

The Journal of Workers Compensation

A quarterly review of risk management and cost containment strategies

VOL. 18 NO. 2

WINTER 2009

PRESCRIPTION COSTS VARY WIDELY FROM STATE TO STATE
WHERE DOES YOUR STATE FIT IN?



MANAGING THE IMPOSSIBLE
RETURNING CATASTROPHICALLY INJURED PEOPLE TO WORK



HOW WILL NEW LEGISLATION AFFECT YOU?
NEW REQUIREMENTS FOR MEDICARE SET-ASIDE ARRANGEMENTS



AVOIDING "ADVERSE SURPRISES"
USING PREDICTIVE MODELING TO INTERVENE EARLY

COLUMNS

FROM THE COURTS
DEVELOPING CASE LAW

COMMENTARY
THE E-MOD EFFECT

OSHA OUTLOOK
THE FALL OF FREQUENCY

NCCI NOTES
VIOLENCE IN THE WORKPLACE

S·P
1 8 6 5

www.spcpub.com

WORKERS COMPENSATION PRESCRIPTION COSTS VARY WIDELY FROM STATE TO STATE

MARIA SCIAME AND MATTHEW FOSTER

Given the current financial crisis in the United States and across the globe, today's businesses must be ever more vigilant about controlling costs. Unfortunately, the myriad of rules and regulations governing workers compensation benefits across the nation continues to confuse insurers, employers, and third-party administrators. At the same time, separate rules from state to state make it difficult to establish standardized cost-containment strategies. To better understand the opportunities and challenges associated with workers compensation, this article specifically looks at prescription drug costs among injured workers state-by-state. The goal is to educate payors across the nation regarding state-specific variations in cost of medication therapy.

STATE TRENDS

One of the key differences that distinguish workers compensation from

cost per injured worker from low-cost to high-cost states.

Exhibit 2 shows that the average pharmaceutical cost per injured worker in a low-cost state is \$579.08; that number jumps to \$1,722.31 in a high-cost state. This cost increase is accompanied by an increase in prescription price and in the number of prescriptions per injured worker.

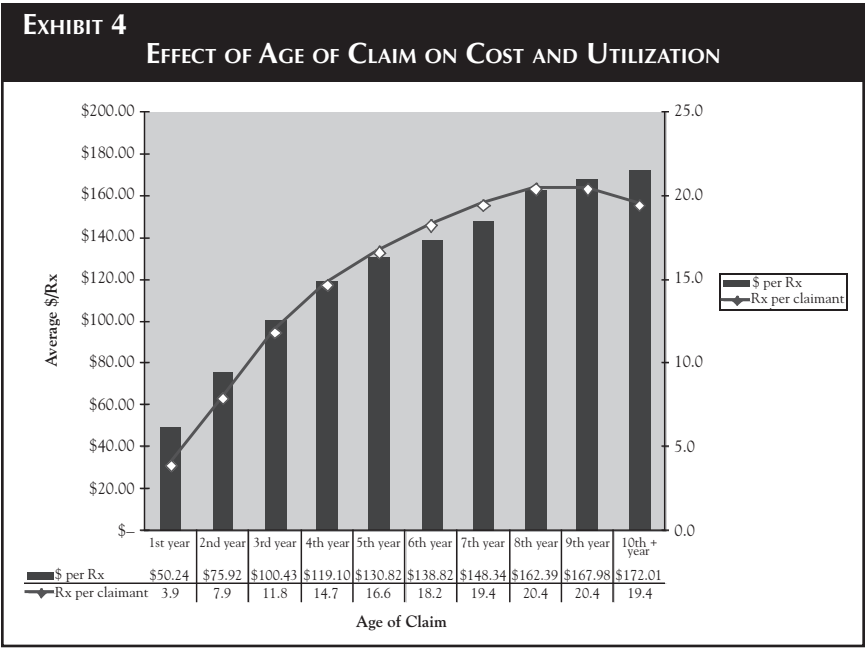
As an injury progresses into a chronic phase and therefore older age of claim, higher doses of existing medications or more expensive, typically brand-name medications, may be prescribed, resulting in higher prescription prices and higher cost per injured worker. In order to determine the true impact of utilization changes on prescription costs, it is necessary to normalize utilization by the age of claims. As anticipated, high-cost

EXHIBIT 2
2007 AVERAGE COST PER INJURED WORKER BY STATE CATEGORY

State Category	Average Price/Rx	Number of Rx/ Injured Worker	Cost/Injured Worker
Low Cost	\$95.40	6.07	\$579.08
Medium Cost	\$124.06	8.19	\$1,016.05
High Cost	\$151.08	11.40	\$1,722.31
Overall Average	\$130.11	8.77	\$1,141.06

EXHIBIT 3
**2007 AVERAGE COST PER INJURED WORKER BY
STATE CATEGORY, NORMALIZED FOR AGE OF CLAIM**

State Category	Average Age of Claim in Years	Average Price/Rx (AWP)	Number of Rx/Injured Worker	Cost/ Injured Worker
Low Cost	3.87	\$95.40	1.57	\$149.78
Medium Cost	5.16	\$124.06	1.59	\$197.26
High Cost	7.42	\$151.08	1.54	\$232.66
Overall Average	5.61	\$130.11	1.56	\$202.97



states had an average claim age of 7.42 years, while low-cost states had an average claim age of 3.87 years (Exhibit 3).

