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by Evernorth

Demystifying Drug Pricing in Workers' Compensation

Part 1 | Segmenting the market to identify critical cost drivers

As rising drug prices continue to make headlines, there are certain conceptions about the pharmaceutical market that can benefit from clarification. When discussing the growing cost of drugs, we tend to frame the topic around name-brand versus generic drugs, with a view that despite the cost-saving opportunities of generics, overall spending on drugs continues to increase. This is backed up by a recent RAND study, which reports that generic medications represent 84% of drugs sold in the United States by volume but only 12% of U.S. spending.

In the workers' compensation sector, data from myMatrixx also supports this trend. For years, we have seen generic utilization continue to increase among our clients, with 10% or more having a 100% substitution rate for medications where a generic equivalent is available. In 2020 alone, we saw overall generic utilization increase from 87% to 88.6% among our clients.

If we look at the drug market purely through the traditional lens of brand versus generic, overall drug spending should be going down, both in the general health sector and in workers' compensation. Explanations for why this is not the case, particularly from drug companies themselves, include the high costs of research and development and an increased focus on drug safety.

It is possible for drug spending to decline even when drug prices are increasing based on enhanced patient outcomes resulting from clinical pharmacy management and changes in claim counts and injury severity.

While both R&D and safety measures do drive costs, these two factors alone do not account for the entirety of the increased spending. It also isn't beneficial to a workers' compensation payer or program manager that suddenly encounters a rare but significant increase in drug costs over the course of a year or two.

Segmenting the drug market into categories beyond purely brand versus generic drugs will enable us to more accurately identify the major trends and drivers for drug prices in workers' compensation. It is possible for drug spending to decline even when drug prices are increasing based on enhanced patient outcomes resulting from clinical pharmacy management and changes in claim counts and injury severity. Therefore, in part two of this report, we will examine the overall pharmaceutical market looking at trends impacting price and utilization. In this part, we will provide an overview of three of the most important market segments driving pharmaceutical spending: the specialty drug market, compounding and physician dispensing.

These three categories are a major source of high drug spending, but they do not receive the same level of attention as traditional name-brand drugs. While most workers' compensation payers may not experience all three of these trends in their pharmacy portfolio, any one of them can have a dramatic impact on overall spending even as claim counts decline. Understanding these segments and how to appropriately manage them should be a key component of any cost-savings strategy in today's drug market.

