MEDICATION FORMULARIES

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PRESCRIPTION DRUGS IN WORK COMP - SCOPE OF THE ISSUE

- The prescription drug (Rx) share of total workers compensation (WC) medical costs for Accident Year 2014 = 17%
- Rx averages approximately 45% to 50% of annual medical costs for active claims older than 10 years
- Rx payments were over $1 billion in 2014
- Rx is among the most active subjects of

legislative activity in WC

- In 2014, Rx price inflation was higher than overall medical price inflation

- Rx prices increased 11% in 2014 (substantially higher than the 10-year average increase of 4%).
- Rx utilization declined by 4%
- Controlled substances prices increased 16% in 2014 while utilization was down 7%.
- Both physician-dispensed Rx prices and utilization increased 4% in 2014.
- The share of generic Rx costs increased in 2014 due to increases in prices and utilization.

- Rx continue to be a significant share of WC costs, largely due to increasing prices
- Legislative reform and stakeholders' efforts to contain costs
- Formularies, physician-dispensing laws, and other reform efforts expected to continue to impact the WC experience
- 👍〰oice of pharmacy and the role of PBMs and PDMPs are emerging in the dynamic world of prescriptions and workers' compensation

FORMULARIES - WHAT ARE THEY & WHAT PURPOSE DO THEY SERVE?

- A list of medications that are usually covered under a member's medical coverage agreement
- Exist to allow health care providers to offer the most effective drug therapy possible for a certain condition
- Consideration for the limited resources in today's environment of increasing drug prices
- Allows us to offer the safest, most effective, and most cost-effective health care possible
- Provides quick treatment reference based on EBM and science

FORMULARIES - WHO CREATES THEM?

- The Pharmacy and Therapeutics Committee (P&T Committee) often develops the formulary
- The P&T committee, composed of physicians from various medical specialties, reviews the medications in all therapeutic categories based on safety, effectiveness, and cost, and selects the most cost-effective drugs in each class
- The P&T Committee regularly reviews new and existing medications to ensure that the formularies remain responsive to the needs of members and providers
- Updates to the formulary periodically and it is subject to change
- Needs to consider changes in standard of care

FORMULARIES - WHAT DO THEY COVER IN GROUP HEALTH?

- Health plans cover certain prescription drugs, but not all medications in the formulary – Huh?
- Coverage for certain medications is often subject to an individual member's medical coverage agreement
- Generally does not cover drugs not in the formulary, although may cover some under special circumstances
- Items that are often not covered include:
- Over-the-counter medicines (examples include cosmetics or drugs for motion sickness, diarrhea, and so on.)
- Dental prescriptions
- Drugs used for non-Food and Drug Administration (FDA) approved reasons
- Certain prescription drugs

PRE-AUTHORIZATION

- A process by which a provider must obtain prior approval for coverage of a formulary medication.
- P&T Committee determines criteria that must be met in order for a patient's health plan to cover a drug.
- Usually addresses medications with safety issues or with a high potential for inappropriate use. These medications also usually have lower-priced clinical alternatives
- Prescribers do not need authorization to prescribe the drug, only to determine coverage (reimbursement) for a patient

FORMULARIES - WHO USES THEM?

- In the United States in 2010:
  - 63% of individuals who had health insurance were insured through private plans,
  - 24% by government health programs, and
  - 13% by both types of programs.
  - The vast majority (approximately 85%) of privately insured Americans had access to health insurance through private employers.
- The main government programs are Medicaid and Medicare, covering 19% and 17% of the insured population, respectively.

FORMULARIES - WHEN DO THEY COME INTO PLAY?

- Covered drugs assigned to “tiers,” with the copay varying by tier (the lower the tier, the lower the copay).
- Access to on-patent (brand) drugs in the lowest copay tiers (1 and 2) was higher in employer, union, and pharmacy benefit management plans than in commercial plans.
- However, in Medicare plans, substantially fewer on-patent drugs were included in these tiers, which may create choice restrictions and thus compliance issues

BRAND VS. GENERICS

- List brand names to serve as a guide
- Does not imply coverage of a specific brand
- The generic column indicates whether a generic product is available for a drug.
- Substitution with generic drugs occurs when available and allowed by the prescriber
- When a generic is available, brand medication considered non-formulary and subject to higher cost /shared cost
- Patent usually granted for 20 years

GENERICS

- **FDA-approved generic equivalents:**
  - Same active ingredients as brand-name drugs.
  - FDA expects these generics to work the same way as the original brand drugs because available in the same dosage strengths and dosage forms. They must meet FDA standards for quality and purity. You usually save the most with generics.
- **Generic alternatives** contain different active ingredient(s) than the brand-name drug you are taking but can sometimes treat the same condition as the brand-name drug. Generic alternatives are not the same as generic equivalents.

TIERS

- A drug's tier determines the degree to which the patient will have to contribute a payment for the drug—the lower the tier, the lower the copayment.
  - Tier 1 is typically for generics,
  - tier 2 for preferred brand name drugs,
  - tier 3 for non-preferred brand name drugs, and
  - tiers 4 (and above) for coinsurance brands.

