

California Workers' Compensation Institute

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Implementation Issues Concerning the Adoption of a State Formulary Into the California's Workers' Compensation

Testimony before the
Senate Committee on Labor and Industrial Relations
& Assembly Committee on Insurance

March 2, 2016

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My name is Alex Swedlow and I serve as President of The California Workers' Compensation Institute, a private, nonprofit organization conducting primary research and analyses to improve the California system.

I'd like to thank Chairman Senator Tony Mendoza of the Senate Committee on Labor and Industrial Relations and Assembly Committee on Insurance Chair Tom Daly for the opportunity to present our research before the your committees.

Background

For more than a decade, the cost of prescription drug costs has been a primary cost driver in California. Exhibit 1 shows the average price increase for sole source (brand) and multi-source (generic) drugs¹. Between 2002 and 2015, the average price of brand and generic drugs increased by 275% and 34% respectively.

¹ 2015 CWCI Industry Research Information System data.
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Exhibit 1: Average Cost of Sole (Brand) and Multi-Source (Generic) Prescription: Calendar Years 2002 – 2015

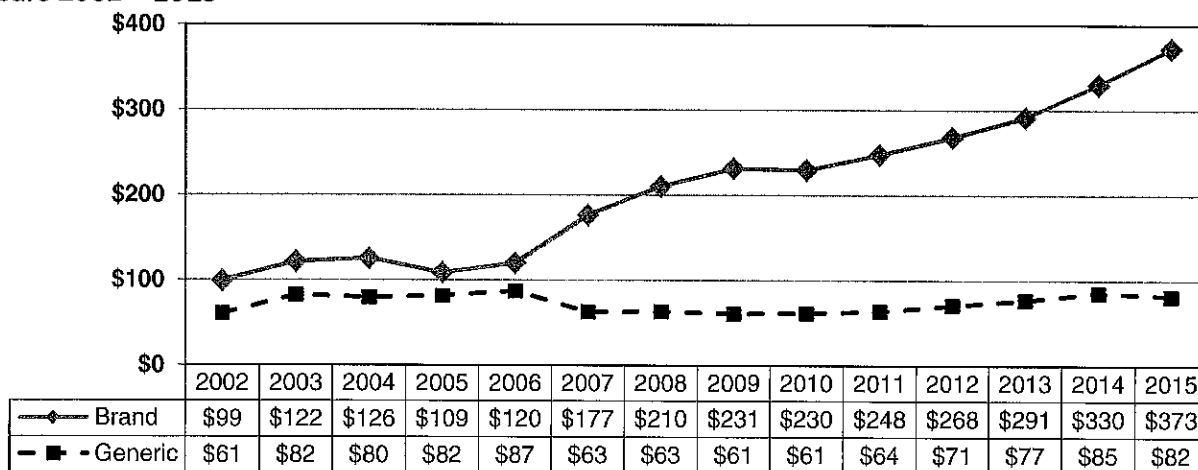
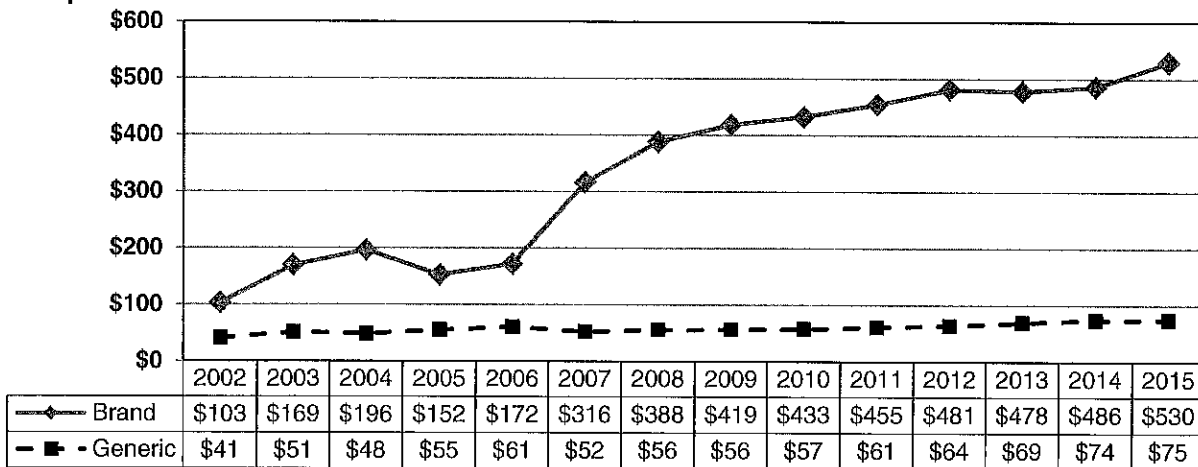