Key market segments driving pharmaceutical spending

1 Specialty drug market

2 Compounding

3 Physician dispensing

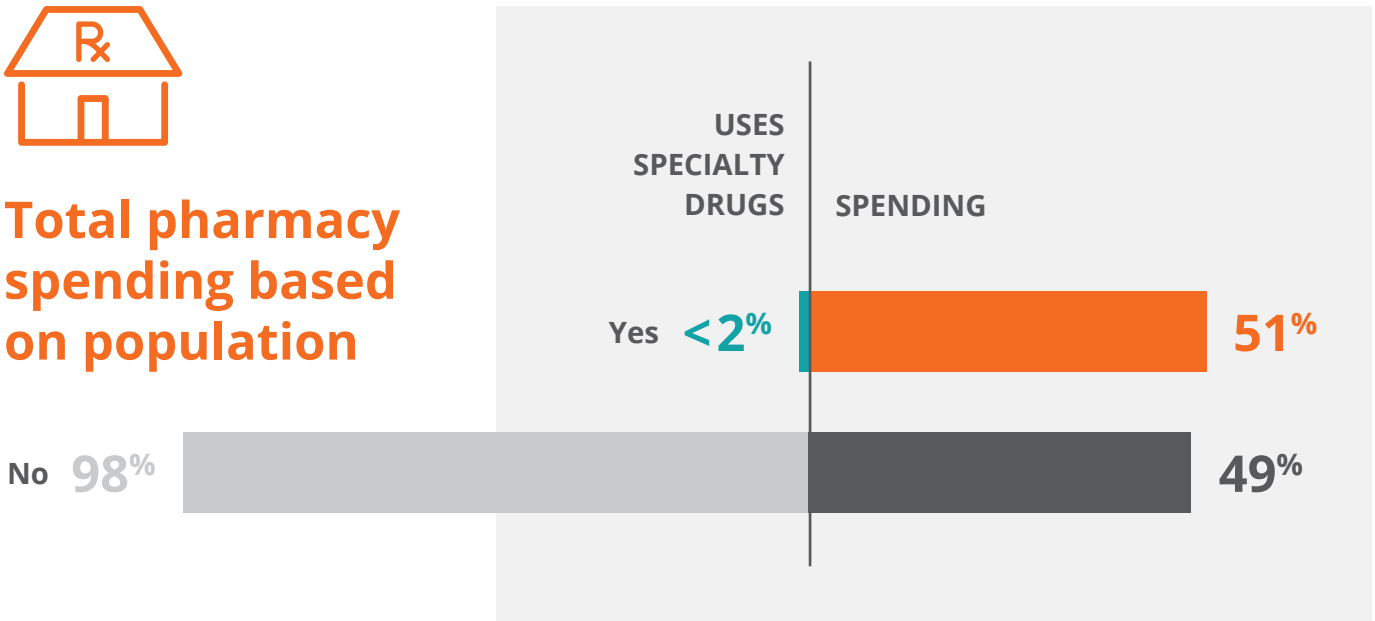
Specialty drugs

Specialty medications are used to treat complex conditions such as cancer, rheumatoid arthritis, HIV, and hepatitis C. These drugs may require special handling, administration and monitoring, and often come with an extremely high price tag.

In 1991 it was estimated that there were only 10 specialty drugs on the market, a number which grew to more than 300 by 2015, with more being approved each year as biotechnology continues to develop. Even though less than 2% of the population uses specialty drugs, those prescriptions account for a staggering 51% of total pharmacy spending. Since specialty medications typically impact drug trend the most addressing the high cost of specialty medication is crucial.

Although most compensable workplace injuries do not require specialty drugs, there are cases where they will be prescribed. This includes frontline health care workers or other first responders exposed to HIV or hepatitis through needlesticks. Presumption laws will also have an impact on this category and patients with a work-related cancer diagnosis may also require specialty drug treatment. Compensable COVID-19 claims are also driving increased use of specialty drugs for conditions such as pulmonary fibrosis.

According to the 2020 myMatrixx Drug Trend Report, specialty medications were responsible for only 0.7% of all retail prescriptions for workers' compensation, but they drove 9.5% of costs. This disproportionate impact on costs represents a ratio of 13.5 to 1, which is up from 11.8 to 1 in 2019. Despite a low instance of compensable cancer cases in workers' compensation, spending on specialty cancer medication increased 40.4% in 2020.



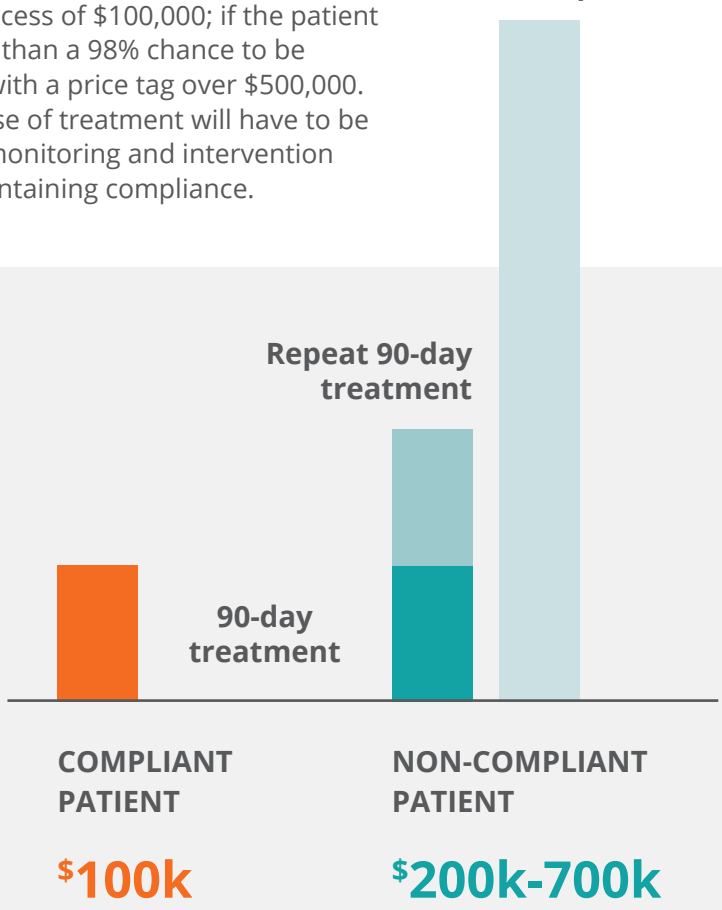
When it comes to reducing specialty drug spending, the conventional view of generic versus name-brand drugs does not fully account for the complexity of this sector. Because many specialty drugs have come to market so recently, they are still under patent protection and do not have generic equivalents available. In some cases, a high-cost specialty drug may have no other current alternative treatment, but a pharmacovigilant approach can monitor for lower-cost options that are either on the market or coming to market. On the other hand, there is a very true observation regarding specialty drugs, and that is the most expensive specialty drug is the one not taken.

