Physician Dispensing

Dialogue, Data, and Collaboration Drive Positive Change

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White Paper

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Helios believes that through thoughtful dialogue and the exchange of ideas, we can achieve greater understanding, increased innovation, and better outcomes for injured workers. One of the ways we execute this belief is by orchestrating forums for discussion. In 2013, Helios gathered key stakeholders in the workers' compensation industry to discuss the impact that physician dispensing is having on claim costs, patient safety, and recovery time. The group, which included payers, employers, third-party administrators (TPAs), insurance companies, industry associations and researchers, regulators, and thought leaders also contemplated ways to overcome the challenge and achieve better claim outcomes.

In doing so, the group reached consensus that dialogue, data, and collaboration can drive positive change.

Dialogue: Experiences must be shared, awareness heightened, and consumers informed. There is a need to educate the industry, legislators, physicians, and injured workers.

Data: We must share data that illustrates not only the cost differential of physician-dispensed medications, but the influence on injured worker recovery and return to work. Pre- and post-reform findings at the state level are particularly valuable, as are outcomes studies.

Collaboration: Successful advocacy requires a unified front that includes public payers, employer and labor groups, pharmacies, TPAs, insurance companies, Pharmacy Benefit Managers (PBMs), and associations. In order to drive change, we must work together.

Prior to the Summit, the topic of physician dispensing was generating a lively discussion with proponents and opponents of the practice locked in bitter debate. Over the past year however, the rhetoric has changed and a wave of artful compromise has started to spread, due in part to the leadership of Helios.

Media Coverage and Research Heightens Awareness

Many industry and mainstream media outlets have drawn attention to physician dispensing through articles, blog posts, and other features that highlight the cost differential between medications dispensed by physicians versus those dispensed in retail pharmacies. The topic continues to be covered by publications such as *Risk & Insurance, Business Insurance, A.M. Best, Baltimore Sun,* and *The New York Times*. Several industry organizations also provide much-needed research and data, including:

- The Workers Compensation Research Institute (WCRI) continues to release studies examining the prevalence and cost of physician-dispensed medication. These state-specific reports examine the prevalence, prices, and costs of physician-dispensed medication in each of these states, including pre- and post-reform data where applicable.
- The California Workers' Compensation Institute (CWCI) keeps a close eye on the trend, and has released several California-specific research studies that show the growth and impact of physician dispensing in California.
- The National Council on Compensation Insurance (NCCI) includes the impact of physician dispensing in its Prescription Drug Study,[1] most recently released in July 2013.
- The American Insurance Association (AIA) made a very public stand about its support for legislation in Pennsylvania (H.B. 1846), which is aimed at controlling costs associated with physician dispensing.[2]

The persistent media coverage keeps the challenge of physician dispensing top of mind. Meanwhile, data and research findings provide a strong basis for arguments in favor of policies that establish a fee schedule, or some other measure, for greater cost control.

As for Helios, hosting the Physician Dispensing Summit last year provided a forum for discussion, and was just a piece of a larger effort to proactively address the challenges of physician dispensing. Following the event, we kept the conversation going, delivering insightful perspective through a variety of mediums, including editorials in *Risk & Insurance* magazine, white papers, and videos[3]. We addressed trends in physician dispensing as part of our Drug Trend Report[4], and Florida State Senator D. Alan Hays appeared in a Signature Series segment[5], providing insight to the journey of Senate Bill 662. Topically relevant, the segment also affirms the consensus reached—dialogue, data, and collaboration can lead to positive change.