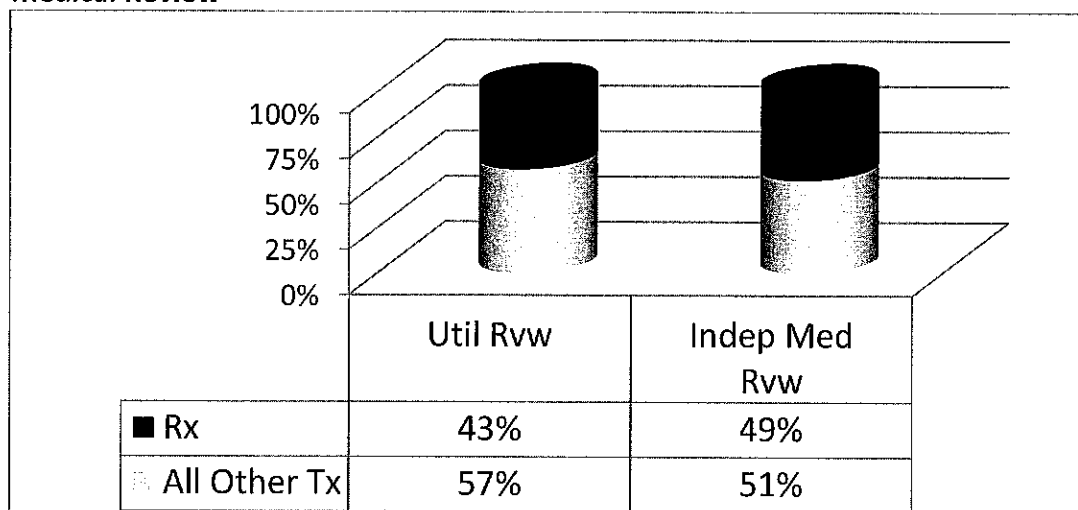
Exhibit 2 shows that average costs for opioid prescriptions rose even faster, with a five-fold increase in average costs. In 2002, the average price of a brand opioid prescription was \$103. By 2015 it climbed to \$530.

Exhibit 2: Average Cost of Sole (Brand) and Multi-Source (Generic) Analgesic Opioid Prescriptions: Calendar Years 2002 – 2015



Since 2005, average payments for pharmaceuticals within the first two years of the injury have more than tripled from \$593 to \$2,048². Our analysis of pharmaceutical delivery also points to high friction costs, measured by medical oversight programs such as utilization review and independent medical review. Exhibit 3 shows that review of pharmaceuticals make up 43% of utilization review's estimated \$300 million fees in 2015 per year and almost half of all independent medical review's \$100 million in vendor costs.

Exhibit 3. Percentage of Pharmaceutical Review of all Utilization Review and Independent Medical Review³



How Did We Get Here?

