



Demystifying Drug Pricing in Workers' Compensation

2023
Report Series

Part One: A Closer Look at the Traditional Prescription Drug Market

Over the years, drug manufacturers have increased list prices, which has affected nearly every American. Some patients must weigh the costs of needed medications against the costs of other essentials. Organizations that provide health benefits, such as employers, government agencies and others, face higher costs for prescription drug benefit plans.

As with other goods and services, determining the price of pharmaceuticals is an intricate process based on supply and demand, research and development costs, federal and state regulations, and patent laws. With this topic continuing to receive coverage in the media in regards to general health care, the goal of this report is to provide education and clarity on drug pricing as it pertains to workers' compensation pharmaceuticals.

In our 2022 report, we showcased how identifying and proactively addressing areas of specialty drugs, compounding and physician dispensing are critical to understanding perceptions of rising costs in our sector. These are all key examples of where an unidentified and/or unmanaged outlier can significantly increase total drug spend for a workers' compensation payer. In an upcoming part of our 2023 series, we will provide an update on how each of these continues to affect the market and, more importantly, a strategy to mitigate unnecessary costs.

For our 2023 series, we will start with the traditional prescription drug market in workers' compensation and discuss the most effective cost-reduction strategies payers and plan managers can adopt. While the potential costs of unmanaged outliers such as specialty drugs or physician dispensing can be exceedingly high, a large proportion of workers' compensation payers may not encounter these types of drugs in their claims portfolio and instead will see predominantly traditional prescription drugs. By isolating and examining the current traditional drug market, the surprising result is that drug prices are actually decreasing for a large number of payers thanks to the support of focused drug management.

