Workers' Comp

Closing Loopholes: Tackling Drug Price Inflation in Work Comp

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Tom Kerr (TK): Rising drug prices have been a major concern in health care for years and have had a significant impact on comp costs as well. Today, Brian Allen joins us to discuss the issue and what's being done to curb the costs. Brian, thanks for joining us.

Brian Allen (BA): Thanks, Tom. Appreciate it.

TK: Brian, Congress has wrestled with drug costs for quite a while now. Can you talk about the number of bills currently in Congress that address these concerns at the federal level?

BA: Sure. There's a number of things happening at the federal level. There are bills in Congress right now and one of the most attention?getting things that's going on is CMS negotiating some drug prices for Medicare recipients. That's in its early stages.

It'll be interesting to see what kind of impact that has on the marketplace, if any. The conventional wisdom is that if Medicare negotiates lower rates for those drugs, the marketplace should see lower rates. There are some who are more cynical about that, like me, who believe that it will just be a cost shift to the private marketplace that's outside of Medicare where they'll raise costs for the drugs that are negotiated lower in Medicare.

So, we don't know what's going to happen until we see it happen. So, we're watching that carefully. There are a number of bills in Congress dealing with drug pricing. Most of them are transparency type bills in government programs, just trying to figure out where costs are added to the price of a drug throughout the supply chain.

There is a bill to outlaw rebates, which would be interesting. I don't know what that impact would be if that were to happen. Rebates have a safe harbor exemption right now from the kickback statutes. And there's an effort underway in Congress to remove that safe harbor and to make kickbacks or make the rebates illegal. Kickbacks are already illegal; it just makes the rebates considered kickbacks.

That bill has not moved very far. I know that in the halls of Congress, there's been a lot of discussion about rebates and injured drug pricing in general. What you don't see a lot of — which is interesting — are things that might make a real difference in drug pricing, which is getting rid of some of the patent abuses that go on, where they extend patents out unnecessarily for branded drugs so that they can charge the higher prices.

The other thing that hasn't been done is addressing direct?to?consumer advertising. If you look at the statistics on drug pricing, if you look at when advertising became legal to do, the next years, it's like a rocket going straight up in the air on the graph as to how fast the drug spend per person increased in this country.

So, direct?to?consumer advertising has an impact on the kind of drugs that people buy, and there's a lot of that out there. There's been some talk among some circles in Congress and other policymakers and health-policy wonks that maybe it's time for Congress to look at that and see if that's appropriate. So, there are things like that in Congress that you're not really seeing a lot about that might have real impact, but you know, we're waiting to see.

There's a lot of things being bandied about in Congress, but Congress right now isn't doing a whole lot. So, we're not optimistic about anything coming out Congress this year that's going to be very productive, especially it being an election year.

TK: OK. And when you look at the state level what does the pharmacy focus look like for workers' comp?

BA: Well, I think at the state level in general, there's still a lot of effort around transparency. Some states in the past had transparency on pharmacy benefit management (PBMs) and wholesalers, but now they're adding drug manufacturers to that.

They want to see the price changes from the drug manufacturer all the way out through the supply chain. So, states are starting to get aggressive about that. There's a lot of bills this year on drug price transparency at state level and most of them target PBMs, pharmacy services administrative organizations (PSAOs).

But a lot of states now are adding drug manufacturers to that list. So, that'll be interesting to see. Drug manufacturers have typically lobbied hard against getting included in those. They don't want to pull back the covers and let people see how the pricing works, but the states are really getting active, and some states have been successful at getting them in.

So, it's a huge lobbying effort. It's probably a lobbyist employment act in most of the states when these kinds of things are happening, but the reality of it is that states are really looking at transparency.

The other thing that you're seeing in the workers' comp space is the outliers. It really becomes a game of whack ?a?mole because what happens is, for example, when you shut down physician dispensing in a state or narrow it down, what you see is a transition to these physicians and referring to out-of-state mail-order pharmacies, where they're likely must be some sort of financial incentive to do that. We don't really know what that is, but there's this shift to the out-of-state mailer, which is more expensive than you're in-state retail pharmacy.