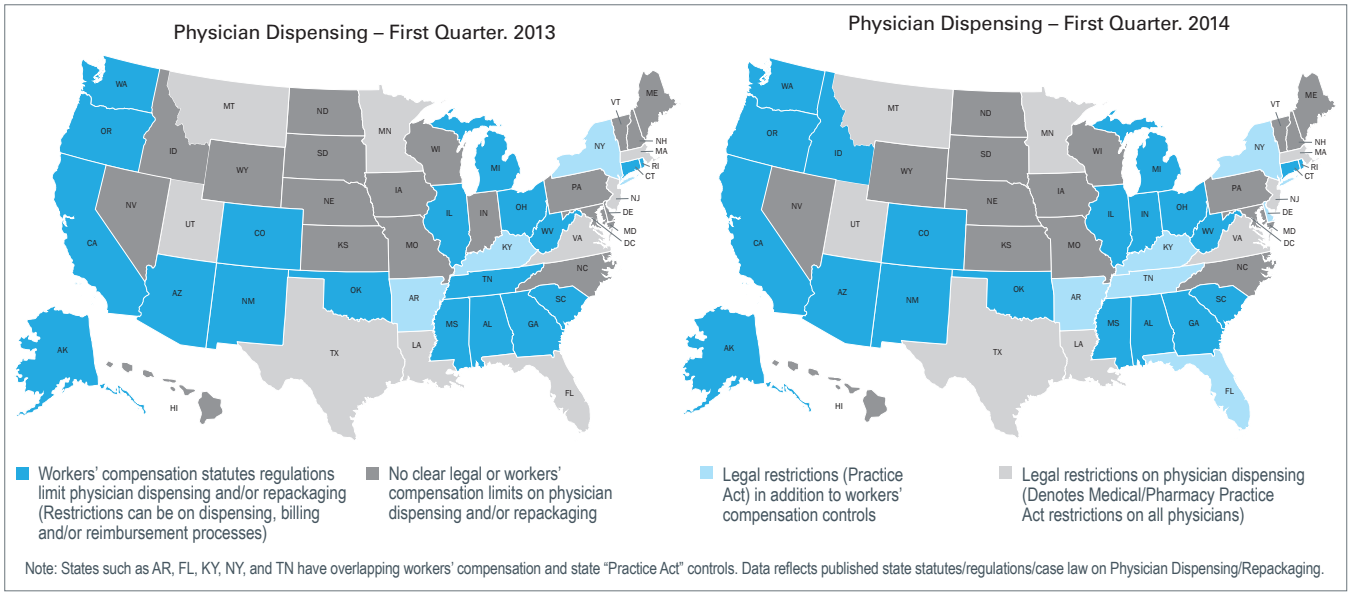
Legislative and Regulatory Establish the Ground Rules to Control Cost

Last year, many states either initiated or artfully resolved regulatory and legislative action to address physician dispensing. Largely these actions fall into one of two categories: 1) those that limit, restrict or ban the practice itself, and 2) those which cap reimbursement based on the original manufacturer's national drug code (NDC) and associated average wholesale price (AWP), and either set a maximum dispensing fee or outright deny its reimbursement.

The following maps show the changes in regulatory and legislative action on physician dispensing over the span of just one year. Following is a synopsis of the states with regulatory and/or legislative changes in the past year and our involvement in those changes.

Alabama. A fee schedule update in late 2013 eliminates reimbursement of a dispensing fee to the physician. The fee ($8.77 for brand and $11.39 for generic) is only available to licensed pharmacies. This regulation joins existing restrictions in Alabama that require bills for repackaged/relabeled drugs to include the original underlying NDC and that of the repackaged/relabeled product. Reimbursement for repackaged/relabeled drugs is the lesser of the AWP of the original NDC and repackaged/relabeled NDC.

Delaware. Passage of House Bill 175 in June 2013 directed the Delaware Office of Workers' Compensation Health Care Advisory Panel to develop rules restricting reimbursement for repackaged medications. Therefore, effective September 11, 2013, reimbursement for repackaged drugs is now based on the AWP of the underlying drug as identified by the NDC from the original labeler. Physicians are required to utilize the original underlying NDC when billing for repackaged drugs dispensed from their offices,



and reimbursement is the same as the overall fee schedule. However, they will not receive a dispensing fee. Our government affairs team met with Lt. Governor Matt Denn and offered our support for the legislation and suggested some additional changes that could be considered in coming years to strengthen their approach against prescription drug abuse in the workers' compensation system.

Florida. For the past three years, Florida has been a hotbed of debate over the issue of repackaging and physician dispensing. Senate Bill 662, sponsored by Senator Alan Hays, finally passed in May 2013. The bill inserts new language outlining a separate fee schedule and processes for relabeled and repackaged medication dispensed by a practitioner (a physician or practitioner other than a licensed pharmacist/ pharmacy who is permitted to dispense). Effective July 1, 2013, reimbursement for repackaged and relabeled medications dispensed by a physician is 112.5% of the AWP (on the date of dispense) of the medication, plus an $8 dispensing fee. Additionally, all claims submitted for repackaged or relabeled medicine must include the NDC of the original manufacturer and AWP set by the original manufacturer as published in Medi-Span. SB 662 also allows providers and payers to contract at rates which are less than the fee schedule but only when the carrier (or their agent paying on their behalf) has a direct contract with the provider seeking reimbursement for a lower amount. Our government affairs team joined forces with other groups in Florida to support the legislation. Our team submitted letters of support and met with Senator Hays and other legislators, educating them about the financial impact of repackaged medication and encouraging their support for the legislation.

