



FORMER JACKSONVILLE JAGUARS quarterback Mark Brunell is helped off the field after injuring his right knee against the New York Giants in August 1997. Diagnoses of knee and leg injuries have increased the most in cost severity between 1996-1997 and 2001-2002, according to the National Council on Compensation Insurance.

● WORKERS' COMPENSATION

The Utilization Side of the Story

Utilization management is an increasingly important component of controlling pharmaceutical costs. No wonder workers' compensation PBMs are multiplying like rabbits. BY MADDY BOWLING AND DAVID HUTH

Let's say you and your pharmacy benefit manager are sophisticated and vigilant in your efforts to control spending on pharmaceuticals. Despite the wholesale pricing complications, you feel confident that your injured employees are getting what they need to heal the injury and return to work quickly at the lowest possible price.

Despite vigilance on pricing, your efforts could be almost entirely wasted if the treating doctor is prescribing the wrong medicine, for too long a time and without monitoring the effectiveness of the treatment. Utilization—how often and how much of a drug is used—can offset any savings.

And it isn't whether the injured worker is taking

too many drugs or too much of a single drug. With some therapies an insufficient amount of treatment with a pharmaceutical can delay recovery and keep the worker off the job longer. But, by combining ongoing analysis of claims data, benchmarking with existing data and following the most recent treatment protocols for return to work, employers probably have a better chance of keeping utilization costs where they should be.

Much worse, however, is that insufficient monitoring of drug treatment therapies can result in further complications to the original injury and possibly additional disabling issues. Our confusion about the cost of prescription drugs

is only compounded by an industry-wide lack of information about what represents appropriate utilization of pharmaceuticals in workers' comp claims.

Many readers should be familiar with the "traditional managed care" formula: unit cost management plus utilization management plus disability management equals workers' comp managed care.

Unit cost management is managing the price of each component of the care. Utilization management is managing the necessity, appropriateness, setting, intensity and duration of each component of the care. Disability management boils down to managing the quickest sustainable return-to-work program.

The same basic formula applies to managing the pharmaceutical aspect of care. For different claims, different jurisdictions, different employers, one component may carry more weight than others, but the best overall outcome results from managing all three elements simultaneously.

Unfortunately, managing pharmaceutical unit pricing in the current workers' comp environment can quickly become an exercise in futility given all the different drug pricing mechanisms, conflicting sources of price data and potentially contradictory state fee schedules. (See Part I, now available at www.riskandinsurance.com.)

Managing the utilization aspect of pharmaceutical costs can be almost as challenging given the lack of standards of care and the paucity of timely industry-wide data for comparison and benchmarking. Here we're talking about, from a medical point of view, how long the patient should be on a particular drug regimen, what are the criteria for ending that treatment and where does a return-to-work program fit into that mix.

Most of the available workers' comp-specific data on pharmacy unit cost and utilization rates comes to us from organizations such as the National Council on Compensation Insurance and the Workers Compensation Research Institute. They focus on reporting developed claim data that is typically at least three to four years old. The age of the available industry data makes it especially difficult for companies to control the utilization component of their pharmaceutical costs and to know whether their efforts are successful.

For example, an excellent study of workers' comp prescription drug costs and utilization was published by NCCI in July 2006. Unfortunately, that study only included data on claims through 2003. In fact, two of the top 10 prescribed drugs presented in the NCCI study—Vioxx and Bextra—have already been withdrawn from the U.S. market. The FDA has also recommended "black box warning" labels for another top 10 drug—Celebrex.

According to the NCCI study, these three drugs represented nearly 15 percent of the total prescription drug payments in workers' comp in 2003. But they were restricted or removed from the market nearly four years ago. Payers and employers are now in the dark on what drugs have emerged as the industry's leaders in terms of utilization or cost and how overall prescription drug costs are trending since 2003.

This is where payers and employers can benefit tremendously from the assistance of a workers' comp pharmacy benefit manager, or PBM. Historically, PBMs have offered their clients access to discounted pricing arrangements with a network

Summary

- Utilization can derail any efforts to control spending on pharmaceuticals.
- It is difficult for companies to control the utilization component of their pharmaceutical spending, and to know the success level of their efforts, because of outdated industry data.
- Partnering with a pharmacy benefit manager that has true workers' comp experience is crucial.

of pharmacies, akin to the PPO arrangements used for traditional medical care. As anyone who has attended an industry conference in the last five years knows, workers' comp PBMs have been multiplying like rabbits.

Partnering with a PBM that truly has workers' comp expertise is becoming increasingly important as the utilization management component of managing pharmaceutical costs catches up to, or in many cases even surpasses, the unit price component.

While it may be slightly dated information, data from a recent NCCI study suggests that managing pharmaceutical costs is no longer simply a matter of applying pharmacy network discounts to prescriptions. In a January 2007 research brief in which they sought to measure the factors driving increasing medical costs, NCCI determined that higher utilization was nearly as much of a factor as increasing prices when comparing the cost of drugs, supplies and DME per claim between 1996-1997 and 2001-2002 accident year claims.

In the case of knee and leg sprains—the diagnosis that has increased the most in cost severity between 1996-1997 and 2001-2002, according to NCCI—the growth in drug and supply utilization has been nearly twice as great as the corresponding price increases.

