Workers' Comp

When Good Intentions Misfire in Workers' Comp Pharmacy

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In workers' compensation, well-meaning pharmacy regulations can have unintended consequences. Without careful alignment between appropriate care, cost controls and clinical oversight, policies can shift costs, not reduce them. Jurisdictional rules that seem like good solutions for workers' compensation payers may deliver less than favorable results. Here are a few unintended consequences regulators and legislators should consider for avoiding future pitfalls.

From Opioids to Alternatives

Consider Florida's physician dispensing policy designed to limit opioid exposure by prohibiting physicians from dispensing Schedule II opioids out of their offices. The intuitive expectation was that opioid volume would move into network retail pharmacies where contracts, oversight, and clinical programs are stronger. On a positive note, overall opioid prescribing did decrease. Unexpectedly, non-opioid office dispensing of non-steroidal anti-inflammatory drugs (NSAIDs) and other opioid alternatives increased significantly, suggesting opioids may not have been necessary. The pharmacy spend didn't disappear; it just shifted office dispensing to medications allowed under the updated regulation.

Lessons Learned: If a rule targets drug class without addressing site of service and network status, prescribing behavior will adapt to preserve provider profit in the least governed setting.

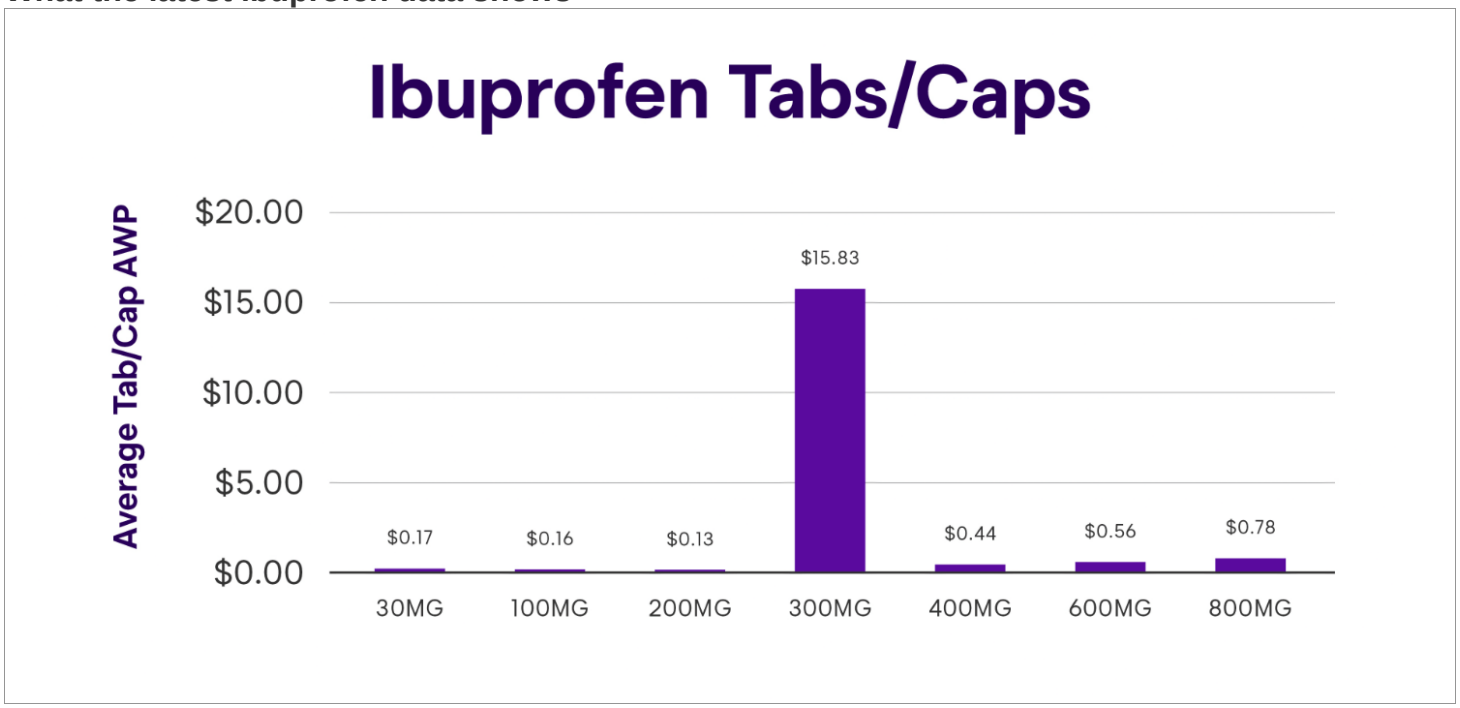
How Ibuprofen Turned into a Loophole

State-mandated formularies and mandatory drug review are powerful tools. Formularies guide the prescriber to medications that are generally safe, cost-effective and typically related to workplace injuries. Pharmaceutical therapy outside of the formulary requires a drug review to ensure its

relatedness and appropriateness in workplace injury treatment. Medications included on these formularies are typically listed by drug name (ibuprofen, cyclobenzaprine, etc.). While this process can be highly effective in assuring appropriate and cost-effective treatment, listing formulary inclusion by drug name only can result in system manipulation for profit.

