Closed Drug Formularies: A Growing Trend in State Workers' Compensation Reforms

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Government officials at the national, state and local levels are grappling with various measures to eliminate prescription drug abuse and rein in pharmacy costs.

These challenges are rife in the states' workers' compensation systems. Cost containment is a common goal among stakeholders across state lines in the workers' compensation arena; however, the best mechanisms to reduce costs while maintaining the integrity of care provided to the injured worker are often debated. Similarly, in recent years, concerns have arisen around the lack of alternatives to opioid therapy as a first defense to treat chronic pain in injured workers. One solution that appears to be gaining ground quickly is the implementation of a closed drug formulary. A drug formulary is not a new concept to most players in administering workers' compensation claims. Pharmacy benefit managers (PBMs) have been using them for quite a while, claiming reductions in costs and utilization, and lawmakers are starting to take notice.

What is a drug formulary?

In simple terms, a drug formulary is a predetermined list of prescription medications that specifies which drugs, both brand-name and generic, are approved for treatment of certain conditions.

Express Scripts, a large PBM, states in developing a drug formulary, "we first perform a rigorous assessment of the available evidence regarding each drug's safety and clinical effectiveness. No new drug is added to the formulary until it meets standards of quality established by our National Pharmacy & Therapeutics Committee ("P&T")…. in making its clinical recommendation, the P&T Committee has no information regarding the discount or rebate arrangement we might negotiate. …"[i] Once the health insurer has created its formulary plan, members may only utilize approved medications or pay out of pocket for drugs not on the formulary-typically at a high cost to the individual. Similarly in workers' compensation, in states with legislated closed drug formularies, insurance carriers will only pay for approved medications. Those drugs not approved, referred to as "N" drugs, will need prior authorization for payment. States may create their own formularies or utilize a nationally available workers' compensation drug formulary such as that offered in the suite of services by the Official Disability Guidelines (ODG).

Presently only four states have implemented a drug formulary for workers' compensation claims: Texas, Ohio, Washington and Oklahoma (currently on an interim basis).

Texas, which utilizes the ODG product, is widely considered to have effectively reduced its pharmacy costs and challenged the physician's traditional approach to opioid therapy. In February, the Texas Department of Insurance (TDI) released a report titled "Impact of the Texas Pharmacy Closed Formulary," which found the cost of N-drugs fell by 83 percent in claims subject to the formulary, which was adopted in 2011. The total number of prescriptions for N-drugs decreased by 76 percent and the generic substitution rate for N-drugs increased to 74 percent.[ii] Pursuant to TDI's 2014 Annual Report, total pharmacy costs have decreased year over year since 2011.[iii]

The Ohio Bureau of Workers' Compensation's 2014 Annual Report highlighted a reduction in opioid doses by 10.9 million since 2010 and a 29 percent reduction in opioid prescriptions in 2014 compared with 2010.[iv]

A study released by the Workers Compensation Research Institute (WCRI) found Washington state's prescription drug costs among the lowest, 40 percent lower than the median, in comparison with 17 other states.[v] The study attributed the low costs in part to the formulary for approved drugs that was instituted in 2004.

Oklahoma adopted a closed formulary via emergency rules promulgated by the Workers' Compensation Commission to be used for all dates of injury on or after Feb. 1, 2014. Permanent rules have not yet been adopted and will require approval by the state Legislature.

California is set to add a drug formulary by July 2017, and Louisiana recently announced it has started work on implementing a formulary as well. Other states, such as Georgia, South Carolina and Maine, are expected to make moves in 2016.

An additional report published by WCRI examines how a Texas-like closed drug formulary may impact costs in 23 states. The study concludes that a closed formulary may cut prescription costs by up to 29 percent in New York, 16 percent in Illinois and 18 percent in Florida. Cost savings across the 23 states range from 14 percent to 29 percent of prescription drug costs.[vi] These numbers will likely attract the attention of stakeholders in workers' compensation insurance industries as they seek to rein in costs.

Lawmakers should, however, approach closed pharmacy formularies with caution.