So, there's always this shift; they go to compounded medications, or they go to topical creams, in some jurisdictions. We still have a problem where you have these high-price topical creams that are not FDA-approved. There are no efficacy studies on how well they work, but they cost thousands of dollars a month. The doctors are dispensing or prescribing those in the commercial health care space and in the Medicare and Medicaid space, there's contracts that prohibit a lot of that kind of behavior.

But in workers' comp, anytime a state allows for free choice of provider by the injured employee, there's no real way to control the behavior of the injured employee and what provider he or she chooses. And there's no incentive on the part of the injured employee to choose a low-cost provider or a better value provider. They're going to go wherever they're told to go, usually by whoever they're going to listen to or trust the most, which is often an attorney or their doctor.

So, those kinds of outliers, every time we shut one down, there's a new one. And, they're very creative. They're very smart. When we went with physician dispensing, they were creating new NDC. So, we had these NDCs for repackaged drugs and they were very costly.

So, we shut that down. Well, then the purveyors of this pharmacy supplies to doctors went to manufacturers and had them do boutique drugs just for them that had their own NDC. So, it was the manufacturer's NDC, not the repackaged NDC, but it was high cost. So, then you have to shut that down.

TK: So, what can be done to discourage those from abusing the system?

BA: So, there's this constant chase at the regulatory and legislative level to shut down the abusive practices or the outliers as I call them. And so, it just really becomes challenging. And, you know, at some point, it gets bad enough that they get prosecuted. I know there's been several prosecutions recently of bad actors, multimillion dollar fraud schemes, primarily in the federal space. So, it's the Department of Justice doing it, but it's the federal workers' compensation program that's getting hammered. So, they go after them and enforce it.

States don't have the same resources, so it's a little tougher. And the numbers are smaller, so it's harder to see it. But at the federal level, the numbers get big fast, and so they do go after those guys.

But it's just this constant whack-a-mole, chasing the rabbit, whatever you want to call it, but you never quite catch up to the problem. They're always a step ahead of you.

TK: Is what they're doing technically illegal?

BA: Some of the examples we talked about — physician dispensing, out-of-state mail order — they're not doing anything illegal. They're perfectly within what the law allows. It's just that the law has these large loopholes where you can take advantage of it.

And some, not all, of the out-of-state mail order pharmacies do this. I'm not talking about all of them. Some of them behave very appropriately in the marketplace. But there are others who, if there's a generic drug that you can usually dispense for $10 or $15, but there's also a same generic from a different manufacturer that has a higher profit margin that goes for $25 or $30, they'll do the most expensive one so the margins are higher.

It is challenging and it does add cost to the system that doesn't necessarily need to be there. We got that shut down. We're slowly getting into the states and getting the topical cream shut down. But when you see a tube of cream that's being built for $3,500, $4,500, $5,500 for a 30?day supply that, if you look at the ingredients, actually cost about $20 or $30 to make, it's outrageous. But there's nothing in a lot of state laws that prohibit or prevent that from happening. It's legal, but is it really ethical and should it be done?

So, we try to shut all those things down. For example, in Pennsylvania, we worked very hard to get legislation passed to restrict physician dispensing. What's happening now is that physicians are referring their patients to a particular pharmacy. It seems that pharmacy dispenses the medication at the highest cost possible. Then that pharmacy sells the receivable back to the doctor at a discount, and then the doctor collects at the build price, which is different than the discounted price they paid for it, so they collect the margin. So, they can't profit directly from dispensing the medication, but they buy their own receivable back so they can profit that way.

It's an end-run around the law, but it's allowed, it's not illegal. And there's a court case right now trying to figure out if the third-party vendors that are processing and collecting the bills for the doctors are considered providers under the workers' comp statute, or are they just outside of that?

And so, we're waiting to see what that ruling is. We have this happen all the time in states and it's frustrating. It adds costs to the system. And people say, "Well, you know, workers' comp costs are going down. It's not really that big of a deal." Well, it is a big deal because it's still wasted money and it's money that could be going to benefit injured employees. It's money that could be going to benefit the system. Instead, it's money that I believe is unjustly enriching people for abusive practice that shouldn't be allowed but are. So that's the challenge that we have.

TK: What are some of the main implications impacting the work comp pharmacy benefit?

