Department of Legislative Services

Maryland General Assembly
2014 Session

FISCAL AND POLICY NOTE

Senate Bill 507 (Senators Feldman and Astle)
Finance

Workers' Compensation - Reimbursement for Repackaged and Relabeled Drugs - Fee Schedule and Requirements

This bill requires the Workers' Compensation Commission (WCC) to adopt, in regulation, a specified pharmaceutical fee schedule.

Fiscal Summary

State Effect: State expenditures (all funds) increase significantly to the extent that the Chesapeake Employers' Insurance Company (Chesapeake), as the administrator of workers' compensation claims for the State, is required to pay the reimbursement rates for repackaged and relabeled prescription drugs established by the bill. General fund revenues may increase minimally to the extent that WCC is required to impose fines on employers or insurers that fail to pay for prescription drugs.

Chesapeake Employers' Insurance Company Effect: Chesapeake expenditures increase significantly to the extent that Chesapeake is required to pay the reimbursement rates for repackaged and relabeled prescription drugs established by the bill. Revenues increase correspondingly.

Local Effect: Self-insured and privately insured counties' and municipalities' expenditures decrease to the extent that current reimbursement rates for repackaged or relabeled prescription drugs are more costly than the reimbursement rates for prescription drugs established by the bill; however, to the extent that the bill results in additional physician dispensing of repackaged or relabeled drugs, expenditures increase, and the net effect may be an increase in expenditures. Expenditures for counties and municipalities insured by Chesapeake increase significantly to the extent that Chesapeake is required to pay the reimbursement rates for repackaged and relabeled prescription drugs established by the bill. Revenues are not affected.

Small Business Effect: Meaningful.

Analysis

Bill Summary: The fee schedule adopted by WCC must (1) for brand name and generic equivalent repackaged or relabeled prescription drugs, set the reimbursement rate at 130% of the average wholesale price (AWP) of the drug plus a dispensing fee of $12 and (2) for brand name repackaged or relabeled prescription drugs without generic equivalents that are dispensed instead of drugs that are controlled dangerous substances (CDS), set the reimbursement rate at 150% AWP plus a dispensing fee of $12.

If WCC finds that an employer or its insurer has failed, without good cause, to pay for drugs as required by workers' compensation law within 45 days after WCC approves the fee for the drugs, WCC *must* impose a fine on the employer or insurer, not exceeding 20% of the amount of the approved fee or charge.

A pharmaceutical bill submitted to an employer or its insurer for reimbursement of a repackaged or relabeled drug must include the original manufacturer or distributor stock package national drug code for each drug used in the repackaged or relabeled drug. An employer or its insurer must reimburse a provider for a repackaged or relabeled prescription drug at the rate in the fee schedule adopted by WCC unless the employer, its insurer, or any entity acting on their behalf directly contracts with the provider or its representative to allow reimbursement at a lower rate.

With regards to these provisions, "average wholesale price" means the average wholesale price of a drug that is established by the original manufacturer of the drug as identified by the drug's national drug code and is published in the medi-span master drug database as of the date the drug is dispensed.

Current Law/Background:

Physician Dispensing of Repackaged and Relabeled Prescription Drugs: In addition to prescribing authority, a licensed physician may personally prepare and *dispense* prescription drugs or devices if he or she holds a written dispensing permit from the State Board of Physicians and meets other specified criteria. Chapter 184 of 2013 repealed an exception that had allowed certain physicians to dispense without such a permit at a medical facility or clinic that specializes in the treatment of medical cases reimbursable through workers' compensation insurance. If the Chairman of WCC finds or has cause to believe that a physician or health care provider has a pattern of providing excessive medicine, services, or treatment, the chairman must refer the case to the State Board of

Physicians for review. The board may then revoke the physician's or health care provider's license and impose a fine.

A physician who dispenses prescription drugs or devices must comply with prescription drug labeling requirements, record the dispensing on a patient's chart, allow the Division of Drug Control to enter and inspect the practitioner's office at all reasonable hours, provide the patient with a written prescription, and maintain prescription files in a specified manner. According to the State Board of Physicians, 1,509 physicians hold dispensing permits in Maryland. A physician who holds a dispensing permit may dispense prescription drugs or devices to a claimant in a workers' compensation case for any period of time and for an unlimited amount of refills.