Statistics are slim in terms of negative impacts of a drug formulary, likely in part to the limited use in workers' compensation around the country, but there are concerns from a medical standpoint. Medical societies tend to warn against legislating patient care. Every patient presents as an individual, and physicians charge that they should be the ones to determine the best care for their patients. An additional drawback is concern about access, especially for those patients who may need specialized medications such as compound drugs. This concern has been raised in the group health arena, where patients have borne exorbitant costs of medications not on a plan's formulary.[vii]

Delay in care is already an ongoing area of concern in treating injured workers, and a restrictive closed pharmacy formulary will no doubt

further contribute to limiting a patient's ability to obtain medications in an expedient manner. Another area of caution is how exactly a formulary is drafted and updated. Objective approaches, such as implementing the ODG's formulary, will likely present themselves as more agreeable to all parties as opposed to panels of individual stakeholders who may be impressionable or self-serving. A restrictive formulary very well could lead an injured worker to utilize personal health insurance or a government program to obtain a prescribed medication, thereby simply shifting costs to another entity or to the employee.

Workers' compensation is a state-run system, and each state faces individual challenges and barriers.

Given that the number of states considering a closed formulary is still in the vast minority, it is likely that closed formularies will be a hot topic over the next few years, and successes in large states like Texas will surely attract the attention of other states. A recent report published by the IMS Institute for Healthcare Informatics found U.S. spending on prescription drugs soared in 2014, by 13 percent to a total of $374 billion.[viii] Comparatively, pharmacy trends in workers' compensation appear to be more modest. Express Scripts released data finding costs only increased by 1.9 percent for its workers' compensation clients, noting that a 7.0 percent increase in the cost per prescription was offset by a 5.4 percent decrease in per-user-per-year utilization.[ix] Formularies provide predictability around claims pharmacy costs, which is advantageous to payers and providers. A well-defined closed formulary that utilizes input from various stakeholders and is designed with flexibility is certainly a likely option for legislators to consider as they seek to contain costs and maintain the principle of the grand bargain that is workers' compensation. In addition to the financial impact, policymakers would be remiss not to research and acknowledge the potential for a closed formulary to counter the prescription drug abuse epidemic. Debates continue at the national, state and local levels on how to better curb opiate abuse, and evidence of a reduction in opioid prescriptions as a result of closed drug formularies will certainly resonate with lawmakers. Combating prescription drug costs and abuses are two universal and significant concerns for stakeholders in the workers' compensation field, from payers to injured workers to elected officials. The success in these areas evidenced by Texas, Ohio and Washington's data certainly at the very least warrants consideration and open dialogue regarding the implementation of a closed drug formulary by stakeholders in the state's workers' compensation industry.

[i] United States. Securities and Exchange Commission. Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the Fiscal Year Ended December 31, 2013. Express Scripts Holding Company, n.d. Web. 23 April 2015.

[ii] Impact of the Texas Pharmacy Closed Formulary. Rep. Texas Department of Insurance Workers' Compensation Research and Evaluation Group, Feb. 2015. Web. 13 March 2015.

[iii] Health Care Cost and Utilization in the Texas Workers' Compensation System. Rep. Texas Department of Insurance Workers' Compensation Research and Evaluation Group, Dec. 2014. Web. 13 March 2015.

[iv] Fiscal Year 2014 Report Rep. Ohio Bureau of Workers' Compensation, Web. 23 April 2015.

[v] Wang, Donshung, and Te-Chun Liu. Prescription Benchmarks for Washington. Publication no. WC-11-30. Cambridge: Workers Compensation Research Institute, 2011.

[vi] Thumula, Vennela, and Te-Chun Liu. Impact of a Texas-Like FormularyinOtherStates.Publicationno.WC-14-31.Cambridge: Workers Compensation Research Institute, 2014.

[vii] Gottlieb, Scott, MD. "Under Obamacare's 'Closed Formularies' PatientsWithSeriousChronicDiseaseslikeMSDon'tGetAccess toVitalMedicines."Weblogpost.Forbes.com,13June2014.Web. 8 May 2015.

[viii] "IMS: US Prescription Drug Spending Jumped 13 Pct. In 2014." The New York Times, 14 April 2015. Web. 22 Apr. 2015.

[ix] Henderson, Rochelle, PhD, Jennifer Kaburick, RN, Brigette Nelson, PharmD, and Reethi Iyengar, PhD. The 2014 Drug Trend Report Workers' Compensation. Rep. no. 14-EME27270. N.p.: Express Scripts, 2015. Print.