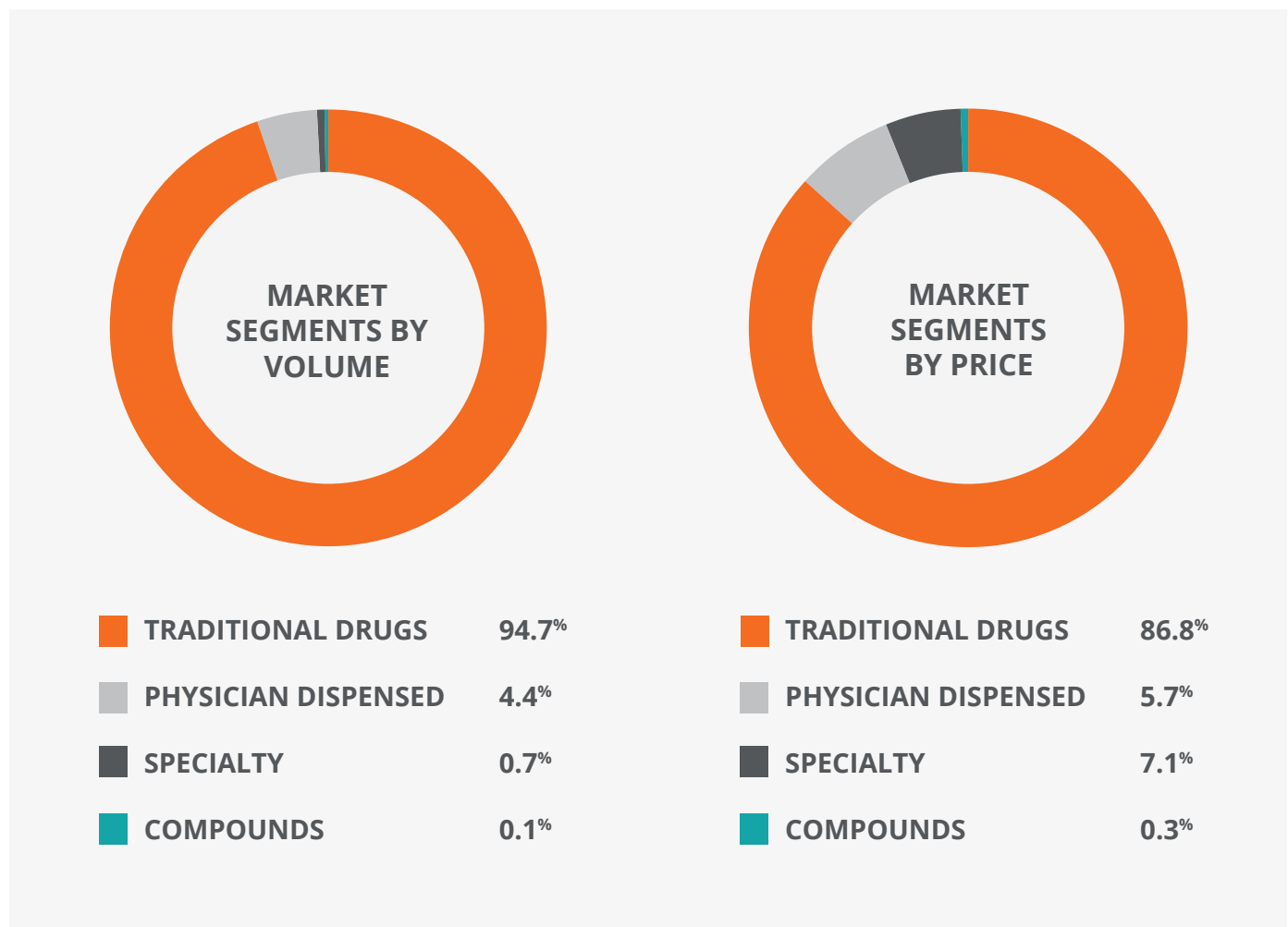


Our focus for this report:

- 1** Impact of inflation on drug pricing trending lower than the consumer index
- 2** Drug segmentation comparisons by volume and price
- 3** Cost-reduction strategies to enhance your workers' compensation program

Traditional Drugs in Today's Workers' Compensation Market

For the purposes of this paper, traditional prescription drugs are defined as medications prescribed by physicians to treat general health conditions and chronic diseases; these drugs were developed as part of the brand and generic drug market that dominated pharmaceutical research for decades. This is largely in contrast to specialty drugs that treat rare and complex diseases, such as cancer, rheumatoid arthritis and multiple sclerosis. Traditional drugs include antibiotics to treat infections, antihypertensives to treat high blood pressure and many others. The chart below illustrates the different segments and the disproportionate impact smaller quantities can have on overall price:



Of particular importance is the fact that traditional drugs drive almost 95% of volume but only 87% of price. On the other hand, specialty drugs drive just 0.7% of volume but over 7% of price.¹

In workers' compensation, frequently prescribed traditional drugs for work-related injuries and conditions include nonsteroidal anti-inflammatory drugs (NSAIDs), skeletal muscle relaxants, anticonvulsants for neuropathic pain and antidepressants. Prescription opioids are of course another significant class of traditional drugs in workers' compensation, and we will give this category more attention in part two of this series.

From a big-picture perspective, price increases for traditional drugs in workers' compensation have been moderate. According to data from myMatrixx, by isolating traditional prescription drugs and using average wholesale price per days' supply of medication, payers have seen a modest 1.06% increase in price between 2020 and May 2023, which is far below the 5.44% inflation rate reported by the U.S. Bureau of Labor Statistics consumer price index² for this same time period. If we break the traditional drugs down by brand and generic, the value of generic substitution becomes apparent since generic prices dropped 0.52%³ during this same period.

A combination of factors can cause a reduction in workers' compensation spending, including increased generic substitution rates, the growing adoption of home delivery pharmacy and increased pharmacy network penetration. It is critical for any workers' compensation plan manager attempting to lower traditional drug spending to understand how these elements work to drive down costs as part of a holistic cost-reduction strategy. Furthermore, please note that it is common for drug prices to be reported on a per-prescription basis.

However, a prescription is not a set unit of measure and may range from as few as one dosage unit to several hundred or thousand units. Therefore, using the cost for a day's supply of therapy is the only methodology that normalizes all the competing influences observed in workers' compensation, such as a decline in the quantity of opioids per prescription or the increase in quantities when home delivery is used.



Cost-Reduction Strategies for Traditional Drugs

There is no single clinical pharmacy strategy that will produce optimal savings for every payer. In fact, many payers will need multiple strategies to effectively lower their drug spend. The first step for any payer, regardless of size, is to understand their current pharmacy spend. Traditionally, this meant looking at total prescription spend, average cost per prescription, percentage of generic substitution and opioid utilization.