WCC is currently authorized to regulate fees and other charges for medical services or treatment. These fees and other charges are generally regulated through the Medical Fee Guide, except there is no fee guide for prescription drugs which are to be set at the "usual and customary" rate. In the Medical Fee Guide, each fee or other charge for medical service or treatment is limited to the amount that prevails in the same community for similar treatment of an injured individual with a standard of living that is comparable to that of the covered employee. If WCC finds that an employer or its insurer has failed, without good cause, to pay for the charge or fee for services approved by WCC, WCC *may* impose a fine on the employer or insurer, not exceeding 20% of the amount of the approved fee or charge.

Physician dispensing of repackaged pharmaceuticals may increase costs for the workers' compensation system in states where physicians are not bound by state fee schedules and prescription drug cost controls. According to a study by the Workers' Compensation Research Institute (WCRI) released in September 2013, physicians directly dispensed 40% of all medications prescribed to injured workers in Maryland in 2011/2012, representing 55% of total spending on pharmaceuticals for workers' compensation claims in those years. Although the report did not include data on Chesapeake, it determined that, for other insurers in Maryland, from 2008 through 2012, prices paid for physician-dispensed prescriptions increased meaningfully, while prices paid to pharmacies decreased or changed only slightly. (For example, the average price per pill paid to physicians for Vicodin increased 47% to $1.46 per pill, while the price paid per pill to pharmacies for the same drug fell 5% to $0.37 per pill.)

WCC has previously proposed two sets of regulations that would have established a pharmaceutical fee schedule. (Several states have lowered overall workers' compensation costs by implementing similar measures.) However, neither set of regulations was adopted.

According to WCRI, some states limit physician dispensing of prescription drugs. For example, in New Jersey physicians may dispense prescription drugs up to a seven-day supply except in rural areas. Louisiana, Florida, and Arkansas limit physician dispensing of CDS. Some states, including Massachusetts, New York, Texas, Minnesota, Utah, and Wyoming, generally prohibit physician dispensing of prescription drugs. Other states allow physician dispensing of prescription drugs with reimbursement to physicians based on a fee schedule or other cost controls. Some states have a fee schedule and dispensing fee similar to the system established by the bill. For example, Florida allows reimbursement at 112.5% of the original manufacturer's AWP plus an $8 dispensing fee. Maryland, like a few other states, allows reimbursement for physician dispensing of prescription drugs at the "usual and customary" rate.

Pharmacy Benefits Managers (PBM): WCC reports that, in Maryland, medical providers, including pharmacies, can be selected by a claimant (injured worker). However, sometimes a claimant cannot find a medical provider in his or her area who is willing to provide medical treatment because no provider in the area is willing to accept the rules of the Medical Fee Guide. In these circumstances, it is often suggested that parties should consider contacting the employer or its insurer for suggestions for medical providers in the area. Insurers often have data listing participating medical providers in the various regions of the State, based on their payment records. Employers may also prefer an injured worker to have prescription drugs filled by their PBM. This type of program, which may include a list of covered pharmacies, may save the employer money at no additional cost to its workers. For example, Montgomery County reports that it saves as much as $500,000 in expenditures per year due to employees using its PBM network.

Controlled Dangerous Substances: In August 2013, a study, titled *Reducing Inappropriate Opioid Use in Treatment of Injured Workers*, was released by the International Association of Industrial Accident Boards and Commissions. The report states, "The impact of opioid abuse in the general population is well documented, but research is just beginning to show the extent of opioid use and abuse in the U.S. workers' compensation system. The epidemic is damaging lives and driving up costs." The report discusses the increased costs to the workers' compensation system caused by opioid abuse due to additional medical care required in the case of addiction and delays with injured employees returning to work. It recommends that states may take various policy actions to address the issue, including (1) requiring physicians to meet specified standards when monitoring and evaluating patients who are using opioids to manage chronic pain; (2) establishing documentation requirements for physicians who prescribe opioids to mange chronic pain; and (3) determining whether treatment guidelines will describe any preauthorization requirements.