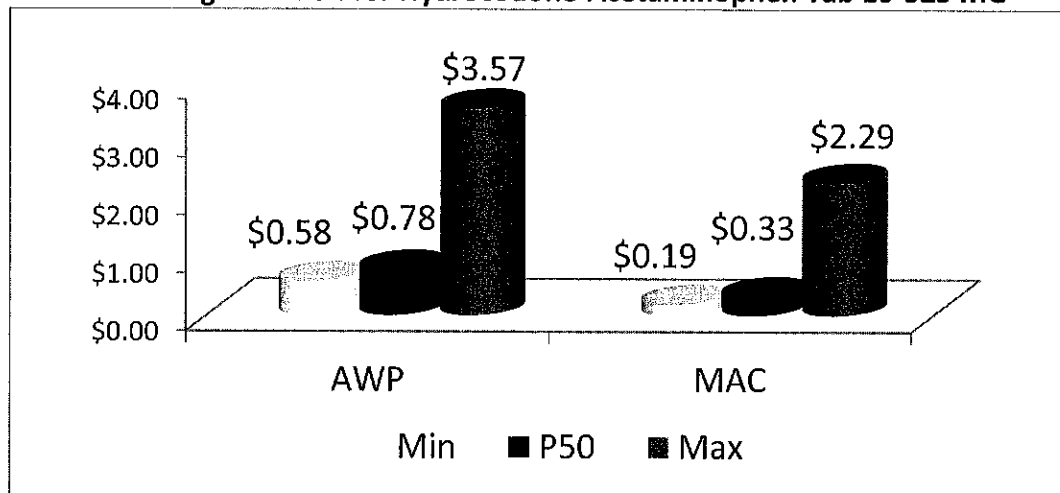
Multiple factors explain the rapid increase in pharmaceutical costs, including the expanding choice and extreme pricing variability. Despite fee schedule changes and pain management guidelines, there has been the dramatic increase in the use and cost of pain management therapies, including Schedule-II & III opioids and compound drug ointments which have become commonplace even in the treatment of relatively minor injuries. There are many examples of excessive pricing variation for common drugs. Exhibit 4 shows that for the number one drug in California workers' compensation, Hydrocodone-Acetaminophen, has a six-fold variation in

² Ireland, J., Swedlow, A., Gardner, L. Analysis of Medical and Indemnity Benefit Payments, Medical Treatment and Pharmaceutical Cost Trends in the California Workers' Compensation System. CWCI, July 2014.

³ CWCI 2014 and 2015
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average wholesale price and a 12-fold price variation on maximum allowable cost, two variables used in calculating reimbursement.

Exhibit 4. 2015 Pricing Variation for Hydrocodone-Acetaminophen Tab 10-325 MG



The Potential of a State Formulary

The missing piece to managing the utilization and cost of prescription drugs in workers' compensation is the use of a formulary, a concept that has been adopted by a growing list of workers' compensation jurisdictions including Texas, Washington, Tennessee, Ohio and others. Formularies are lists of approved drugs that define the scope, and in some cases, limit the variability in prices for specific therapeutic drug categories.

CWCI's October 2014 study modeled the outcomes of applying the Texas and Washington State formularies to California. This was accomplished by compiling a database of over 1 million prescriptions of 2013 California workers' compensation prescriptions. Our study found that depending on the scope of allowed drugs and the degree to which low cost considerations are adopted, California has the potential to save between \$124 - \$500 million per year.

There are important selection and implementation issues that must be addressed

- Alignment with the MTUS

Care must be taken to align the formulary with the Medical Treatment Utilization Schedule's evidence-based medicine protocols wherever possible.

- Focus on quality of drug selection and price
Formularies can range from the inclusive, those which have extensive approved drug listings, to the more exclusive with fewer approved drugs. Some formularies allow wider choice of more expensive brand drugs while others are more selective when equally effective, less expensive generic substitutes are available. Can we agree that if no discussion of cost can ignore quality, then no discussion of quality can ignore cost. What is the public policy justification in spending \$3.57 per unit of a drug when the chemically identical drug is available at one-sixth the price?
- Access to pharmaceuticals
It is highly doubtful that the implementation of a formulary would reduce access to needed medication. Our prior studies have shown that regulatory intervention to curb high priced, physician-dispensed repackaged drugs coincided with improved access to pharmacies.
- Lowering friction costs
I've mentioned the high cost of utilization reviews and independent medical review for pharmaceutical requests. A state-sponsored formulary could remove much of the confusion that triggers medical disputes and could reduce the reliance on Rx medical cost containment by as much as one-third.

I'd like to thank both committees for the opportunity to present our research and issues on adopting a formulary. If you have any questions, I'd be happy to answer them.