- Copayments are required from patients for drugs in tiers 1 through 3 to cover some of the drug costs.
- In 2012, those with employer coverage had copays of:
  - $10 for first-tier drugs,
  - $29 for second-tier drugs,
  - $51 for third-tier drugs, and
  - $79 for fourth-tier drugs.

  - The Medicare Part D coinsurance rate on the specialty tier ranged from 25% to as high as 33%, with a median of 30%.
  - In 2009, the average Medicare Part D copayment was $10 for first-tier drugs, $37 for second-tier drugs, and $75 otherwise.

PREFERRED VS NON-PREFERRED BRAND NAME DRUGS

- **What are preferred brand-name drugs?**
- Brand medications listed on the plan's formulary
- Safe, effective alternatives to other brands that may be more expensive.

- **What are non-preferred brand-name drugs?**
- Brand medications not included on the plan's formulary
- Higher co-insurance (pay more)

- **Why should I take generic or preferred brand-name drugs?**
- Pay a lower coinsurance amount for generics and preferred brand-name drugs.

FORMULARIES - PATIENT'S EXPERIENCE (GROUP HEALTH)

- From a patient's perspective, plans that offer drugs relevant to their condition in the low copay tiers are likely to be more attractive, assuming the monthly premiums are comparable.
- There is a favorable degree of choice of drugs within a therapeutic class in the low copay tiers. The ability to choose (doctors, hospitals, and drugs) is seen as very important or extremely important by the vast majority of Americans when selecting healthcare plans.
- Patients recognize they have skin in the game

FORMULARIES – PATIENT'S EXPERIENCE (WORKERS' COMP)

- May see it as decreased choice
- May feel entitled to whatever doctor chooses
- No skin in the game – but they do and may not realize it
- May see as delay
- May see as employer doesn't care about my treatment
- May not realize OTC is covered

FORMULARIES - PHARMACY VIEW

- Many different formularies to check
- May provide PDMP use reminder
- Adds to time which is already limited
- Delays fill often with patient waiting in front of them
- Varied communication
  - With physician's office for substitution approval
  - With carrier for authorization or more information
  - With pbm for instructions
  - With patient – what to tell them?

FORMULARIES - CLINICIAN VIEW

- May see carrier or PBM as dictating to them how to practice medicine
- Do not recognize or know about abuse that has occurred in the system
- Pulled out of clinic to discuss with pharmacist
- Based on EBM and patient safety data
- Not just about cost but cost effective care is part of it
- May not realize OTC is covered under work comp
- PDMP use reminder

WHAT IF "I" DON'T AGREE…

- Clinician and patient have appeal rights
  - Medical necessity
  - Attempted reasonable prior use with formulary medication
  - Side effects
  - Allergy

NON- FORMULARY MEDICATIONS

- Medications not listed in the formulary not covered unless approved by the health plan as medically necessary.
- The patient or clinician can request an exception to prescribe non-formulary medications
- In most cases, there is a formulary alternative your doctor can use
- Examples in WC may include:
  - Naproxen sodium, diclofenac sodium, capsules, omeprazole, experimental/investigational, cds

FORMULARIES & PBMS

- Enough acronyms already…What is a PBM?

- Communication with pharmacies limited by technology of each
- Communication with carrier limited by technology of each
- First fills
- Good Samaritan dosing

FORMULARIES ARE NOT A SECRET

- Usually listed on carrier website
- Physicians should have access to most up to date formulary
- Can be a little confusing if not introduced to formulary properly

MEDICARE PART D

- Each Medicare Prescription Drug Plan has its own list of covered drugs placed into different "tiers" – each associated with a different cost.
- If the prescriber thinks the patient needs a drug on a higher tier, the patient or prescriber can ask the plan for an exception to get a lower copayment.
- A Medicare drug plan can make some changes to its formulary during the year within guidelines set by Medicare. If the change involves a drug you're currently taking, your plan must do one of these:
- Provide written notice to you at least 60 days prior to the date the change becomes effective.
- At the time you request a refill, provide written notice of the change and a 60-day supply of the drug under the same plan rules as before the change.

TEXAS – DWC EXPERIENCE

- A closed formulary
- ODG (adopted by TX, OK, and in 2016 TN)
- 24% of drug costs and 17% of prescriptions in a service year are for N drugs
- The intent of formularies is to use evidence-based guidelines in order to:
  - Reduce over prescribing (opioids in particular)
  - Maximize healing and improve return-to-work outcomes
  - Contain drug costs

- **Status Description**

Y Preauthorized for use

N Not allowed, or needs authorization

***** Both Y and N are possible depending on intended purpose

GROWING TREND

- WA
- TX
- OK
- TN
- OH
- NV

- MN, WI, NY,
- CA

- FL discussions

- Political issue

FORMULARIES CREATE EDUCATIONAL OPPORTUNITIES

- Links to drug information should be provided
- Patient education key to successful treatment
- Understanding rights and responsibilities
- How to appeal and form to use if needed
- Contact information for carrier or pbm

RESOURCES

- www.medicare.gov
- www.ncci.com
- www.ajmc.com
- www.optum.com
- www.kp.org
- www.zenith.com
- www.cwci.org
- www.acoem.org
- www.healthesystems.com

QUESTIONS