Schedule II opioids such as hydrocodone (Lorcet, Norco, and Vicodin) and oxycodone (Percocet, Oxyfast, and OxyContin) are commonly used as pain relievers in cases of workers' compensation injuries. Opioids provide extremely effective pain relief that work by binding to receptors present in the brain and spinal cord; however, they have inconvenient and dangerous side effects such as constipation and respiratory depression. Despite the effectiveness of these types of drugs, long-term opioid use can lead to dependence and addiction. The U.S. Census Bureau reports that prescription painkillers, including opioids, were involved in 14,800 overdose deaths in the United States in 2008. Additionally, they report, the misuse and abuse of prescription painkillers was responsible for more than 475,000 emergency room visits in the United States in 2009.

State/Chesapeake/Chesapeake Insured Local/Small Business Effect: Expenditures increase significantly to the extent that Chesapeake is required to pay the reimbursement rates for repackaged and relabeled prescription drugs established by the bill and to the extent that additional physicians begin to dispense repackaged and relabeled prescription drugs to earn the reimbursement and dispensing fees established by the bill. The number of physicians who will choose to dispense repackaged or relabeled drugs due to the bill, as well as any related expenditure increase, cannot be reliably estimated at this time.

Chesapeake reports that prescription drug payments amounted to approximately $9 million per year over the six-year period between 2008 and 2013, and almost all of these prescriptions were filled at about 80% AWP using its PBM. *For illustrative purposes only*, if 20% of Chesapeake's prescriptions were repackaged or relabeled and thus filled at 135% AWP (130% AWP with some additional expenditure assumptions to account for the $12 dispensing fee and the possibility of reimbursement at 150% AWP in some cases), Chesapeake expenditures would have increased by $1.7 million per year due to the 69% increase in costs for those drugs. Chesapeake reports that the costs for these drugs would be passed on to its customers who include businesses, some local governments, and the State. Over that period, about 25% of prescription benefits were paid by Chesapeake on behalf of the State; thus, State expenditures would have increased by $425,000 per year.

Additionally, to the extent that the bill results in any additional physicians applying for a dispensing permit, State Board of Physicians and Division of Drug Control revenues and expenditures increase accordingly. The number of physicians who will choose to dispense repackaged or relabeled drugs due to the bill cannot be reliably estimated at this time.

Self-insured and Privately Insured Local/Small Business Effect: The bill directly results in expenditure reductions to the extent that current reimbursement rates for repackaged or relabeled prescription drugs are more costly than the reimbursement rates for prescription drugs established by the bill and to the extent that the bill results in fewer

CDS prescriptions. However, the bill may also result in expenditure increases to the extent that additional physicians begin to dispense repackaged and relabeled prescription drugs to earn the reimbursement and dispensing fees established by the bill. If repackaged and relabeled dispensing expands significantly, direct expenditure reductions may be negated or the bill may result in a net increase in expenditures.

The National Council on Compensation Insurance (NCCI) estimates that the fee schedule may directly reduce expenditures for prescription drugs in the workers' compensation market in the State, excluding self-insureds and Chesapeake, by as much as $7 million annually due to reduced costs for repackaged and relabeled drugs. To create the estimate, NCCI used 2012 data from First Databank's "National Drug Data File: Descriptive and Pricing Data" and compared actual expenditures for repackaged or relabeled drugs under the current system to the expenditures that would have occurred using the fee schedule for drug costs. The ratio obtained by this comparison was then applied to Maryland workers' compensation expenditures in the 2010 through 2012 period. NCCI reports that, in Maryland in 2012, total prescription drug payments accounted for 16.1% of the total workers' compensation medical costs and repackaged drugs accounted for 26.3% of the total prescription drug payments, excluding self-insureds and Chesapeake. NCCI also reports that CDS payments account for 43.2% of the total prescription drug costs. The Department of Legislative Services concurs with this estimate.

Small businesses, in particular, may be affected more meaningfully from the bill than larger employers because larger employers are better able to negotiate for lower prescription costs. For this reason, any reduction in prescription drug costs or expansion of physician dispensing of repackaged or relabeled drugs has a greater impact on small businesses.

Additional Information

Prior Introductions: None.

Cross File: HB 1342 (Delegate Tarrant, *et al.*) – Health and Government Operations and Economic Matters.

Information Source(s): Department of Health and Mental Hygiene, Maryland Insurance Administration, Injured Workers' Insurance Company/Chesapeake Employers' Insurance Fund, National Council on Compensation Insurance, Subsequent Injury Fund, Uninsured Employers' Fund, Workers' Compensation Commission, Workers' Compensation Research Institute, National Council on Compensation Insurance, Department of Legislative Services

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