

Workers' Compensation Division
Medical Quality Initiative – Pharmacy Project

Executive Summary and Recommendations

January 2007

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Attachments:

- 1) Project charter
- 2) Definitions and Glossary
- 3) Data Analyses
- 4) Drug Effectiveness Review Project (DERP)
- 5) Follow the Pill - U.S. Commercial Pharmaceutical Supply Chain
- 6) Health Strategy - Payer Prescription Drug Management Survey
- 7) Heinz Report – The Oregon Blueprint
- 8) Kaiser Foundation Drug Trends
- 9) Oregon Payer Survey
- 10) NCCI Prescription Drug Study – 2004
- 11) NCCI Prescription Drug Study – 2006 Update
- 12) Pharmacy Fee Advisory Task Force 2003
- 13) WCRI 2006 Pharmaceutical Guide for Policymakers

MQI – Pharmacy Project
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This summary report contains:

- Project overview
- Current pharmacy issues
- Data analyses and conclusions
- Project recommendations

Overview

As stated in the Project Charter, the focus of this project is to explore pharmaceutical cost-containment models from a statewide perspective and provide systemic solutions to current issues. The project team worked closely with key stakeholders, surveyed workers' compensation (WC) payers, researched pharmacy literature, completed data analyses, and prepared recommendations relating to pharmaceutical cost controls to be submitted to Workers' Compensation Division (WCD) Executive Team for further consideration.

The pharmacy terms used in this summary report are explained in the attached "Definitions and Glossary."

Pharmacy Issues

The attached summary reports from a variety of national studies that frame the many complex issues surrounding WC pharmacy benefits and the difficulty in reaching viable cost-containment options. Some of the key points found in these studies are:

- While pharmacy payments continue to rise nationally, the most recent trend indicates a decline in the pharmacy growth rates.
- WC payers report that average prescription payments (nationally) are **74 percent** higher than in general health care. Several studies point to the fact that WC prescriptions have complex issues, such as: claim acceptance status, burdensome paperwork (not required for general health), and difficulties in collecting payments. These factors increase the risk of nonpayment to the pharmacy, resulting in higher reimbursement rates and fees for WC prescriptions.
- Utilization controls (such as mandating generic drugs when available) are the key to cost containment, even more so than price controls (i.e., reimbursement rates and dispensing fees). Efforts to provide cost containment by reducing reimbursement rates and dispensing fees need to be balanced with worker access issues.
- Twenty-nine states (out of 50 included in the 2006 WCRI study), including Oregon, use Average Wholesale Price (AWP) as the pricing benchmark for their WC fee schedules. Currently no state regulates or defines the AWP. Additionally, pharmaceutical manufacturers heavily influence the establishment of the AWP, thus, there remains a question as to whether the AWP is an appropriate pricing benchmark.

- Enrollment in the pharmacy benefit manager (PBM) programs provides cost-containment opportunities to the payers as well as ensures that the workers receive proper and effective medications. In Oregon, all payers, except self-insured, self-administered entities, contract with a PBM. Although PBMs appear to provide cost savings and utilization controls, nationally there is a rising concern regarding the lack of transparency for rebates and other inducements paid by the manufacturers to the PBMs.
- Some states provide a tiered WC pharmacy fee schedule, paying higher reimbursement rates and/or dispensing fees for generics and less for brand drugs. In nine states, the worker can obtain the brand if the worker pays the difference between the brand and the generic.
- Oregon's WC pharmacy fee schedule pays the lowest AWP rate (- 12 percent), of the 29 states (WCRI, 2006), and has the second highest dispensing fee (\$8.70).
- According to the Information Management Division's (IMD) first quarter 2004 Pharmacy Payment report, generic drugs represented 67 percent of dispensed medications in Oregon's WC system compared to 56 percent dispensed medications in general health care, nationally.

Data Analysis

IMD team members provided extensive and in-depth analyses of pharmacy data mainly from Bulletin 220 medical data. Below are the major highlights from the data analysis.

- The growth rate of pharmacy payments dropped significantly from 22.4 percent in 2002 to 3.2 percent in 2005 (Table 1).

Table 1. Pharmacy Payments and Growth Rates, 2000-2005

Calendar Year	Total Payments	Growth Rate
2000	\$8,877,943	N/A
2001	\$10,703,551	20.6%
2002	\$13,103,785	22.4%
2003	\$15,100,958	15.2%
2004	\$16,055,352	6.3%
2005	\$16,573,788	3.2%
Average	\$13,402,563	13.6%

