Auto Casualty, Workers' Comp

Fewer Prescriptions, Bigger Price Tags

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Tom Kerr (TK): Prescription utilization in workers' compensation continues to decline, but that doesn't mean drug costs are no longer a concern. The latest Enlyte Drug Trends Report finds that a relatively small number of high-cost prescriptions are creating an outsized impact. In today's Enlyte Envision podcast. I'm joined by Enlyte's Brian Allen to explore what's driving these costs, how some providers are exploiting gaps in the system and what states can do to rein in abusive pricing.

Brian, let's start and talk about the Drug Trends Report. The report shows that overall prescription utilization continues to decline, yet costs are being driven by a relatively small number of high-cost outlier prescriptions. What's happening behind the scenes, and why are these cases so expensive?

Brian Allen (BA): Well, Tom, that's a great question. And there are a number of factors, and there's nothing consistent across the board on all of these drugs. In some cases, we have higher-cost medications that are new to market. They're branded drugs. They have a unique application and are expensive because they're new and they're a single source. So, those are expected to be expensive.

Another thing happening is people, I think, are gaming the system. That's probably a polite way of putting it. You see these high-cost drugs that are extremely expensive; some of them, several thousand dollars. I think part of it is profiteering, and I think people are looking to squeeze costs out of the system. So as reimbursement rates go down, as office expenses go up, providers are looking for ways to make more money and, in some cases, they're shifting to dispensing medications. In some cases, they're setting up referral systems to other sources.

In a lot of cases, drugs that typically you could find in a retail pharmacy for less than a $100, we're seeing dispensed out of offices or these specialty pharmacies for thousands of dollars. And it's really all about just making money.

And I think there's no real reason they have to be that expensive. It's just that they can be and so they are. And sometimes money drives bad behavior. And in this case, I think that's what's happening.

And so, we're looking at a number of those different avenues. And, again, in some cases, there's a legitimate reason a drug could cost extra money, but the challenge is as people look for more ways to make more money, they're going to find ways to abuse the system.

And then workers' comp is one of the last areas in health care where there's a lot of unregulated activity that can go unchecked. I think as more regulation happens in other parts of healthcare, you're going to see workers' comp continue to be sort of the last place where those who want to game the system can play, and they're playing hard right now.

TK: Got it. And, we have talked about topicals for a long time being an outlier. Are they still the main culprit, or are there other drugs that are being underregulated?

BA: They're still a culprit for sure, and there are other drugs emerging. Topicals continue to be a big issue. In some cases, they're again, several thousand dollars for something that you could buy probably over the counter for a few dollars. They're still out there, and there's still a lot of work and activity around those types of medications.

But we're starting to see other things happening that are unique and interesting. For example, New York has a pretty strict drug formulary. And there are some drugs on there that require pre-approval, there are some drugs that don't. And what's happening is that a lot of the drugs are generic drugs, that are sort of pre-approved on the drug formulary. And there are, in the generic world, multiple different manufacturers, so there's a lot of options. And that competition is supposed to drive down prices.

But what we see happening are some generic manufacturers who have what I would call a boutique drug or a unique NDC (National Drug Code) that's commonly prescribed in the generic space, that might be from another manufacturer. They'll manufacture it for $3 or $4 and add an NDC that has an average wholesale price of several hundred dollars.

And what happens is these specialty pharmacies in the workers' comp system know what's pre-approved in New York's formulary, so they select and dispense that high-cost generic drug. And there's really nothing you can do to stop it. We try to talk to the physicians about dispensing a lower cost, but if they're making money on it, why would they do that?

Even though there's really more affordable options out there, they turn their attention towards the most expensive and most profitable drug, so it continues to drive costs up. There are other compounded medications — all sorts of examples like this — where there are multiple options, and they pick the highest cost.

Another thing that is unique in workers' comp is you'll have a medication that comes in a 5mg. or 10mg. tablets. But these, what I would call, profiteering dispensers have workers' comp specialty pharmacies dispense a 7.5mg dosage and charge 20 times more for that particular medication. There's no clinical difference. It doesn't serve any real clinical need, but yet it's a way to profiteer and make money.

We see that happening all the time. And unfortunately, the drugs are on formulary or they're medically necessary. And as long as that's the case, it is really difficult for payers to figure out how to get around paying or steering the physicians to actually prescribe and dispense more common and more affordable medications. It's a challenge.

TK: So, are these drugs serving legitimate clinical needs?

BA: The high-cost generics do serve a legitimate clinical need, because it's a drug that's being prescribed. It is medically necessary. The challenge is, if you can buy it for $2 or you buy it for $200, what should you do, right? And what should the payer be responsible for? I mean, it's clinically appropriate, but it's not fiscally appropriate because they're gaming the system.

