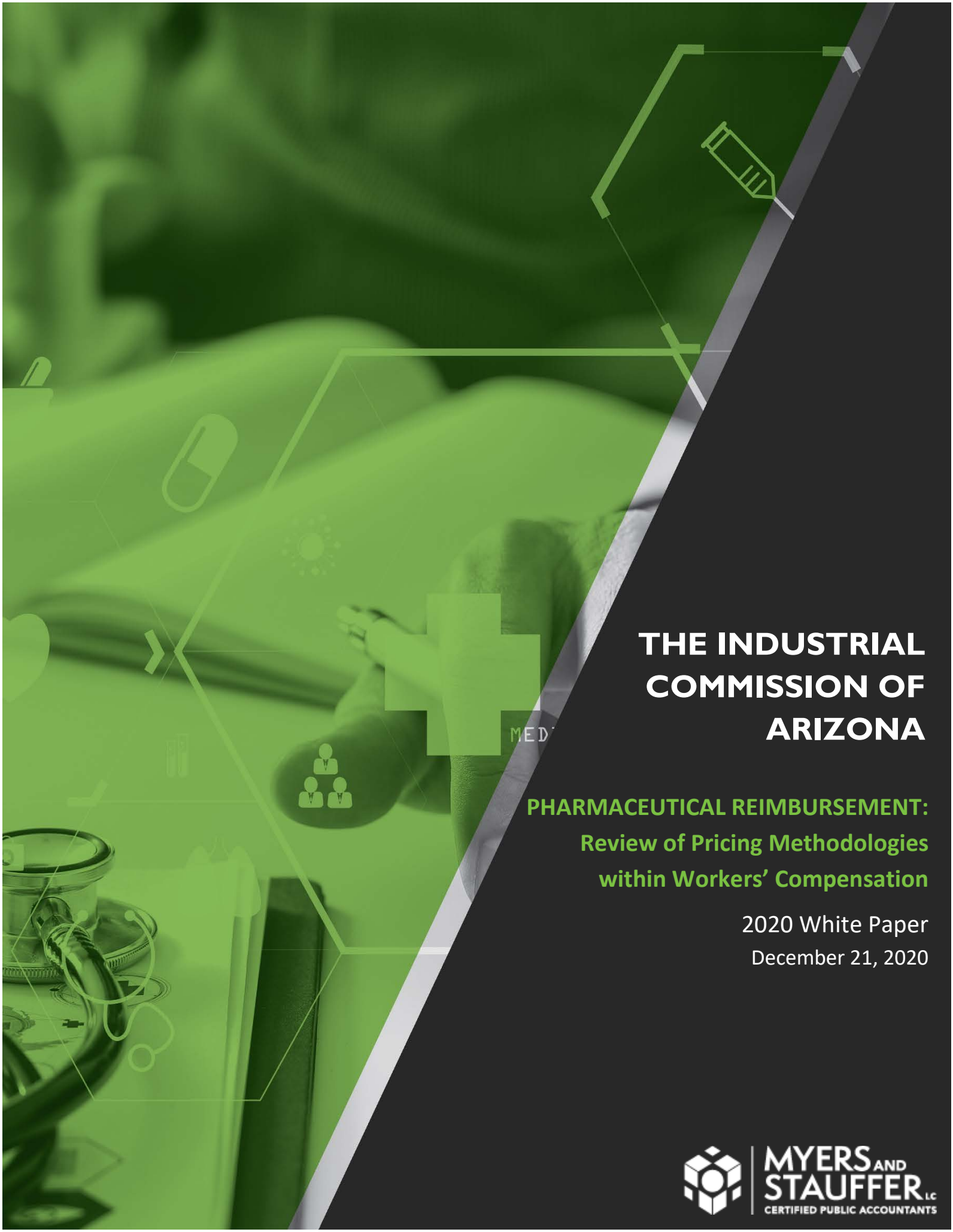


# THE INDUSTRIAL COMMISSION OF ARIZONA

## PHARMACEUTICAL REIMBURSEMENT: Review of Pricing Methodologies within Workers' Compensation

2020 White Paper

December 21, 2020

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

# Table of Contents

# Introduction

The Industrial Commission of Arizona (ICA) is responsible for oversight and administration of the Arizona Workers' Compensation System (the "System"), which includes setting reimbursement fee schedules for medical and pharmaceutical services. Myers and Stauffer LC is a national certified public accounting (CPA) firm with over four decades of experience providing health care reimbursement services exclusively to state and federal government agencies.