BA: Well, if you're talking about things that states are doing to try to control costs, one of the things that we're seeing are states adopting formularies — either the ACOM formulary, the ODG formulary, and those are helpful.

Texas has done a marvelous job of analyzing the impact of their drug formulary. They were one of the first states to adopt a formulary in their system, and they've kept really good data on their drug span. And it does show that a drug formulary reduces cost, it reduces the number of prescriptions per claim.

And then one of the big things it did in Texas, is it reduced opioid dispensing. Now, a lot of states have passed laws to limit opioids, and those are having an impact as well, but the drug formularies do seem to do a fairly good job of helping to control costs.

And within the drug formulary rules, you can put in things like pre?authorizing topicals, pre?authorizing compounds, pre?authorizing physician dispense drugs so that you can get at some of the outliers that way, but there's still ways around all of that.

The other thing that you're seeing is just more attention on fee schedules adding the outliers to the fee schedule so that they're captured. I know that Arizona tried to get at some of the outliers by limiting reimbursement to pharmacies that are only accessible to the general public and then had to go through a whole gyration of trying to define what that is.

It was a valiant effort on their part. It's not had quite the effect that we hoped it would've had, but it's hard because there's so many ways around it. All you have to do is open one pharmacy in one location, and now you're a pharmacy accessible to the general public, and so everything else you do through the mail or whatever

then goes around that law.

So, there's no perfect solution, regulatory or legislative, that we've seen that covers it in a blanket fashion. Except one thing that does work is allowing employers to direct injured employees to use a pharmacy network that's established by the employer. That way, the outliers are all handled by the marketplace, right? The network contracts for prices for different medications. You have to join the network to be able to really get reimbursed. And in that network contract, you can control the outliers. That is the one thing I've seen that works very well.

Unfortunately, in states like New York, you see where they do have direction of care, and it has had a remarkable impact on controlling cost that along with their drug formulary, we're seeing efforts to unwind that because there's a profit motivation, right?

It's not because it's going to be better for the injured employee. It's not necessarily because it's going to be better for the system as a whole. And so, that's a challenge and it's not working. Why do we want to do that?

A lot of times in the political world, it's who has the best lobbyists and who's going to scream the loudest or tell the best story? Who's got the best relationship with whoever's running the bill? There are all these kinds of factors that influence how bills get passed, but the reality is it will increase costs.

If that changes in New York, there's no question it's going to increase costs. And, there's nothing in the legislation that does any kind of cost analysis to see what it does to cost, and so it's this who-are-you-going-to-believe kind of bill. And there's no mechanism to actually study or even look at its impact before they pass it.

So, those are challenges we see all the time, but we do know in the states where there is managed directed care that you see a significant reduction in the abuse practice. It doesn't eliminate them 100 percent, but it does significantly limit them compared to the other states that don't have those controls in place.

And it does reduce costs for employers which ultimately is good for every state's economy. It's good for injured employees because, if there's money on the table, there's money that can be spent to help benefit them and help them get well. Everybody else should be allowed to make a reasonable profit, but not an unreasonable profit, and those are the challenges you face.

Direction of care is a way of really kind of reigning back those outliers, and this slows down the game of whack?a?mole. Instead of whacking one every day, you're whacking one every month, and that's helpful.

I can't imagine anything worse than an employer paying $5,000 for a cream that an injured employee gets that doesn't help them. That's got to be frustrating for injured employees because they're given something that doesn't work. And they're wondering, "Why am I getting this?" They don't know how much it costs. They're isolated from that. But then you the employer asks, "Why am I paying for something that I know isn't working?"

The best way to address this is through a managed care network that employers can direct injured employees to. And the beauty of that is, in the workers' comp world, generally 90 percent or more of the pharmacies in the state belong to the workers' comp network.

TK: So, what can be done to facilitate effective managed care networks in workers' comp?

BA: Workers' comp is an anomaly in the managed?care world because they want more providers, not less. And in other forms of health care, they try to restrict providers, especially in the world of vertical integration.