Idaho. Through the rule-making process, the Idaho Industrial Commission sought to establish reimbursement limits on all medications from various dispensing sources, including repackaged, compounded, and over-the-counter medications (OTCs). Effective July 2013, general pharmacy reimbursement is fee schedule of AWP plus $5 for brand name drugs and AWP plus $8 for generics. However, dispensing physicians receive the same rate as pharmacies (AWP) without the dispensing fee. AWP required for calculating reimbursement is the original manufacturer's AWP. Our government affairs team submitted written comments supporting the changes.

Indiana. In May 2013, the Indiana Legislature passed House Bill 1320, which focuses on repackaged medications dispensed outside of retail or mail order pharmacy settings. Similar to reforms in other states, the bill puts a ceiling on reimbursement for non-pharmacy dispensed, repackaged prescription medications at the AWP set by the original manufacturer. In addition, if a dispensing physician

fails to provide the underlying NDC for a repackaged/relabeled medication, payers are permitted to reimburse at the lowest cost generic drug, if available. Non-repackaged medication, and those dispensed by a retail or mail order pharmacy, are not impacted. Letters to key committee members outlining the reasons we support the legislation were sent by our government affairs team.

Kentucky. In October 2013, Kentucky engaged in a rulemaking process to modify their physician fee schedule. Our government affairs team submitted written comments suggesting the inclusion of language to limit reimbursement for repackaged medications to the average wholesale price as determined by the NDC of the original manufacturer's product. In November, we received a letter confirming that our recommendation would be included in the final rule.

Suffice it to say, 2013 was an active year; and, not only is there no sign of activity abating, but bills previously stalled seem to be sustaining their momentum and moving forward.

Tennessee. Also in May 2013, Tennessee passed two bills, HB 868 and SB 676, which impact prescribing and dispensing of controlled substances within the state. HB 868 adds a new section to the state's existing pain management clinic statutes that no pain management clinic or medical doctor shall be permitted to dispense controlled substances—with the exception of a 72-hour maximum dose of a Schedule IV or V controlled substance at no charge. SB 676 added a new provision to the state's existing prescription requirements that no prescription for any opioids or benzodiazepines may be dispensed in quantities greater than a 30-day supply. This became effective October 1, 2013. Both bills apply, regardless of the jurisdiction governing the particular workers' compensation claim (federal or otherwise). Aligning with the Tennessee Chamber and their workers' compensation advisory committee, our government affairs team offered input on solutions we saw working in other states. We also met with Administrator Abbie Hudgens of the Tennessee Workers' Compensation Division and shared our ideas on how she might help shape language to curb some of the abuses we are seeing in repackaged medication pricing.

Suffice it to say, 2013 was an active year; and, at the time of this writing, not only is there no sign of activity abating, but bills previously stalled seem to be sustaining their momentum and moving forward.

Arizona, Maryland, New Jersey, Pennsylvania, Tennessee, Wisconsin, and numerous other states have legislation pending in their respective state legislatures that will in some fashion restrict reimbursement or utilization of physician-dispensed and/or repackaged medications.

Louisiana is anticipated to take a regulatory approach to the problem either via rule-making or by overhauling pharmacy fee schedules to include limits on reimbursement for repackaged medications based on the AWP of the original manufacturer's drug.

In Utah, physicians historically have been prohibited from dispensing medications, but new legislation just passed. First Substitute Senate Bill 55 creates a "dispensing medical practitioner" licensing designation that would allow practitioners to dispense certain cosmetic medications, injectable weight loss drugs, cancer treatment regimens and pre-packaged medications if dispensed in an employer-sponsored clinic (excluding Schedule I, II, III, IV, or V drugs). While the current legislation will have little impact on workers' compensation cases, limitations on repackaged medications will be addressed later this year.