Although all of these factors remain relevant and important, there are multiple factors that must be considered in the rapidly changing prescription drug market. Some of the most basic strategies include:



Generic substitution



High-cost single-source drug interventions



Pharmacy network penetration



Home delivery pharmacy utilization



Medicare set aside pre-settlements



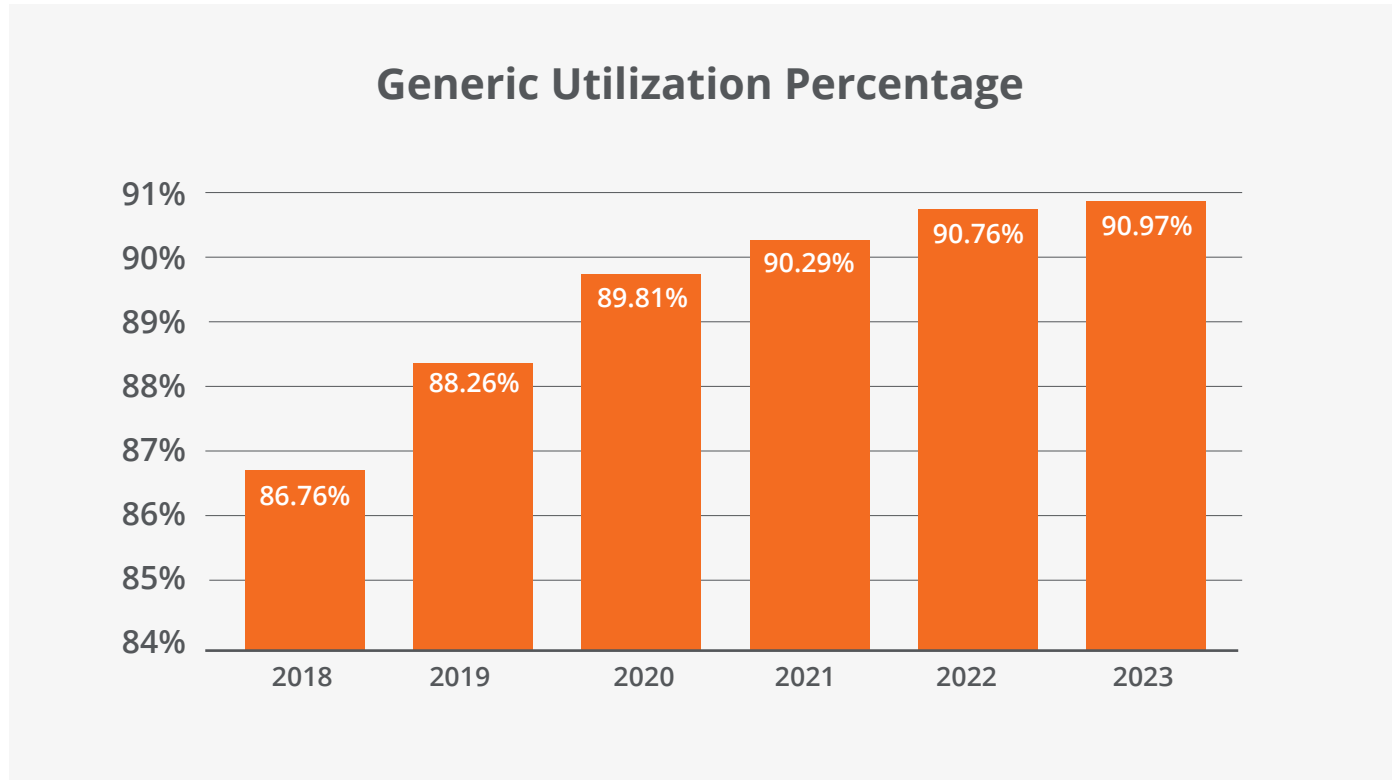


Generic Substitution

In the traditional workers' compensation drug market, the most important cost driver remains spending on first-to-market brand-name drugs. Patent laws enable drug companies to recoup research and development costs before lower-cost generics enter the market. In workers' compensation, many of the few remaining medically necessary brand-name drugs are due for patent expiration in the coming years.