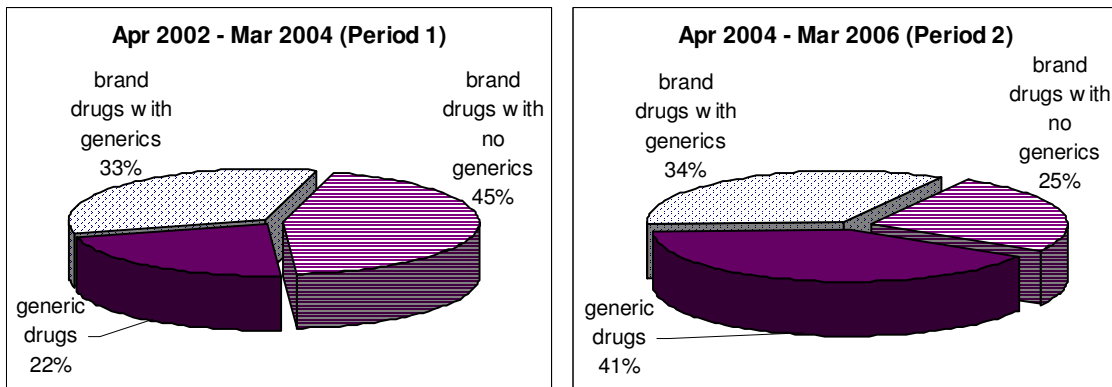
* Growth rates are calculated as percentage change between two consecutive years.

In April 2004, the WC pharmacy fee schedule changed from 95 percent of AWP to 88 percent of AWP. Additionally, the dispensing fee increased from \$6.70 to \$8.70.

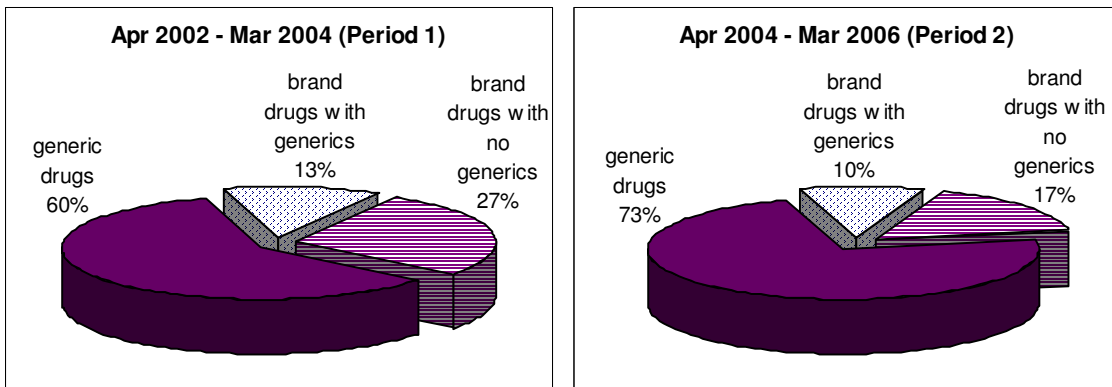
The following charts summarize total payments and dispenses for the top 20 drugs in period 1 (prior to the April 2004 rule change) and period 2 (after the rule change). Period 1 and period 2 are equal periods of time.

- The proportion of generic drug payments and dispenses increased in period 2.
- The proportion of payments and dispenses for brand-name drugs decreased in period 2. Two actions may have driven this reduction: 1) generic substitutes for Oxycontin, Neurontin, and Duragesic became available in period 2, and, 2) Vioxx and Bextra were taken off the market.

Total Payments



Total Dispenses



In addition to the information above, Chart 3 (in the attached data analysis report) provides the following information:

- Payments and charges (as a percent of fee schedule) were lower for generic drugs compared to brand drugs.
- Payments for generic drugs were at **58 percent** of fee schedule whereas payments for brand drugs were at **94 percent** of fee schedule.
- Charges for generic drugs were at **84 percent** of fee schedule while charges for brand drugs were at **106 percent** of fee schedule.

Data Analysis Conclusions

- Decreasing the current fee schedule's percentage of AWP is likely to impact higher-priced (brand) drugs, whereas decreasing the dispensing fee is more likely to impact lower-priced (generic) drugs.
- The change in the fee schedule in April 2004 (\$2 increase in the dispensing fee and the 7 percent reduction of AWP) had a positive impact on the utilization of generic drugs.

Recommendations

1. Research the current pharmacy fee schedule and work with stakeholders to tier AWP reimbursement rates and dispensing fees for generics and brands. Furthermore, consider alternative drug pricing benchmarks such as the Federal Upper Limit (FUL), Maximum Allowable Cost (MAC), and the Wholesale Acquisition Cost (WAC).
2. Educate providers and pharmacies to promote the increased use of appropriate generics, step therapy, and cost-effective prescribing protocols using evidence-based models.
3. Develop rule language that clearly delineates the above-recommended protocols.
4. Assist the Medical Advisory Committee (MAC), by providing the necessary tools and expertise to allow for timely review of WC pharmacy issues and rules.
5. Purchase or contract for comprehensive pharmaceutical pricing information, including consistent and up-to-date national drug codes (NDC) and other necessary data elements in order to better analyze and provide more detailed pharmacy cost data.
6. Reconvene the internal WCD/IMD pharmacy work group in order to keep up to date and report back on WC pharmacy issues and/or updated national studies and data.
7. Coordinate with WCD's medical indicator group to determine if there are pharmacy indicators that need to be included.

The MQI Pharmacy project team thanks you for taking the time to review this summary report as well as the attached summary reports and data analyses. The team also appreciates your consideration of the seven recommendations and looks forward to your feedback.

If you have any questions, please contact Holly Mercer or Nanci Johnston.

Attachments