The ICA monitors expenditure levels for claims from injured workers and benchmarks those expenditures against the experience of other states' workers' compensation systems. One data source that the ICA monitors to perform such comparisons is the Medical Data Report published by the National Council on Compensation Insurance (NCCI), which presents statistics and benchmarks derived from states' workers' compensation systems claims data. According to NCCI's 2020 Medical Data Report, the cost per lost-time claim within the Arizona System is approximately 145 percent of the national average.[1] Additionally, of the total payments for claims, approximately nine percent is attributed to prescription drugs within the Arizona System as compared to a national average of eight percent.[2]

To assist the ICA in evaluating its current pharmaceutical reimbursement methodology and whether the methodology aligns with industry best practices, the ICA has contracted with Myers and Stauffer to perform the following tasks:

(1) Evaluate the pros and cons of pharmaceutical reimbursement methodologies that utilize other viable pharmacy pricing benchmarks (or a combination of benchmarks) in lieu of, or in addition to, average wholesale price (AWP) in Arizona's Workers' Compensation System.

(2) Evaluate the impact on Arizona's Workers' Compensation System of adopting other viable pharmaceutical reimbursement/pricing benchmarks (or combination of benchmarks), including:

   a. Whether, and to what extent, the adoption of the alternative methodology would impact access to pharmaceutical care for Arizona's injured workers.

   b. The overall financial impact on Arizona's Workers' Compensation System of adopting an alternative methodology (compared to using 85 percent of AWP).

   c. Whether, and to what extent, the adoption of the alternative methodology would adversely impact pharmacies, workers' compensation payers, case managers, pharmacy benefit managers, treating physicians, or injured workers.

[1] National Council on Compensation Insurance, Medical Data Report for the State of Arizona (2020).
[2] Id.

d. Whether the alternative methodology would eliminate the adverse effects (e.g., excessive billing practices) associated with using an AWP-based methodology.

e. Sources of information (and associated cost) that would be needed for workers' compensation stakeholders in Arizona to utilize the alternative methodology.

# Background

## Overview

The ICA was created in 1925 to implement and enforce Arizona's workers' compensation laws. Since that time, the ICA's role has expanded to include other labor-related issues, including enforcement of occupational safety and health standards; employment discrimination under A.R.S. § 23-425; enforcement of youth labor, wage, minimum wage, and earned paid sick time laws; and administration of vocational rehabilitation benefits for injured workers. See A.R.S. § 23-107(a) (2) (describing the duties of the ICA). In these capacities, the ICA exists to protect the interests of Arizona's diverse population of workers.

Since 1925, when the Arizona Legislature passed the state's first Workers' Compensation Act, the Commission has administered Arizona's Workers' Compensation System. Under A.R.S. § 23-908(B), the Commission is required to "fix a schedule of fees to be charged by physicians, physical therapists or occupational therapists attending injured employees and . . . for prescription medicines required to treat an injured employee" and to "annually review the schedule of fees." Under § 23-908(B), the schedule of fees may include "other reimbursement guidelines for medications dispensed in settings that are not accessible to the general public."

The Fee Schedule establishes the reimbursement values for physicians and other medical practitioners for services performed for injured workers under the Arizona workers' compensation laws. The Fee Schedule contains guidelines, codes, relative value units, and reimbursement rates pertaining to medical care in the following areas: (1) anesthesia; (2) surgery; (3) radiology; (4) pathology and laboratory; (5) medicine; (6) physical medicine; (7) special services; (8) evaluation and management; (9) and Category III. In addition, the Fee Schedule includes specific reimbursement guidelines pertaining to pharmaceuticals, which address the following areas: (1) general provisions and applicability of the Pharmaceutical Fee Schedule; (2) definitions; (3) general guidelines for billing and reimbursement of prescription medications; (4) billing and reimbursement for repackaged medications; (5) billing and reimbursement for compound medications; (6) billing and reimbursement for medications administered by a medical practitioner; (7) reimbursement for medications dispensed by a medical practitioner or in a pharmacy not accessible to the general public; (8) dispensing fee; and (9) additional billing guidelines.

As with any reimbursement system, it is critical to routinely assess the transparency, reasonableness, and effectiveness of the system, to ensure that providers are fairly and appropriately reimbursed and that injured workers have sufficient access to care. Given continually rising health care costs, the volatile nature of the drug market, and heightened public awareness regarding lack of transparency within the drug supply chain, an evaluation of the System's reimbursement methodology in the pharmaceutical fee schedule is warranted.