This means the vast majority of widely used traditional drugs in workers' compensation have lower-cost generic equivalents. As a result, the first step to reducing overall spending on traditional drugs for many payers is to identify any brand-name drugs in the portfolio that have generic equivalents and implement a substitution plan. High rates of generic substitution invariably lead to reduced overall drug spending.

In 2023, myMatrixx attained an average generic substitution rate of 90.97%, and as seen in the chart below, this rate has been increasing steadily year over year:



This measure, also called generic fill rate (GFR), should continue to increase as more brand drugs lose their patent. Payers should still understand that because GFR is simply a utilization measurement, it does not necessarily indicate if a pharmacy benefits manager (PBM) is fully maximizing and optimizing use of generic drugs.

A better measure of the effectiveness of a generic substitution strategy is generic efficiency. This is a measure of the percentage of prescriptions dispensed with a generic when a generic drug is available, and it removes single-source brand drugs from the calculation. The formula for generic efficiency is as follows:

(Number of generic Rx/all Rx - single source brands multiplied by 100 = generic efficiency)

Using this calculation, the goal of an effective clinical pharmacy strategy is to attain 100%—and this number will not fluctuate based on patent expirations. Among the most common obstacles to 100% generic efficiency are prescriptions marked **Dispense as Written (DAW)** or Brand Medically Necessary by the prescriber, depending on the state, both commonly referred to as DAW 1 prescriptions. Another important DAW class, DAW 2, refers to prescriptions filled by injured worker request in non-generic mandatory states. When comparing generic efficiency rates between different sources, it is important to ensure that DAW codes are included in the definition.

DAW laws are promulgated at the state level and therefore must be managed at the state level by the PBM. There are 10 codes—zero through nine. All are intended to determine when a multi-source brand (MSB) name drug should be allowed. Zero is the default code and should never allow the use of an MSB. The number one indicates that a prescriber has determined that the brand is medically necessary. This should be a rare situation, and most DAW 1 prescribing should be challenged by a clinical pharmacist working at the PBM.

Brand-name Percocet is the drug that is most frequently prescribed as a DAW 1 in workers' comp and is always challenged by our pharmacy program because there is no difference between the brand and generic – the same company manufactures them. The remaining DAW codes are used less frequently and are included in the table below (**please note that seven and nine are not typically used in workers' compensation**):