When normalizing the number of prescriptions per injured worker to this variable, high-cost states had an average of 1.54 prescriptions per year of claim age compared to 1.57 for low-cost states. This comparison suggests that since utilization normalized by the age of claim is relatively constant, the variance in utilization from state to state is influenced almost exclusively by the age of the claim versus any regional or state-specific trend in prescribing patterns. Therefore, the driver for state variations in cost per injured worker can be attributed primarily to variations in the age of claim (Exhibit 4).

GENERIC MANDATES

Requirements for mandatory dispensing of generic formulations are state-specific strategies for controlling workers compensation costs. As of 2008, there were generic mandates in 32 states and the District of Columbia. Several states, such as Texas, Kentucky, and North Dakota, allow the injured worker to pay the difference in price between the brand and the generic prescription if choosing a brand medication when a generic alternative is available. However, this expense is overridden if the physician indicates on the prescription that the brand name is medically

EXHIBIT 5

GENERIC USAGE BY GENERIC MANDATORY STATUS

Status	Generic Utilization	Generic Efficiency
Non-Mandatory Generic States	69.1%	92.6%
Mandatory Generic States	67.9%	93.8%
Mandatory Generic with Co-pay Differential – DAW-1 Exception (TX, KY, ND)	71.5%	95.8%
Manadatory Generic with Co-pay Differential – No Exceptions (OH)	70.7%	95.2%

necessary. Ohio currently requires the injured worker to pay the price difference in all situations, regardless of whether the physician indicates that the brand is medically necessary.

Exhibit 5 demonstrates the small variability that exists in actual generic utilization between generic-mandatory and nonmandatory states. In fact, states that require the use of generics have a 1.5 percent lower generic utilization rate than states that don't require the use of generics.

This discrepancy may be explained by the fact that generic substitution is already integrated into the practice habits of most pharmacists, as substitution is required by law (outside of workers compensation) in many states.

RECENT AND PENDING STATE REGULATORY AND LEGISLATIVE ACTIVITY

During 2007 and 2008, workers compensation pharmacy providers and payors continued to see state regulatory and legislative activity aimed at controlling increases in total drug spending. In general, state governments have three distinct means by which they can regulate costs — fee schedules, drug utilization mandates, and generic mandates.

Fee Schedules and Generic Mandates

Regulated fee schedules are the most direct means to control drug costs. In 2007 and 2008, the following 13 states implemented fee schedule changes, 11 of which were fee schedule reductions, and 2 increased dispensing fees. In addition, two states implemented generic mandates.

AL	Increased dispensing fees
AZ	Reduced fee schedule reimbursement
DE	Reduced fee schedule reimbursement
GA	Reduced fee schedule reimbursement
MA	Reduced fee schedule reimbursement
MI	Reduced fee schedule reimbursement — implemented split dispensing fees
MS	Reduced fee schedule reimbursement — reduced dispensing fees, implemented generic mandate
MT	Reduced fee schedule reimbursement — changed dispensing fees
NV	Increased dispensing fees
NM	Reduced fee schedule reimbursement — changed dispensing fees
NY	Reduced fee schedule reimbursement — implemented reduction in dispensing fees and generic mandate
OR	Reduced fee schedule reimbursement
WY	Reduced fee schedule reimbursement

Drug Utilization Mandates

Another strategy for long-term cost containment is to manage drug utilization. Public policies can include clinical programs, pharmacy direction-of-care programs, drug formularies, or treatment guidelines. In 2007 and 2008, Texas and New York implemented programs that target utilization. Initial versions of the New York legislation permitted payors and providers to direct pharmacy care for injured workers through their established pharmacy networks, which include not only mail-order pharmacies, but also PBMs and their network of retail pharmacies. Whether this initial version will be incorporated into the permanent rule remains to be seen. Texas is finalizing the implementation of the Occupational Disability Guidelines (ODG) for chronic pain management.