In New York, ibuprofen appears on the state formulary and is commonly available in strengths of 200mg, 400mg, 600mg, and 800mg tablets or capsules. Some manufacturers have introduced atypical strengths (e.g., 300 mg) at exorbitant prices. Prescriptions written for an odd strength can prevent pharmacists from substituting to a lower-cost equivalent, even when the daily dose is subtherapeutic relative to over-the-counter products. This results in an extraordinary unit price for a common, typically very inexpensive drug.

What the latest ibuprofen data shows



A formulary can function as a “covered items menu” when authorization logic permits formulary drugs and only requires authorization for those off formulary. Niche products can slip through at higher prices unless the formulary addresses therapeutic equivalence, and not only the drug name.

Lessons Learned: Formularies should enable therapeutic equivalency, not only specific drug names. This would allow for lower-priced alternatives to be required through the drug review process while ensuring the efficacy of the prescribed therapy. New York recently excluded ibuprofen 300mg from its formulary.

Patient Choice vs. Network Control

Most jurisdictions do not allow workers’ compensation payers to demand use of pharmacy networks, often termed “pharmacy direction of care”. Restrictions on directing pharmacy care are touted to protect patient access and shield independent pharmacies from the stiff competition of chain drug

stores. In the past, commercial health plans employed narrow networks and introduced mandatory mail order programs. These actions are seen as limiting access to patients and creating unfair network participation requirements, further contributing to the mistrust of pharmacy benefit managers (PBMs). In workers' compensation, pharmacy networks are typically broad and allow any pharmacy agreeing to network contract terms to join. Instead of protecting small, independent pharmacies, prohibiting direction of care can have the undesired effect of prescriptions being filled by out-of-state, out-of-network mail-order operators, disintermediating local pharmacies.

Rules meant to protect local "mom-and-pop" pharmacies can siphon millions of dollars away from local communities when high-priced topicals and other low-value medications are prescribed and shipped from remote facilities. Meanwhile, the PBM loses the ability to steer to contracted pharmacies with proper quality, safety, and fraud-waste-abuse controls.

Lessons Learned: In workers' compensation, transparent direction of care can align patient access, local pharmacy participation and cost integrity.

When New Benchmarks Hit the Wrong Target

To lower workers' compensation pharmaceutical care costs, some jurisdictions have considered moving from average wholesale price (AWP) based fee schedules to national average drug acquisition cost (NADAC) or similar acquisition-cost benchmarks. Out-of-network prescriptions account for 84% of abusive drug pricing in workers' compensation, while in-network prescriptions represent only 16% of such pricing abuse. Furthermore, many of the egregiously priced medications dispensed outside PBMs are not listed in the NADAC database. The unintended effect is NADAC-based fee schedules can squeeze reimbursement to the payers' contracted PBM partner and participating pharmacies, while leaving the pricing abuse from out-of-network pharmacies that dispense high-cost niche products untouched. Pharmacy direction of care is better at preventing abusive pricing than fee schedule manipulation.

Lessons Learned: If the fee schedule change doesn't address the source of abusive pricing and manipulation of the system, you may penalize compliant providers and PBM partners while having little to no impact on abusive pricing practices.

What Actually Works

- Allow PBMs to direct care to in-network pharmacies that meet quality, transparency and cost standards
- Build formularies around drug equivalence and cost efficiency, not drug name only
- Incorporate therapeutic substitution into clinical guidelines and medication reviews to allow for equally efficacious, cost-effective pharmaceutical therapy that supports equal or better outcomes at a lower cost.
- Evaluate all out-of-network bills with the same clinical rigor that occurs with prescriptions processed in-network through the PBM
- Monitor cost-per-milligram by NDC and flag outliers. Create strategies to intervene in occurrences of pricing abuse

- Involve workers’ comp pharmacy experts in drafting policies and legislation

Moving Forward with Purpose

These examples demonstrate that effective pharmacy management requires comprehensive solutions that anticipate how market participants will respond to new rules. Policymakers must resist the temptation to implement piecemeal fixes that address symptoms while ignoring root causes. Instead, successful pharmacy cost containment requires a holistic approach that aligns financial incentives with clinical best practices, maintains robust oversight across all dispensing channels, and preserves patient access to quality care. By learning from these unintended consequences and engaging workers’ compensation pharmacy experts in the policy development process, we can craft regulations that improve outcomes, reduce costs and protect injured employees without creating new avenues for abuse. The path forward is about smarter, more thoughtful governance that recognizes the complexity of the pharmacy ecosystem and responds accordingly.

About Dr. Mitch Freeman

Dr. Mitch Freeman, Pharm.D. is the chief clinical officer for Enlyte Pharmacy Solutions. In his role, he is responsible for the strategic direction of clinical products and programs and leads the division’s account management organization. Dr. Freeman has been recognized as a leader in innovative clinical solutions for both workers’ comp and auto casualty industries and is a frequent author and speaker. Freeman has more than 20 years of P&C industry experience and is a graduate of Florida A&M University, where he received his doctorate of pharmacy.

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