## Current Reimbursement

Pursuant to Ariz. Rev. Stat. §23-908(C), "[I]f the [ICA] considers the adoption of fee schedule provisions that involve specific prices, values or reimbursements for prescription drugs, the [ICA] shall base the adoption on studies or practices that are validated and accepted in the industry, including the applicability of formulas that use average wholesale price, plus a dispensing fee, and that have been made publicly available for at least one hundred eighty days before any hearing conducted by the commission." The ICA's current pharmaceutical fee schedule establishes reimbursement for brand and generic drugs at 85 percent of AWP. It also establishes a dispensing fee of up to $7.00 pursuant to Section VIII as follows [3]

A. If a prescription medication is dispensed by a pharmacy accessible to the general public pursuant to a prescription order, a dispensing fee of up to seven dollars ($7.00) per prescription medication, repackaged medication, or compound medication may be charged. The dispensing fee does not apply to OTC medications that are not prescribed by a medical practitioner.

B. If a prescription medication is dispensed by a medical practitioner or in a pharmacy not accessible to the general public pursuant to Section VII (A), (B), or (C), a dispensing fee of up to seven dollars ($7.00) per prescription medication, repackaged medication, or compound medication may be charged. If an OTC medication is dispensed by a medical practitioner or by a pharmacy not accessible to the general public, a dispensing fee is not permitted.

C. If a prescription or OTC medication is administered by a medical practitioner, a dispensing fee is not permitted.

## AWP History and Concerns

Utilized since the 1970's, AWP was created to help provide a pricing benchmark to third-party payers and government prescription drug programs. Currently, the benchmark is based on information supplied by manufacturers and is determined via two methods: (1) AWP is set at the Suggested Wholesale Price (SWP) supplied by the manufacturer; or (2) In instances where an SWP is not supplied, AWP is set using a markup factor of up to 120 percent of the Wholesale Acquisition Cost (WAC). In the context of federal health care program reimbursement, WAC is defined as "the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data."[4] Common commercial publications (i.e., compendia) for AWP and WAC include Medi-Span and Micromedex Red Book.

[3] Industrial Commission of Arizona, 2020-2021 Fee Schedule Pharmaceutical Guidelines, Section VII. Dispensing Fee (2020), *available at* https://tinyurl.com/y28ecxz2.
[4] 42 U.S.C. §1395w–3a(c)(6)(B) (2019).

Because AWP is not defined in law or regulation, a manufacturer may set the AWP at any level, regardless of the actual price paid by purchasers. As a result, health care providers are incentivized to prescribe and/or dispense drugs where the greatest difference or "spread" exists between the AWP and the actual price they pay for the drug. For example, federal regulations historically required state Medicaid programs to reimburse pharmacies based on the "lesser of" the "estimated acquisition cost" (EAC) plus a reasonable dispensing fee, or the pharmacy's "usual and customary charge" to the public. As such, the basis for determining the EAC for most programs relied on a discount applied to AWP. Studies conducted by the Office of the Inspector General (OIG) showed that these discounted AWP-based EAC formulas of state Medicaid programs were not reliable at predicting the true acquisition cost for pharmacy providers.[5] For most generic products, the difference between the benchmarks of AWP and WAC and actual acquisition cost (AAC) are significant. For a glimpse at some of these differences, Table 1 below presents the average acquisition cost as a percentage of the AWP for 10 highly utilized generic products within the Arizona Workers' Compensation System.

**Table 1: Average Acquisition Cost Percentage of AWP for 10 Highly Utilized Generic Drugs**

| Drug Name | Brand Name | AWP | Average Acquisition Cost | Percentage of AWP |
|---|---|---|---|---|
| | | a | b | (b-a)/a |
| DULOXETINE HCL DR 30 MG CAP | CYMBALTA | $7.85167 | $0.13164 | -98.1% |
| CELECOXIB 200 MG CAPSULE | CELEBREX | $7.58136 | $0.15453 | -97.5% |
| CYCLOBENZAPRINE 10 MG TABLET | FLEXERIL | $1.11424 | $0.02751 | -97.3% |
| TRAMADOL HCL 50 MG TABLET | ULTRAM | $0.83800 | $0.02392 | -97.0% |
| BACLOFEN 10 MG TABLET | LIORESAL | $2.47100 | $0.07330 | -96.8% |
| IBUPROFEN 800 MG TABLET | MOTRIN | $0.83390 | $0.07961 | -88.4% |
| GABAPENTIN 300 MG CAPSULE | NEURONTIN | $1.34180 | $0.05112 | -79.6% |
| LIDOCAINE 5% PATCH | LIDOCAINE | $10.27567 | $2.20195 | -76.5% |
| DICLOFENAC SODIUM 1% GEL | VOLTAREN | $0.54820 | $0.13749 | -73.5% |
| HYDROCODONE-ACETAMIN 10-325 MG | NORCO | $0.97812 | $0.13794 | -69.8% |