The best workers' comp PBMs are beginning to offer more sophisticated drug utilization review programs that target specific prescription drugs based on injury type as well as the age of the claim. The latter is critical as the major prescription cost drivers typically vary dramatically based on the age of a workers' comp claim, as does the appropriateness of different drugs or classes of drugs.

For example, while OxyContin/Oxycodone may be perfectly appropriate to manage pain in post-surgical claims, it typically would not be appropriate for use as a general painkiller within the first 30 days of a claim. Your selected PBM partner should be able to administer drug formularies that reflect those differences both by claim type and based on the life cycle of the claim, as well as other drugs being administered to the same claimant.

This "claim life cycle" approach to drug utilization review is especially critical when you consider the actual prescription drug spending patterns in workers' comp. Given all the attention the industry focuses on trying to capture the "first fill" for claims, most workers' comp payers and employers naturally assume that a significant portion of their total prescription costs must fall within the first 30 or 60 days of the life of a claim.

In actuality, almost the complete opposite is true. According to Matthew Schreiber, vice president of sales, marketing and product development at PMSI, more than 70 percent of a typical workers' comp payer's prescriptions and more than

80 percent of their prescription costs are for claims that are more than a year old.

These results are consistent with a long-term study by NCCI that looked at how prescription drug costs grew to a larger percentage of total medical costs the longer a claim remained open. During the first year of a claim's life, prescription drugs represented less than 5 percent of total medical payments. By the time claims were six years old, prescription drugs grew to nearly 30 percent of total medical costs in the period.

Another key area where workers' comp expertise is required is ensuring compliance with jurisdictional requirements. Whereas the group health PBM market is driven by the design of individual employers' health plans, the workers' comp market is ruled by the regulations set by individual states.

Workers' comp PBMs should have staff dedicated to monitoring all these regulations and ensure that their processes and systems maintain compliance for their clients. It is sad but telling that a new startup, CompPharma, recently

began marketing these jurisdictional research and compliance services on an outsourced basis to PBMs that clearly do not have that industry expertise within their organizations. Not many payers will be comfortable with their contracted PBM outsourcing their workers' comp law interpretations. Payers should expect their PBM to be internally equipped with workers' comp industry and regulatory expertise and experience.

Workers' comp-specific expertise is also critical in helping claims adjusters truly manage the cost of

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prescription drugs on their claims. A company's drug utilization review program may flag questionable prescriptions based on detailed formularies or early refills. But the program doesn't help if the adjuster doesn't know enough about the drug in question to deny payment.

According to Gary Daly, vice president of sales at ScripNet, "Our job is to give the adjuster enough information and the right tools so that they feel empowered to say 'No' when it is appropriate." For that reason, many of the leading workers' comp PBMs are implementing more sophisticated tools such as "adjuster portals" that put drug reference materials, comprehensive utilization review results and detailed claim-specific prescription histories right at the adjusters' fingertips.

Workers' comp PBMs also need a strategy for dealing with third-party billers. Unlike the group health world, workers' comp patients rarely know who their workers' comp claims payer is. This means that the pharmacy often cannot determine the claimant's eligibility or where to send the invoice for the first prescription on the claim.

Since the pharmacies typically do not have the time or resources to research these claims, companies such as WorkingRx and Third Party Solutions offer to "buy" the prescription invoice—usually at a discounted amount—from the pharmacy. They then research the claim and rebill the appropriate claims payer.

Payers complain that the amounts invoiced by these third-party billers are more than they would have paid the pharmacy. They are often significantly more than the contracted rates offered by their PBMs, and therefore represent lost savings opportunities.

The fundamental challenge for PBMs is to ensure that the pharmacy knows where to send their invoices as early as possible in the life of a workers' comp claim so that they do not need to sell that bill to a third-party biller and the payer does not pay any more for the prescription than is necessary.

Many PBMs have been aggressively implementing "carded programs" in which an injured worker is given a workers' comp prescription benefit card either before or immediately following an injury so that the pharmacy will then know who to invoice and won't turn to the third-party billers.

ScripNet has taken the most aggressive stance against the third-party billers, arguing that since ScripNet has direct contracts with their pharmacies (unlike many other PBMs which merely lease access to pharmacy networks), even if a participating pharmacy sells a covered prescription to a third-party biller, the payer is only obligated to reimburse that biller for the lower contracted amount originally agreed to by the pharmacy.

Other PBMs have taken a

more conciliatory approach to the third-party billers. They negotiate arrangements in which either the PBM pays all the third-party bills at a "discounted" amount below the biller's normal rate, or in which the third-party biller is paid their full rate for the first fill on any claims they receive. That's done in exchange for agreeing to transition any future prescriptions on those claims to the PBM to process as an in-network prescription.

Whichever approach you favor, one thing remains certain—your PBM should have a strategy for

dealing with the third-party billers in order to maximize your prescription savings.

The final criterion we recommend for selecting the "right PBM" is integrated analytics. Your PBM partner should be able to routinely provide your organization with analyses.

Since there is such a dearth of industry-wide benchmarks, your PBM should provide you with comparative data from their book of business to help put your trends into a broader perspective and also to identify problem areas that merit

additional focus. You should also expect an action plan from your PBM and changes to your specific program that deal with the areas that merit this focus. Ultimately, network penetration and savings only matter if you are getting overall reductions in the duration and cost of your workers' comp claims. Be sure your PBM is on the same page as you are in regards to ultimate outcomes.

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