The key take-away message here is that compliance with specialty drug therapy is vital to ensure success. Using the hepatitis C specialty drugs as an example: a 90-day course of therapy will cost in excess of $100,000; if the patient is compliant with their regimen, they have greater than a 98% chance to be cured avoiding a future potential liver transplant with a price tag over $500,000. However, if the patient is not compliant, that course of treatment will have to be repeated for an additional $100,000. Pharmacist monitoring and intervention has been proven to be an effective strategy in maintaining compliance.

Specialty drug therapy compliance effect on cost*

Hepatitis C example

*Costs are approximate



A growing number of specialty drugs have lower cost alternatives in the form of biosimilar medications, near-identical alternatives to FDA-approved biologics that can offer similar safety and effectiveness. By providing additional treatment options, biosimilar pharmaceuticals can create greater competition in the marketplace to help drive down biologic prices overall.

Additionally, it is critical for PBMs and payers in the workers' compensation pharmacy space to monitor the expiration of specialty drug patents and push for generic substitution when available or biosimilars as soon as equivalents are approved and available. Taking a vigilant and proactive approach to any claims with specialty drug prescriptions is the best way to ensure both the best patient outcome and the most appropriate drug spend for the payer.

Compounding

Compounding is another potentially cost-driving practice that exists outside the scope of generic versus name brand drugs in both group health and workers' compensation. **This term describes the combination, mixing, or altering of drug ingredients to form a new compound that is unregulated by the FDA.** Therefore, by definition these compounds are neither brand nor generic drugs. Although they account for a small percentage of total prescriptions in workers' compensation, this class has come to be a disproportionate driver of costs.

There are many perfectly valid reasons why a pharmacy would create a compound drug for a patient. This includes patients who are allergic or intolerant to an ingredient that exists in a certain medication as prescribed. Additionally, some patients who are sick or elderly may require a liquid version of a certain drug due to an inability to swallow.

Unfortunately, compounding can also be a source of exorbitant and unnecessary costs for payers across the health care and workers' compensation systems. Because compounds can be created and marketed outside the traditional mechanism of FDA approval, there is enormous potential for cost markup. In one recent high-profile fraud case, a multi-state compounding conspiracy was charged for billing insurance companies nearly $50 million in unnecessary compounds.

In workers' compensation, we can point to compounding as an area where myMatrixx has responded to and addressed this particular issue to a largely successful degree. In the 2018 myMatrixx Drug Trend Report, compounding represented only .02% of prescriptions, with a year-over-year decline in spending of 42.3%.

Despite this success, any payer or program manager needs to have an awareness of this phenomenon and its potential for exorbitant costs, especially in certain regions of the country, a phenomenon we will be exploring further in part two. Prescriptions for compounds need to be carefully monitored from both a patient safety and cost standpoint to ensure the practice is clinically necessary and financially appropriate.