They're looking for a way to profiteer off this drug. And it's not 200 times better or 100 times better or 10 times better. It's the same medication. It just costs 20 times more or 200 times more. And we see some very, very expensive generic drugs that really shouldn't be that expensive. The idea behind generics is that you have competition and competition is supposed to drive down price. It has not worked. And there are a lot of reasons for that. A lot of generic manufacturers have been sued by states for colluding on pricing. I know the state I live in just settled with one of the manufacturers for $25 million.

So, there's a lot of stuff that goes on that games these prices. But in this particular instance, this is just blatant fraud where they're going to a manufacturer and getting a very high-cost generic that's actually, in some cases, from the same manufacturer, and multiple other manufacturers for one hundredth of the cost.

So, it's a big deal. And we're trying to figure out ways to stop it. It becomes a game of whack-a-mole. You stop one practice and they find another way to game the system. We just got to continue working at it.

TK: And many of these high-cost outliers come through physician dispensing and other out-of-network channels. I know that the industry has addressed this problem in the past, so why are these pricing patterns still continuing?

BA: Well, this is also an interesting question, Tom. And I think part of the challenge is that it's a regulatory race to close loopholes.

And what happens, unfortunately, is that you get a rule that's written to close off a particular practice. And what happens is the people who are making money on these medications figure out a way to adapt to the rule structure and then find another loophole that they can exploit. So, it's like whack-a-mole. Every time you close one avenue off, another one opens up and they exploit that.

And these guys are very smart. They have a lot of money invested in this. They make a lot of money on it. They're not going to go away. They're not going to take their ball and go home. They're going to continue to find ways to exploit the system. We have to continue to find ways to close those loopholes.

And states do the best they can. Unfortunately, regulators can only do what they are allowed to do within the construct of the legislation that they work under. For example, Florida has a rule in place that says injured workers have free and full choice of pharmacy. Well, that makes it very, very difficult to encourage good practice because when they have free and full choice, they have no economic stake in the decision.

They're not exposed to the cost. They never see it because they don't have to pay anything, so they don't know. They don't know when they get referred to a pharmacy that that pharmacy is charging 10 times or 50 times or 100 times more than the pharmacy next door. They have no visibility into that.

It makes it very difficult because there's not an economic force that helps guide behavior. The only economic force guiding behavior right now is profiteering, and that's guiding bad behavior.

Arizona just released a rule to cap the cost of topical medications. And, the unfortunate thing is in the rule, they left a gaping loophole that is going to allow for some bad behavior. It'll have an impact initially, but there's a way around that rule and what's going to happen is they'll be revisiting that rule in two years because it's going to open up a floodgate of other abuse that they're not expecting.

It's one of those things that just happens. It's like the only thing that we've seen that really has a positive effect on curbing this abusive pricing is allowing employers or insurance companies to direct care to a pharmacy network.

Commercial health does this. Your government health programs do this. Your Medicaid programs do this. Every other health care system in the country allows for the direction of pharmacy care, and that helps control cost.

If you were to go to a state Medicaid system and say, "Hey, we want to remove pharmacy networks and just allow Medicaid recipients to go to any pharmacy they want," the fiscal note on that would be astronomical because the states recognize in their Medicaid program that allowing free and full choice, like you see in workers' comp, would cost more money and drive up costs.

But yet, for some reason in workers' comp, some states have decided that recipients should have free and full choice. There's no magic to it. I mean, you'll hear arguments like, "Well, you know, it's access to care." The fact of the matter is if an injured person is getting medication from their physician, they're driving by 10 pharmacies to get to their doctor's office. So, it's not really an access-to-care issue. It's an access-to-profitability issue.

Right now, we're allowing unfettered access to unjust enrichment on some of these medications. We're continuing to work with states to try to figure out how to move their culture to a more cost-effective system.

It really is a challenge because there's been reticence on the part of states to move towards direction of care. We tried to run a bill in Arizona last year and the public safety unions opposed it. Why? I don't know. They claim they can't get access to medications. We've never been able to see anyone demonstrate effectively that direction of care reduces access to medications. I don't think it does. I think it's a red herring. But it's one that sells well in the legislature,

It's just one of those challenges of trying to overcome the political tide, but it's something that really makes sense long term for the system.

TK: OK. And with that in mind, which states have taken meaningful action to curb these high-cost prescribing or dispensing practices? And what lessons can other states learn from them?

BA: Well, I think the states that have adopted drug formularies, New York, Tennessee, Kentucky, Texas, they've taken steps in the right direction. But what we have found and, over time, what others have learned, is that there's ways to exploit those. They work for a while and then people figure out a way around them, and then we have to start clamping down.