Workers' comp is a very small piece of the marketplace. And we want employees, injured workers, to have access to care and have as many pharmacies in your network as you can get. Allow anyone in who wants to be

in, and there's no reason that a doctor who wants to dispense couldn't join a pharmacy network. There's no reason that these out?of?state mail-order pharmacies who want to dispense couldn't join a pharmacy network. They all can. They're not going to make as much money. They'll still make a little money, but they're not going to be abusing the system.

And the ones who are already doing it right, it won't be a difference to them. They'll still make the same amount of money because they're already doing it prudently. So, it's only really going to hit the outliers' pocketbooks a little bit, but they'll still be able to make a profit, and a fair profit at that.

And the other thing that happens in a pharmacy network is you manage utilization. Oftentimes, you get drugs coming through the system, and there is uncertainty that they're related to the injury. In a managed care network, these drugs are prescreened, so you can make sure that the drug being dispensed is appropriate for the injury. And so those are also important tools as well, that also help reduce costs.

It's not just the price of the drug that matters, it's how many drugs they get, how they use them, and with a managed care network that can all be managed very carefully and get good results. And so, it helps reduce unnecessary costs, and it also helps reduce what we would consider abusive costs.

TK: So, what are some of the other benefits of a managed care network in pharmacy?

BA: Well, the other thing about a managed care network, and allowing the marketplace to work, is that it leads to better cost outcomes. If you want the marketplace to work in workers' comp, you have to let the buying decision happen where the money is being spent, and that's at the payer level.

And the payers aggressively manage their PBM contracts., they shop them every time they're up for renewal. They're looking for the best price, best service, best utilization review, because they're spending the money, so they have a vested interest in making sure that that system works as well as it can.

And they also have a vested interest in making sure the injured worker gets better, because the longer they're off work, the more it costs. So, they want to make sure they're giving the right drugs, at the right time, at the right cost.

So that's one good thing, because you've got market pressure that will work in the workers' comp system. If you take the payer out of the decision about which pharmacy is to be used, then you lose that market choice because there is no financial cost to the injured employee who's making that selection. So, they don't care how much it costs. Probably 99 percent of the time, they don't even know what it costs. Right?

They're not told. They're just trying to get better. They want to get back to work. They want to get back to the life they had before they got hurt. They want to get back to providing for themselves and their families.

So, they're not engaged in that part of it, but the payers are. They care a lot about it because they're the ones paying the bills. So that puts market forces back into the process. The other thing is, it's good for local pharmacies.

I mean, they're losing business to physicians, they're losing business to out?of?state mail order. If I'm a legislator and I care about my local businessmen, I want direction of care because I know that's likely going to stay within the state for the most part. So, that's smart business.

I think the other thing from a regulator standpoint is, you think of all the payment disputes they're not going to have to deal with in the pharmacy world. If there's a managed care network, it's all going to be handled through

the contract process and disputes will be between the pharmacy and the PBM or the PBM and the payer.

There's not going to be disputes that have to be adjudicated at the state level because it's all going to be managed through the contracting process. So, it will significantly limit or reduce the number of disputes they have regarding payments. So, it's good for everybody.

I know to some people, it might seem counterintuitive that while you're telling injured employees where they have to go to get care, but it's pharmacy care. You don't want to disparage what happens in pharmacies. They all do a really good job, but they all do basically the same job. There's not a whole lot of difference from one pharmacy to the next.

There are some nuances for sure. The staff at the particular pharmacy I use are very nice to me. They know me. I'm very comfortable using them. They know my pattern. So, they're great. But, from pharmacy to pharmacy, there's not a ton of difference. So, requiring an injured employee to go to an in-network pharmacy is not going to dramatically change the pharmacy experience.

And, nine-and-a-half times out of 10, the pharmacy they go to for their workers' comp prescription is likely in-network ?? is likely going to be the same pharmacy they are using for their commercial health prescriptions. So, they're not going to see a deviation in care. In fact, they're probably going to get better care because, if they're going to the pharmacy that's already handling all their other stuff, the pharmacist is likely going to have a better understanding of drug interactions and other things that might occur.

Whereas if the employee goes to another provider that doesn't know him or her as well, they may not have that same information. So, there's a whole lot of things that I think are beneficial in a pharmacy network scenario. I think everybody in the system wins. The only people who will lose are the people who are abusing the system, and I don't think anybody really feels bad about that.