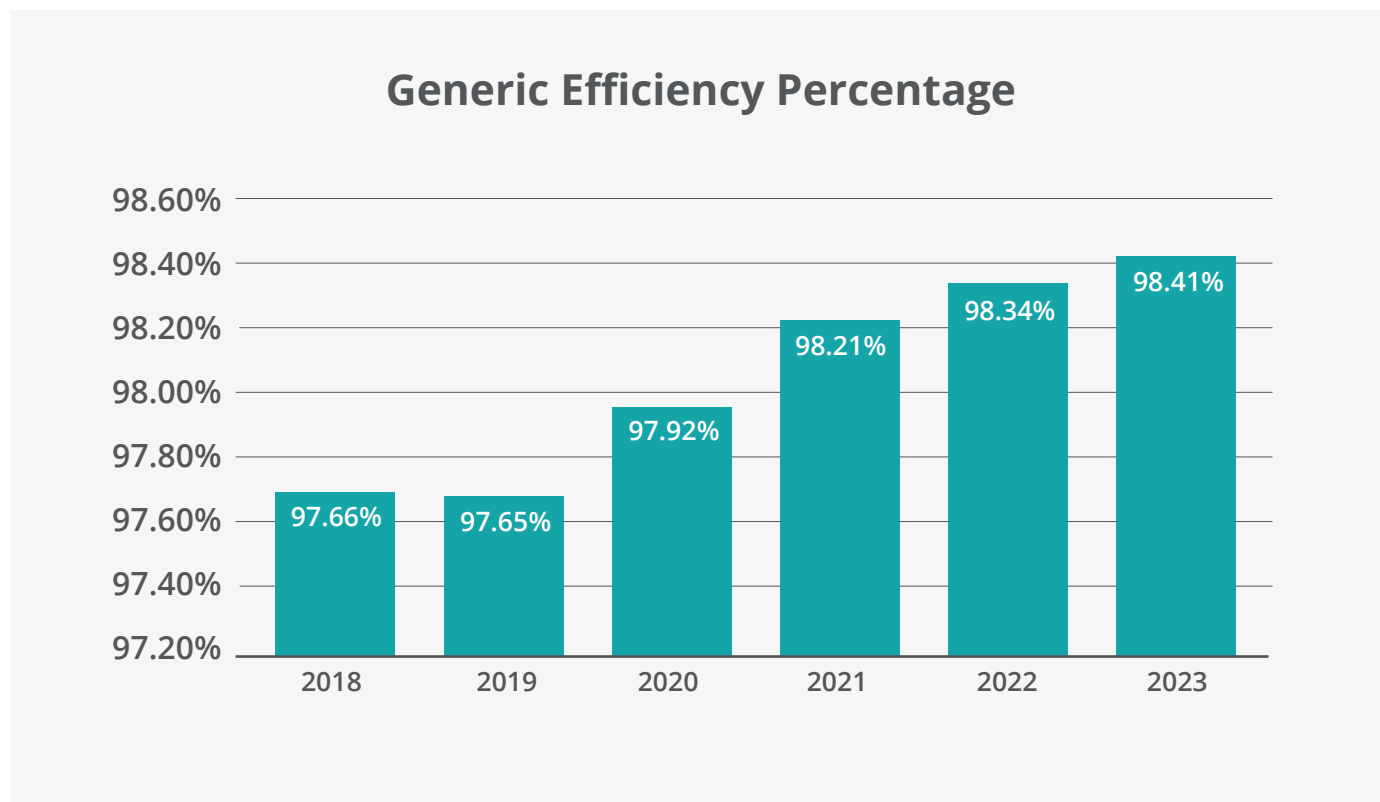
Dispense As Written (DAW) Codes

| DAW Code | Description | Product Type | Product Allowed |
|----------|--|---------------------|--|
| 0 | No Product Selection Indicated Field default value appropriately used for prescriptions for single-source brand, co-branded/co-licensed, or generic products. | Single-source Brand | Brand |
| | | Multi-source Brand | Generic |
| | | Generic | Generic |
| 1 | Substitution Not Allowed by Prescriber This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is medically necessary and is to be dispensed as written. Through point-of-sale step therapy, customized electronic messaging to pharmacies, evidence-based outreach to prescribers and other effective generic substitution programs, myMatrixx minimizes DAW-1 prescribing and drives multi-source brand drugs to more cost-effective generics. | Multi-source Brand | Brand |
| 2 | Substitution Allowed - Patient Requested the Product Dispensed This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. This situation can occur when the prescriber writes the prescription using either the brand or generic name. | Multi-source Brand | Generic, unless the state is not Generic Mandatory |
| 3 | Substitution Allowed - Pharmacist Selected the Product Dispensed This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name brand drugs to more cost-effective generics. | Multi-source Brand | Generic |

| DAW Code | Description | Product Type | Product Allowed |
|----------|--|--------------------|--|
| 4 | <p>Substitution Allowed - Generic Drug Not in Stock</p> <p>This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists because of the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace.</p> | Multi-source Brand | Generic |
| 5 | <p>Substitution Allowed - Brand Drug Dispensed as Generic</p> <p>This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist is utilizing the brand product as the generic.</p> | Multi-source Brand | Generic |
| 6 | <p>Override</p> | Multi-source Brand | Generic |
| 7 | <p>Substitution Not Allowed - Brand Drug Mandated by Law</p> <p>This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace.</p> | Multi-source Brand | Brand |
| 8 | <p>Substitution Allowed - Generic Drug Not Available in the Marketplace</p> <p>This value is used when, in a manner specified by prevailing law, generic substitution is permitted and the brand product is dispensed because the generic is not currently manufactured, is not distributed or is temporarily unavailable.</p> | Multi-source Brand | Brand, if myMatrixx confirms a manufacturing or other shortage |
| 9 | <p>Substitution Allowed by Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product to Be Dispensed</p> <p>This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but the plan's formulary requests the brand product.</p> | Multi-source Brand | Brand |

Generic substitution is a critical part of formulary management to deliver lowest net cost. Our approach at myMatrixx is to utilize generic prescriptions whenever available and appropriate under prevailing law, an approach that is hard coded into our processing system. In addition to processing requirements, our clinical pharmacy team conducts interventions for any potential regulatory hurdles to generic efficiency. This includes prescriber intervention for DAW 1 prescriptions and injured worker intervention for DAW 2 prescriptions to educate both audiences in regard to the benefits and advantages of generic drugs.