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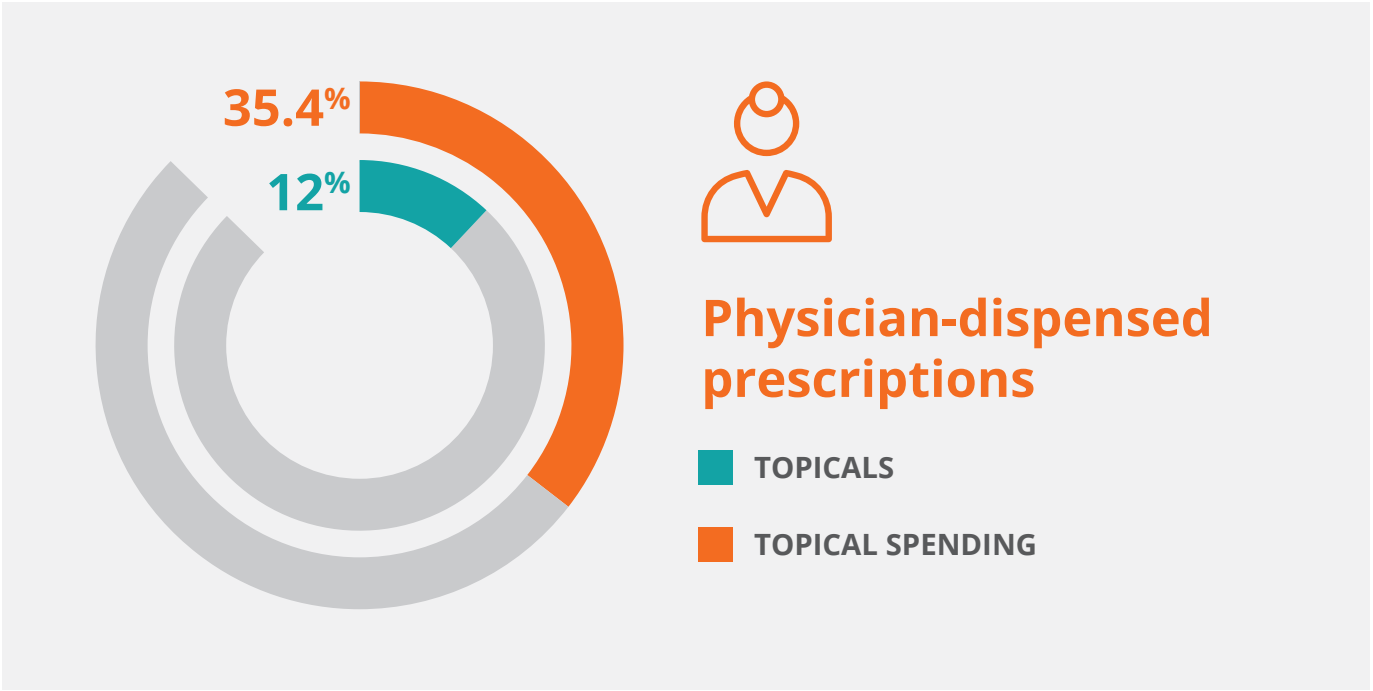
Physician dispensing

A similar but distinct practice to compounding is physician dispensing of medications. This is when doctors will bypass pharmacies and dispense a drug directly to the patient. In some situations, there may be an overlap between physician dispensing and compounding if the physician's office is creating and dispensing a compounded medication.

While there are valid reasons for prescribers to dispense medication directly at point-of-care, there is also a very high opportunity to create unnecessary costs for payers. Physicians who engage in the practice of dispensing medications cite reasons of convenience, effectiveness, and privacy. For example, a certain portion of patients often decline to fill a prescription at the pharmacy, which could have a negative effect on patient outcomes. However, critics of the practice point out the conflict of interest as well as the higher volume of prescriptions dispensed through this practice.

One area of physician dispensing that we have identified as a major cost driver in workers' compensation that offers little-to-no clinical benefit to injured workers is private label topicals. Topical drugs applied to the skin are widely available over the counter or are commonly dispensed affordably through retail pharmacies. **Often, private label topical medications dispensed at point-of-care are egregiously priced and offer little to no therapeutic advantage for injured patients over traditional therapies.**

Data available to myMatrixx indicates that the cost of physician-dispensed private label products may be as much as 5 times higher than a comparable product from a retail pharmacy.



Conclusion

These are the most prominent examples of how popular notions about rising drug prices may be misleading, particularly in workers' compensation. For payers in this sector, controlling costs requires an understanding of these less traditionally understood market segments combined with careful clinical and formulary oversight. Even with high generic utilization and substitution rates it can take only one avoidable high dollar claim to artificially inflate your portfolio.

The role of a high quality PBM is to understand these market forces and use careful analysis and clinical practices to respond appropriately, both to keep injured workers safe and provide value to payers.

In the follow-up to this report, we will be sharing the latest data on these key market segments to show how myMatrixx continues to deliver cost savings for our clients while promoting positive clinical outcomes.

Working together, working for better.

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