TK: From your experience, what are some of the challenges in getting these points across and making legislators care about these issues? Is it a matter of cutting through all the noise so policymakers see it as a priority?

BA: I think the biggest challenge is helping policymakers understand the difference between workers' comp, PBM practices, and commercial health care PBM practices. Across the country, there have been hundreds of bills filed and some passed regulating PBMs because people felt the PBM commercial health space were not playing fairly in the sandbox, taking advantage of pharmacists and patients.

The difference is that, in Medicare, Medicaid, and commercial health plans — which is 98 percent of the insured marketplace — they already use directed managed care networks. Every health plan, every Medicaid plan, every Medicare plan, every Medicare Advantage plan has a pharmacy benefit network that you're supposed to use. I'm not going to say in that space, there have not been problems, but they are trying to get their head around that.

Those problems don't exist in workers' comp because there's no cost sharing with the injured employee. The injured employee has no financial stake in the transaction, so there's no way to play games with copays or play games with deductibles. There's no way to do those things that policymakers have felt were abusive.

The other thing that is happening in the commercial PBM space is this vertical integration and preferred pharmacies where patients were steered towards pharmacies that were vertically integrated or owned by or preferred by the PBM. So that small community pharmacy wasn't, in the end, that preferred game. It was hurting their business. I mean, when you see Amazon opening a pharmacy, and you're a community pharmacist, you're thinking, "OK, that's another blow. That's another bit of business it's going to peel off my local community pharmacy."

It’s unfortunate, but that does not happen in workers’ comp. We don’t have preferred pharmacies. We don’t have places we steer patients to. We give them a list of pharmacies that are located within a reasonable distance of their home and say, “use any one of these that you like.” And, like I said before, 9.5 times out of 10, the pharmacy they’re already using is on that list.

And if their pharmacy isn’t on that list, that pharmacy can get on the list if they want to by just asking to join their network and agreeing to the network terms. We try to make it easy for pharmacists to belong and provide care to injured employees because injured workers need that care and workers’ comp claims are a little bit more complicated than a commercial health claim.

There are things that happen in commercial health that are very predictable. There’s a lot of things that happen in workers’ comp that aren’t predictable. So, if you’re a provider, and you’re giving care to an injured employee, you may find at some point in time, that’s not a compensable claim, and you’re not going to get paid for the services you see, and rendered, at least from the workers’ comp payer.

So, there’s a lot more uncertainty in a workers’ comp transaction. But in a commercial health or Medicare, Medicaid transaction, there’s like 100 percent certainty if it’s approved, it’s going to get paid.

In the workers’ comp space, there’s always a chance it’s not going to be compensable under the workers’ comp statute. So, then they’ve got to go chase it. So, we want to make it easier for pharmacists to belong because they’re the deliverer of services and that’s where we want those services delivered because we think their local pharmacy is the best place for them to get care.

So, that’s really what we promote. Now, unfortunately, the community pharmacists tend to be suspicious of any PBM service, whether workers’ comp or not, because of the things that have happened to them in the commercial health space.

And so, we are trying to bridge that gap and get that message across. But when you’re talking to policymakers, those are the hurdles. There’s a misunderstanding about what we do versus what traditional PBMs do in the commercial health space. And there’s a misunderstanding about how we manage care. We don’t do so many things that happen in the commercial space because we can’t. Injured employees are entitled to whatever care is necessary and medically necessary. We can’t build formularies that exclude drugs that an injured employee might need.

We can’t build formularies that get the best profit margin for us. Whatever gets dispensed is dictated by the doctor treating the patient and by medical treatment guidelines or formularies established by the state.

And so, we do have some formula guidelines we use to help guide care, but at the end of the day, if it’s medically necessary, they’re going to get it. We don’t build formularies around profit margins or anything like that. We build formularies around what’s right for the injured employee for that injury, and then, within that scope, try to find the lowest-priced drug that helps cure that need. But, at the end of the day, it’s driven by the regulatory environment, medical treatment guidelines and other factors that are appropriate for injured employees.

TK: Thanks, Brian. And we’ll be back in a couple weeks with a new podcast. So, until then, thanks for listening.

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