When Texas first introduced its drug formulary, we rarely saw high-cost topicals in Texas or even compounds. That was rare. But once they introduced their formulary then we started seeing them. We had to go back to the state over a period of multiple years, showing them data, until we finally convinced them to put compounds and topicals as drugs that required prior authorization so that there was some control on them. You have to continue to look for ways to gatekeep.

Colorado, South Carolina, a number of states have put very strict restrictions on reimbursement for compounded medications and reimbursement for topicals. And those have an impact for a while, but after clamping down on

some of those money-making schemes, those who exploit the system transition to something else.

Now, in this case, they're transitioning to these high-cost generics that fit within the formulary, that are medically necessary, that are clinically effective. They just cost a hundred times more than the rest of the same drug that is in the generic sphere out there. We haven't found a solution to that problem yet. We're working on it. It's difficult.

We do have, in some states, prior authorization processes. The prescribing physician will submit a pre-authorization for a generic medication and if the generic medication is $4 it'll get approved because it's clinically appropriate and it's affordable.

Well, once it's approved, then the next prescription that comes in isn't for that cost. It's for the same drug, only it's the NDC that's $300 more expensive or 10 times more expensive. Well, you've already approved it, so now what do you do? How do you stop that? So, that's another regulatory challenge that we're trying to figure out, and how do we get to that point of curbing that in?

So, yes, some states have taken meaningful action, and I think there have been some gains made. Those are the states who have allowed for direction of care. New York is one of those. In California, you can set up a pharmacy benefit network. Utah, you don't see as much of the abusive pricing than you see in states where it's just unregulated.

We know direction of care works. We know that passing regulations to attack a single problem is not as effective because they find ways around it. You're constantly having to update rules and regulations or laws, and that's not easy to do. It takes time.

While that clock is running and they're working on a fix, the profiteers are gouging the system, making a lot of money and costing employers, ultimately, a lot of money. But what we have found that works best are the states who have embraced direction of care in their workers' comp space for pharmacy and allowed employers or insurance carriers to establish a pharmacy network and to require injured employees to obtain their medications in most circumstances from those pharmacy networks.

Now, if it's an emergency, or it's a first fill and nobody knows about the network, there's some allowances that are made so no one's going without medication. But yet, that's the only way we've seen right now that's effective at minimizing. It doesn't stop it completely because people are clever, but it does minimize it considerably. And it takes a lot of the wind out of the sails of the profiteers and makes it more sensible long term for the system.

TK: Got it. so now, Brian, I'm going to have you look into your crystal ball, for the moment, as you look over the next three to five years, do you expect high-cost outliers to become a bigger challenge, or are we starting to see enough regulatory momentum to bend the cost curve?

BA: Well, I think it's a mixed bag and I think it's going to vary by state. I think there are some states that are getting smarter about how they manage this. Like, for example, Maryland.

Maryland has really taken a much more, sensible approach from an enforcement standpoint. When there is a dispute involving a very high-cost drug, they're asking a lot of the right questions. And if you're going to dispense a very high-cost medication, you better document and have your numbers available or they're not going to approve it. So, they're taking a very aggressive approach, but it's usually after the fact, and then it's only driven by complaints. So, if a payer doesn't complain, then they don't have a chance to influence that. It has its limitations.

I think some states will embrace direction of care. I think other states will not, and I think they'll continue to allow the profiteers to make money and gouge the system. In most of these cases, when you go to work on them at the regulatory or at the legislative level, it isn't a clinical question. It's not a care question. It's a political question. And that's the wrong way to make these decisions.

You really need to look at the facts, look at the data, and make decisions based on what's really right for the system, what passes the ethical and moral smell test, what really makes sense economically for your system.

But what happens is that it's political, right? There are these forces out there that invest a lot of money in the political process. And, ultimately, nobody in the political sphere wants to make a high donor or a high-profile group angry with them.

I mean, that is the nature of politics. I was in politics. I understand it completely. It doesn't always yield the best result, but it does yield a result.

In this case, it's not yielding a great result. The fact of the matter is, when payers and others get hurt by this, it's a political question for them, too, because in every legislative session, they've got a hundred things they really care about.

Where does this fall on their list of priorities? And are they willing to fall on their sword a little to get this done and exert political pressure and spend some political capital, which is a finite resource, on getting this change?

In the states that don't change, it will likely get worse. Those who look for loopholes typically leave when states start cracking down and go to where there's more fertile soil. They're going to go to a state that isn't regulating it and ply their trade there. So, it'll be a bigger challenge for the states that don't act and a lesser challenge for the states that decide to actually act and to fix it.

TK: Thanks, Brian. And we'll be back soon with another Enlyte Envision Podcast. Until then, thanks for listening.

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