Looking Forward

Ongoing efforts continue in specific states to implement changes in workers compensation regulations to decrease medication costs. California's pharmacy fee schedule remains volatile due to continued budget deficits in the state. The Delaware Department of Labor was charged by the State Legislature in 2007 to implement new health-care fee schedules and treatment guidelines by the end of 2008. Texas continues to move forward with the creation of a workers compensation-specific drug formulary, which will include prior authorization requirements for drugs not included in the "closed formulary." Numerous states continue to look toward electronic billing and state reporting as ways to quickly obtain and analyze data to support decisions in controlling workers compensation pharmacy costs. In 2007, only three states, Florida, Tennessee, and Texas, moved forward

Workers Compensation Prescription Costs Vary Widely From State to State

EXHIBIT 6					
State	State category	Average age of claim in years	Average price/Rx (AWP)	Number of Rx/injured worker	Average cost/injured worker
AK	Low	3.89	\$98.86	7.03	\$694.99
AL	High	9.24	\$135.88	14.99	\$2,036.84
AR	Low	3.7	\$89.47	5.75	\$514.45
AZ	Medium	6.41	\$126.15	5.93	\$748.07
CA	High	6.96	\$158.02	10.59	\$1,673.43
CO	Medium	4.41	\$140.10	7.78	\$1,089.98
CT	Medium	3.89	\$127.70	7.91	\$1,011.38
DC	High	7.29	\$146.95	8.98	\$1,319.61
DE	High	5.97	\$150.75	10.5	\$1,582.88
FL	Medium	6.06	\$125.07	7.89	\$986.80
GA	High	4.92	\$140.37	9.91	\$1,391.07
HI	Medium	8.63	\$138.87	8.82	\$1,224.83
IA	Low	3.69	\$83.61	4.98	\$416.38
ID	Medium	1.54	\$174.92	4.84	\$846.61
IL	Low	2.66	\$104.47	6.69	\$698.90
IN	Low	1.76	\$84.99	4.81	\$408.80
KS	Low	3.09	\$97.37	6.5	\$632.91
KY	High	6.46	\$116.48	12.42	\$1,446.68
LA	High	6.28	\$121.05	15.65	\$1,894.43
MA	Medium	4.62	\$118.75	8.91	\$1,058.06
MD	High	6.41	\$163.98	10.59	\$1,736.55
ME	High	8.85	\$144.16	9.59	\$1,382.49
MI	Medium	6.58	\$126.17	7.4	\$933.66
MN	Medium	8.16	\$111.18	7.4	\$822.73
MO	Low	2.89	\$93.88	5.35	\$502.26
MS	Medium	4	\$100.03	9.56	\$956.29
MT	Medium	6.43	\$109.32	10.83	\$1,183.94
NC	Medium	3.96	\$120.96	8.04	\$972.52
ND	High	11.26	\$204.88	14.5	\$2,970.76
NE	Low	3.25	\$99.81	6.14	\$612.83
NH	Medium	6.51	\$128.31	10.02	\$1,285.67
NJ	High	6.91	\$191.25	8.94	\$1,709.78
NM	Medium	4.58	\$125.00	8.85	\$1,106.25
NV	Low	1.35	\$80.12	4.32	\$346.12
NY	High	6.58	\$156.46	10.19	\$1,594.33
OH	High	9.33	\$133.80	11.4	\$1,525.32
OK	Medium	2.86	\$98.91	8.59	\$849.64
OR	Medium	3.66	\$104.64	7.08	\$740.85
PA	Medium	6.71	\$146.87	8.29	\$1,217.55
RI	Medium	5.01	\$136.35	7.08	\$965.36
SC	Medium	3.72	\$123.73	9.08	\$1,123.47
SD	Medium	6.58	\$133.77	6.61	\$884.22
TN	Medium	4.52	\$117.60	8.19	\$963.14
TX	Medium	4.62	\$98.07	8.94	\$876.75
UT	Low	3.82	\$115.13	5.94	\$683.87
VA	Medium	5.43	\$126.59	8.73	\$1,105.13
VT	Medium	4.84	\$118.40	9.69	\$1,147.30
WA	Low	4.49	\$81.90	8.15	\$667.49
WI	Low	4.48	\$104.39	6.06	\$632.60
WV	Low	10.25	\$126.04	4.88	\$615.08
WY	Low	4.93	\$75.52	8.32	\$628.33
Overall Avg.		5.61	\$130.11	8.77	\$1,141.06

with eBilling conversion and state-reporting programs. However, many states are scheduled to join them in implementing protocols for pharmacy services, including California, Minnesota, New York, North Carolina, and Oregon.

MAKING DECISIONS BASED ON THE DATA

State-specific data as outlined above should be reviewed and referenced by insurers, employers, and third party administrators to effect change and drive down costs. Armed with trends, analysis, and benchmarking data, risk managers and executives can compare and evaluate their workers compensation programs and make informed business decisions to drive successful pharmacy benefit management outcomes.

Maria Sciamè, PharmD, CDE, RRT, is the Director of Clinical Services at PMSI, a workers compensation pharmacy benefits management firm in Tampa, Fla. Matthew Foster, PharmD, BCPS, is a clinical pharmacist at PMSI. Both pharmacists hold Doctor of Pharmacy Degrees from the University of Florida, College of Pharmacy, where they serve as Clinical Assistant Professors of Pharmacy.