This consistent and diligent approach combining formulary management and clinical intervention has enabled myMatrixx to achieve a generic efficiency rate of 98.41%, with many clients attaining 100%.⁵ The impact of our focus on brand medically prescribing can be seen in the chart below:



Accurate Generic Drug Definitions

When integrating generic substitution into a formulary, it is important for the PBM to use a clear definition of this category. At myMatrixx, we strictly follow the widely accepted multi-source MONY code as outlined by leading independent drug data screening solution, Medi-Span:

- M:** Co-marketed brand-name drug
- O:** Originator brand-name drug
- N:** Single-source brand-name drug
- Y:** Generic drug

Best practices for defining brand and generic drugs should be based on clearly defined logic to determine brand/generic distinction, as well as how to interpret and process every DAW code. First-to-market generic versions of brand-name medications are typically granted six months of exclusivity by the U.S. Food and Drug Administration (FDA), which means that no other generic version of that drug may be distributed to pharmacies.

During that six-month period, the sole generic version is usually marketed at an AWP that is only about 10% less than the corresponding brand-name version. Furthermore, because of that exclusive status, a PBM may also price these single-source generic drugs as if they were brand-name drugs, even though they are classified as a generic by Medi-Span (where MONY = Y, for generic).

myMatrixx uses the MONY indicator to determine if the medication is a generic or brand drug in a manner consistent with the manufacturer categorization and in a contractual manner with both clients and retail pharmacy networks. This eliminates any potential disputes over brand and generic definitions and is a key differentiator for myMatrixx in the PBM market.



High-Cost Single-Source Drug Interventions

When the patent expires on a brand-name drug, the original manufacturer often races to find ways to preserve the revenue stream that existed while the drug was under patent. One method is through litigation in an effort to halt or even slow the introduction of the drug to the market. After all, even a three-month delay following patent expiration on a drug such as Sovaldi®, used to treat hepatitis C, would have represented an additional \$1.98 billion in revenue for the brand manufacturer Gilead.

One method is to introduce new versions of existing drugs, such as the launch of Lyrica CR®, a controlled-release version of Lyrica®, just before that drug lost its patent protection. Another method is to combine older drugs that are available generically into a single pill and create a new drug with all the patent protection allotted to actual new molecular entities. The latter is what the industry saw in the form of Vimovo® (naproxen and esomeprazole magnesium) and Duexis (ibuprofen and famotidine), both of which represented the combination of an NSAID with an acid reducer for stomach protection.

While these drugs were under patent, generic substitution was not allowed. Moreover, even after patent expiration, the generic versions of these combinations are still quite expensive. The myMatrixx approach to high-cost drugs that offer little to no therapeutic advantage over less expensive drugs is to conduct a clinical pharmacy intervention with the prescriber. This includes education on the excessive cost of the prescribed drug, suggestion of an alternative and the opportunity to prescribe the alternative(s).



Through this approach, we have generated more than \$800,000 in annualized savings with a return on investment exceeding four to one.



Pharmacy Network Penetration

When developing a cost-reduction strategy with a PBM, plan sponsors should know the fundamental role that direct pharmacy network contracts play in creating value. Like other health providers, retail pharmacies contract with PBMs at agreed-upon rates to provide access to prescription medications. In turn, the retail pharmacies benefit not only from increased prescription sales but also in what the pharmacy industry refers to as “foot traffic,” which may significantly increase sales of over-the-counter (OTC) and non-drug merchandise for the retail store. These contracted rates not only allow payers to provide medications to patients at a reduced cost compared to paying at retail, but they also enable increased clinical oversight.

