the medications prescribed at time of dispensing. A reduction in pharmaceuticals cost was expected to result, yet according to a report prepared by the California Workers' Compensation Institute (CWCI) in October 2014, titled "*Report to the Industry: Are Formularies a Viable Solution for Controlling Prescription Drug Utilization and Cost in California Workers' Compensation?*" showed that for an indemnity claim, the average pharmacy cost for the first year of treatment increased from $390 in 2002 to $430 in 2003 (an increase of over 10%.)

In 2004, further legislature was enacted to utilize the pharmacy formulary of the California's Medicaid welfare program's called "Medi-Cal". Its pharmacy formulary and price schedule are based on the State's negotiated price with suppliers for a medication, which in many cases is the manufacturer. In contrast to California, most other workers' compensation jurisdictions use the Supplier's Average Wholesale Price (AWP) with a plus or minus percentage adjustment (e.g. AWP + 10% or AWP - 5%) to establish the maximum price. Both the Medi-Cal price and the AWP are calculated for a medication before any off-invoice discounts, rebates or other price reduction incentives are applied by the pharmaceutical suppliers. For a number of the top twenty medications dispensed in workers' compensation as identified by the National Council on Compensation Insurance (NCCI) September 2013 report titled, "*Workers' Compensation Drug Study: 2013 Update*", the price difference between Medi-Cal and the AWP are very significant. For example, paying the lowest Medi-Cal price of 4 cents per unit instead of the AWP for the generic medication Meloxicam 7.5mg tablet, provides a saving of up to 98%. Expectations of a significant reduction in pharmaceuticals costs was again anticipated, yet according to the CWCI, the cost only dropped from $321 in 2004 to $282 in 2005 (a reduction of 12%), before increasing again to $352 in 2006 (an increase of almost 25%.)

Effective from January 1, 2005, in a effort this time to control total medical costs, claims administrators in California were allowed to establish their own Medical Provider Networks (MPN). The intent of the legislation was to curtail the adversarial relationship between the medical profession and the claims administrator. The MPN also provided opportunity for establishing contract rates with the physicians for both services rendered and medications dispensed below the mandated maximum prices. This time the expectation was to see a reduction in both costs for medical treatments and medications dispensed by the physician. However, instead of an expected decrease, the CWCI showed an increase from $282 in 2005 to $352 in 2006 (almost 25%) and then to $412 in 2007 (a further increase of 17%.)

To ensure there are adequate supplies of each medication, the Medi-Cal formulary includes a number of manufacturers for the same medication. PBMs and PBNs also have pharmaceutical formularies which may contain only some of the same suppliers of medications as Medi-Cal, especially for medications where there are a large number of suppliers. For example, Gabapentin is available from over 55 suppliers which may include the originator, the generic manufacturers and the repackagers of the manufacturer's medication into various package sizes. Another example is Hydrocodone-Acetaminophen which is available from at least 45 suppliers in different strengths and package sizes.

Although the Medi-Cal formulary includes many suppliers for the same medication, it does not include all suppliers. Also, new suppliers can be added and existing suppliers removed from the Medi-Cal formulary at any time. Until 2007, if a supplier of a particular medication was not listed in the Medi-Cal formulary at the time the medication was dispensed, then the mandated maximum price for the medication was based on the supplier's AWP with a percentage adjustment. In 2007, Legislation was enacted that for a supplier's medication not listed, the maximum price paid was equivalent to similar medications listed in the

Medi-Cal formulary at time of dispensing. Again, a significant reduction in costs was expected because a number of physician were dispensing medications from suppliers that were not listed in the Medi-Cal formulary. However, a decrease did not occur, but instead increased by almost 7%, from $412 in 2007 to $440 in 2008. This percentage increase is very surprising considering the NCCI ranked Meloxicam as the highest physician dispensed medication by dollars paid and the cost savings by applying the Medi-Cal price instead of the AWP are as high as 98%. Tramadol HCL, the second highest ranked physician dispensed medication by dollars paid also exhibited significant cost savings of 89% by applying the Medi-Cal price of 9 cents per unit instead of the AWP.

Legislation enacted in California from 2002 through 2007 provides all the means to control and curtail pharmaceutical costs, yet according to the CWCI, the average first year pharmaceutical cost per indemnity claim reached $953 in 2012 from $390 in 2002 (an increase of 144%.), which is puzzling.

This puzzlement initiated an independent study into pricing based on the list of medications identified in the NCCI report. The study excluded the price of medications from repackagers that are often associated with physician dispensing. The report published from this study listed the following medications:

Meloxicam 7.5mg tablet ranged from 4 cents per tablet through to $5.73 per tablet.

Gabapentin 300mg capsule ranged from 6 cents per capsule through to $1.75 per capsule.

Lidocaine 5% transdermal patch ranged from $102.98 for 30 patches through to $258.97 for 30 patches.

Hydrocodone-Acetaminophen ("APAP") ranged from 22 cents through to $2.69 per unit depending on the strength. The price for Acetaminophen with Codeine was also compared which ranged from 15 cents through to 90 cents per unit.

Omeprazole 20mg an over-the-counter medication used to treat ulcers and heartburn varied in price from 29 cents through to 65 cents.

Cyclobenzaprine HCL 10mg tablets ranged from 4 cents through to $1.13.

OxyContin a brand name extended release or long acting Oxycodone HCL only manufactured by Purdue Pharma and currently under patent protection ranged from $2.27 through to $14.51 per unit based on strength.

Oxycodone HCL ranged in price from 23 cents through to $1.57 depending on strength.

For claims administrators to influence a downward trend in pharmaceutical pricing, consideration should be given to the following initiatives:

1. Be aware of the suppliers of the medications in their PBM/PBN's formulary.
2. Compare the suppliers of the PBM/PBN's formulary to the Medi-Cal formulary to ensure they are not paying for a medication from a supplier with a higher price.
3. Ensure that when the physician states "no substitute allowed" on a prescription that the supplier's medication is not within the PBM/PBN formulary, before paying the "no substitution" price.
4. When a physician within the claims administrator's MPN dispense medications, ensure that (a) they do not increase the price of the medication by identify the medication as "no substitute allowed" and (b) the lowest available price for a medication from a supplier listed in the Medi-Cal formulary is applied, unless a lower contracted rate in already in place within the MPN.
5. Analyze pharmaceuticals costs on at least a monthly basis to (a) ensure the lowest price for a medication has been paid regardless of supplier and (b) monitor medications most frequently dispensed along with their quantities to ensure PBMs/PBNs and physicians are dispensing the lowest cost medication as identified in the Medi-Cal formulary unless a lower contracted rate is already in place.

However, to achieve the most favorable outcome from the above initiatives in a timely and cost effective manner, claims administrator's vendor management, pre-authorization and bill review systems must be seamlessly integrated and also capture data at the most granular level, which in the case of pharmaceuticals in the United States is the National Drug Code (NDC). Failing to do this, pharmaceuticals costs increases associated with pricing as illustrated in California will continue to increase regardless of legislation changes enacted in the future.

The report relating to this study is available in PDF format from the website managingdisability.com under the Dialogue tab.

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