Our government affairs team testified at legislative hearings in Maryland, met with leaders at Labor and Industry and legislators in Pennsylvania, submitted letters to each member of key committees in Wisconsin, met with the Workers' Compensation Division in Louisiana, and was actively involved in committee and legislator discussions in Utah regarding their changes to physician dispensing and future work to place limits on the cost of repackaged medications.

The PBM as a Powerful Ally

The valuable role played by the PBM in pharmacy cost containment is long-recognized. Programs addressing unit cost as well as utilization are continuously evolving as the complexities of the workers' compensation industry ebb and flow. As current issues unfold and new challenges emerge, it is imperative that the PBM not only equip their clients to respond immediately, but also prepare them for tomorrow.

Helios remains committed to ongoing innovation and program development to control the cost and utilization of physician-dispensed medications at every stage of the claim. Since the Summit, our programs continue to evolve to address the issue.

Specialty Networks. We are expanding our specialty network by growing the number of contractual arrangements we have with non-traditional dispensers in order to drive cost savings through network discounts and greater utilization control. Medications brought under the purview of our solution are evaluated against client business rules, injury-specific formularies, and drug utilization review edits to ensure that the injured party receives the right medication at the right time—and at the right price for the payer.

Data gathered as a result of capturing more prescriptions "in-network" allows for deeper inspection and more proactive clinical oversight. It also opens the door for communication with the injured worker to educate them on the valuable role of physicians and pharmacists.

Injured Worker Outreach. Our injured worker outreach campaign is a program where upon the receipt of a bill for a physician-dispensed medication, we send a letter to the injured worker informing them of the value of having future prescriptions filled at a network pharmacy. The letter acknowledges the important role of the physician as well as that of their local pharmacy and pharmacist. It also discusses the value of having the pharmacy perform real-time evaluations of all of their medications to ensure safety and make certain they will not cause any unforeseen risks, even when combined with other medications from other doctors – whether related to the claim or an unrelated or pre-existing health condition. The correspondence includes a temporary pharmacy card, instructions on how to find a convenient network pharmacy, and information on mail order options. We are pleased to share that the program is making a positive impact.

For the time period of April 1, 2013 and September 30, 2013, claims from a particular injured worker population which implemented this program were studied. Over the campaign time period, 5,720 letters were delivered to injured workers who had filled a prescription at the physician's office. Pharmacy transactions were monitored starting 30-days after the letter was mailed. Those who received a letter but did not fill a subsequent prescription were suppressed from the study. Claims that continued to receive transactions were compared against Physician Dispensing Reports to see if there was a change in behavior. Specifically, we looked at whether the injured party continued to receive medications and if so, whether or not all subsequent medications were dispensed through a pharmacy instead of by the physician. Of those that remained, about 22% of the injured workers who received a letter and continued to fill prescriptions did so using a retail pharmacy. As a result, monthly spend decreased by $428,293 (33%) by the end of the 120-day monitoring period.[6]

Government Affairs. With an active government affairs department, a PBM can influence positive regulatory and legislative change. Helios is a tireless advocate, actively engaged in collaborative efforts with regulators and legislators throughout the country, who are addressing physician dispensing and repackaged medications. Our Government Affairs team is present when bills are heard, proposes model language, and voices concerns in the best interests of our clients. They also keep clients informed and encourage them to communicate with their legislators.

The outcome of efforts such as these is better outcomes—both clinically and financially—for the injured worker, the payer and the industry.

Looking Ahead

The practice of physician dispensing continues to challenge the workers' compensation industry. Fortunately, with each passing day, we become even better equipped to address it.

Payers and injured workers alike are benefiting from

advancements in PBM programs such as those offered by Helios. Specialty networks, clinical oversight and letter campaigns, and advocacy are just a few examples of the tools proven effective.

Legislative and regulatory reform is lending clarity by defining the circumstances under which physician dispensing is permitted. Such efforts are also lowering costs as fee schedules are established and the disparity between the cost of physician-dispensed medication and their pharmacy-dispensed counterparts narrows.

The industry is becoming better informed as research studies are released and the media continues its coverage of the issue.

This progress is encouraging; as is the mounting evidence that proves thoughtful dialogue and the exchange of ideas can spark innovation and be a catalyst for artful compromise that makes a difference.

For more information about our programs, visit www.HeliosComp.com

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