Most PBMs that manage prescriptions for workers’ compensation do not have the scale or influence to directly contract with a retail pharmacy network: in other words, they cannot create enough prescription sales or foot traffic to negotiate a discount rate with the pharmacies. Instead, these PBMs subcontract, or lease access, through larger entities. Although this enables them to provide sufficient access to care, it diminishes their ability to pass on substantial savings to their clients. This also impedes their ability to provide transparent pricing since these PBMs do not know the contractual rate paid to the retail pharmacy.

Another important factor is the measure of network penetration, and this term is another where the PBM’s definition will have a direct impact on a payer’s expected and actual prescription savings. A better measure may be a percentage of online adjudication, or processing, but *network penetration* is the term generally accepted. A PBM may define this as the percentage of prescriptions fulfilled in a network pharmacy regardless of whether the prescription was processed online and the contracted discount applied.

Although technically accurate, we at myMatrixx hold our measure to a standard of whether the prescription was processed online in order to undergo real-time plan edits and clinical oversight. We then work with our retail pharmacy partners to maximize the utilization of on-line processing. Not only does this strategy garner larger savings for our clients, but it also enhances clinical oversight of the injured worker’s pharmaceutical care. Even though certain rates and clinical oversight may be applied after the fact to a “paper bill” or a prescription filled outside the PBM’s processing system, patients have already consumed what may have been a dangerous prescription before any clinical review can be performed.



Through its relationship with EvernorthSM and Express Scripts[®], myMatrixx has directly contracted rates with one of the largest retail pharmacy networks, enabling myMatrixx to attain an 88% pharmacy network penetration rate.⁷



Home Delivery Utilization

Mail order prescription fulfillment, also known as home delivery, is another significant strategy for payers to realize significant savings. It can also be a significant aspect of pharmacy care for key injured patient groups, including catastrophically injured workers as well as rural patients with limited access to pharmacies.

myMatrixx, by Evernorth, has a secure home delivery pharmacy platform to address client concerns, such as unnecessary medications, receipt of prescriptions or refills without oversight, and potentially dangerous medication left on the doorstep. In addition, home delivery generates savings for our clients and customers, and will likely lead to better patient health outcomes.

When working with a PBM, payers should make sure that the home delivery pharmacy is owned by or under contract with the PBM. There are many home delivery pharmacies that can provide prescriptions to injured workers but do not participate in the PBM program. Not only are these pharmacies likely to be more expensive but they also cannot provide the level of clinical pharmacy oversight provided by myMatrixx.



Medicare Set-Aside (MSA) Pre-Settlements

When we onboard new clients, our clinical pharmacy team invariably identifies legacy claims that represent both high dollars to our clients and elevated risk to injured patients. Additionally, many of these claims are already slated for an MSA settlement even though the drug costs were not managed by the previous PBM or clinical pharmacy partner. We at myMatrixx recognize these claims as an opportunity to better serve the patient and client. We also recognize that these claims are so unique that they require an in-depth pharmacy review to identify strategies for both increased savings and decreased risk.

Following this review, a telepharmacy intervention with the prescriber is necessary to implement these strategies, which often involve weaning and other lengthy changes to drug therapy. The telepharmacy consult allows one of our clinical pharmacists to discuss the injured worker's therapy with the prescriber in a collaborative manner.

The result is changes to and improvements in therapy, a decrease in pharmaceutical risk to the patient, improved outcomes, and ultimately significant savings from the elimination of unnecessary drugs as well as decreased dosage of other drugs. When the changes are implemented in advance of the settlement, we have generated in excess of \$1 million in savings on individual claims by improving drug therapy.

Conclusion

Despite headlines to the contrary, there are many key drivers in the traditional workers' compensation drug market that point to downward costs. Through a focused pharmacy management program that emphasizes cost-reduction strategies and clinical oversight, workers' compensation program managers and payers can leverage these tools to achieve meaningful savings along with better outcomes and increased safety for injured workers.

In the next report, we will be taking a closer look at opioids. This traditional drug class continues to affect the workers' compensation industry even as we make meaningful progress to lower utilization.

If you have questions about this report, please reach out to our clinical team at clinical@mymatrixx.com.



Working together, working for better

Learn more about our Workers' Compensation products and solutions at: [myMatrixx.com](https://mymatrixx.com).

Sources

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