In addition, manufacturers are incentivized to increase spread pricing by reporting increasingly higher AWPs to drug pricing compendia, thereby encouraging utilization of the manufacturer's drugs. In the early 2000's, the Department of Justice began investigating the activities of more than a dozen large pharmaceutical firms to examine how these firms used spread pricing to incentivize providers to prescribe their products and submit for reimbursement under Medicare and Medicaid, which the government believed represented actionable fraud. Following several high-profile settlements, most

[5] U.S. Department of Health & Human Services, Office of Inspector General, Replacing Average Wholesale Price: Medicaid Drug Payment Policy (2011), *available at* https://tinyurl.com/y22dozaj.

notably Bayer Corporation's agreement to pay $14 million[6] and TAP Pharmaceutical Products agreement to pay nearly $900 million,[7] states began litigating AWP suits independent of the federal government reaching numerous individual and multistate settlements with pharmaceutical firm defendants. Ultimately, this litigation resulted in changes to how the AWP benchmark was calculated and the discontinuation of publication of the AWP benchmark by a major drug pricing compendia publisher.

Given the numerous flaws associated with AWP-based pricing, many state Medicaid programs began to consider the need for alternative reimbursement approaches, including reimbursement based on actual acquisition cost (AAC). The AAC approach is based on the collection of pharmacy provider invoice data to establish a true average acquisition cost for drugs. Myers and Stauffer was an early pioneer of the AAC approach to drug reimbursement and initially assisted several state Medicaid programs to transition pricing for generic drugs to an AAC-based methodology through their state maximum allowable cost (SMAC) programs. Later, Myers and Stauffer assisted some states to transition both brand and generic drug reimbursement within their Medicaid pharmacy programs to an AAC paradigm. Unlike AWP, an AAC approach is less subject to non-transparent pricing approaches by manufacturers, wholesalers, and drug pricing compendia publishers.

In 2010, the AAC-based approach received national attention when the National Association of Medicaid Directors (NAMD) published a white paper titled, "Post AWP Pharmacy Pricing and Reimbursement."[8] Among the recommendations presented in the white paper was the establishment of a national price benchmark for pharmacy reimbursement that would be based on providers' average drug acquisition costs. NAMD, along with the OIG, issued recommendations to the Centers for Medicare and Medicaid Services (CMS) to develop a national benchmark that would accurately estimate actual acquisition cost. The OIG also recommended CMS encourage states to consider such a benchmark when determining Medicaid reimbursement for prescription drugs.

In response, CMS developed the National Average Drug Acquisition Cost (NADAC) pricing benchmark. The purpose of this initiative is to perform a monthly nationwide survey of pharmacies and to provide state Medicaid agencies with weekly pricing file updates. The NADAC pricing files are derived by averaging survey invoice prices from retail community pharmacies across the United States. In 2016, CMS replaced EAC with AAC as the basis of Medicaid reimbursement for pharmaceuticals delivered through fee-for-service programs. The AAC is defined as the state "agency's determination of the pharmacy providers' actual prices paid to acquire drug products marketed or sold by specific

[6] Press Release, United States Department of Justice, Bayer Agrees to Settle Allegations that it Caused Providers to Submit Fraudulent Claims to 47 State Medicaid Programs (Sept. 19, 2000), *available at* https://tinyurl.com/y32cxpex.

[7] Press Release, United States Department of Justice, TAP Pharmaceutical Products Inc. and Seven Others Charged with Health Care Crimes; Company Agrees to Pay $875 Million to Settle Claims (Oct. 3, 2001), *available at* https://tinyurl.com/yy3rto3y.

[8] American Medicaid Pharmacy Administrators Association and The National Association of Medicaid Directors, Post AWP Pharmacy Pricing and Reimbursement (2009) (on file with author).

manufacturers."[9] Medicaid agencies have the option of using the NADAC to meet the requirement to use an AAC benchmark for pharmaceutical reimbursement.

## Alternative Benchmarks

At present, there are 37 state workers' compensation systems with a defined fee schedule for pharmaceuticals and 13 systems without a defined fee schedule. With respect to the former, 34 states (including Arizona), incorporate the AWP benchmark, with or without an adjustment factor, as the primary benchmark for drug ingredient reimbursement. For states without a defined fee schedule, reimbursement is based upon the provider's billed charges. For a complete list of methodologies by each state workers' compensation system, please refer to Appendix A. Despite the fact that the majority of state workers' compensation systems continue to be based primarily on the AWP, the transition from EAC to AAC-based pharmacy reimbursement within state Medicaid programs is beginning to influence other public prescription drug reimbursement programs such as workers' compensation systems. For example, in recent years, California and Massachusetts have adopted reimbursement methodologies that mirror the methodologies of their state Medicaid programs, which rely on AAC-based models.[10]

The adoption of reimbursement methodologies based on AAC within state Medicaid programs has been widely accepted within pharmacy provider communities. However, a significant stipulation of the acceptance of this methodology was the incorporation of a higher dispensing fee. Since an AAC-based methodology was intended to align ingredient reimbursement at a level reflective of a pharmacy's actual acquisition cost to acquire the drug, it was recognized that adequate dispensing fees were also necessary to recognize the professional and business costs of filling prescriptions. One academic evaluation of the incorporation of an AAC-based methodology within the California Workers' Compensation System did not cite any issues with access to medications for injured workers, but did recommend the continued use of the AAC approach in conjunction with AWP and other benchmarks as backups for drugs without an AAC-based price.[11]

When evaluating which benchmark(s) to utilize in a prescription drug reimbursement methodology, there are several factors to consider including, but not limited to, coverage, transparency, and availability. Coverage refers to the availability of the price for individual drug products. Transparency refers to the relationship between the benchmark price and the measurements of actual cost incurred in the marketplace, such as the cost pharmacies incur to acquire a drug product. Availability refers to

[9] 42 C.F.R. §447.502 (2019).
[10] Note: California Medicaid utilizes the lessor of NADAC (WAC if no NADAC), MAIC, and FUL as the primary pricing benchmarks in their methodology. Massachusetts Medicaid utilizes the lessor of FUL, MMAC, and AAC as their primary pricing benchmarks. Massachusetts defines AAC as the state specific AAC, NADAC if no AAC exists, or WAC if no AAC or NADAC exists.
[11] Wilson, L., Turkistani, F. A., Huang, W., Tran, D. M., & Lin, T. K. (2018). The impact of alternative pricing methods for drugs in California Workers' Compensation System: Fee-schedule pricing. PloS one, 13(5), e0197449. https://doi.org/10.1371/journal.pone.0197449.

whether a payer is able to acquire access to the benchmark, or if the benchmark has restricted access or is proprietary.

Each of the above factors of a drug pricing benchmark is important to consider. For example, if a benchmark is easily available but does not have coverage for a large portion of drugs, the methodology would likely require a supplemental or "backup" benchmark. Conversely, if the benchmark provides wide coverage but is not transparent regarding its calculation method or its relationship to true acquisition cost, an adjustment factor to the benchmark or the addition of an alternative benchmark may be necessary. If a benchmark has wide coverage and a transparent relationship to true acquisition cost, but it is not available due to statutory restrictions or proprietary ownership, the benchmark may not be usable within a particular context. The ultimate goal of a pharmacy reimbursement methodology is to provide appropriate and fair reimbursement to pharmacy providers, but does not restrict access to necessary medications for covered individuals. To accomplish these goals, a pharmacy reimbursement methodology should rely on a benchmark, or combination of benchmarks, that best incorporate each of these factors. The following table defines the most common pharmacy pricing benchmarks. Where applicable, federal statutory or regulatory definitions have been used.

**Table 2: Common Pharmacy Pricing Benchmarks**

| Benchmark | Definition | Pros | Cons |
|---|---|---|---|
| Average Wholesale Price (AWP) | AWP is "a list price for drugs published in commercial publications (or drug price compendia). Two companies' compendia (Medi-Span and First DataBank) are used as the basis of pricing most pharmacy claims in the United States. Two other recognized drug price data sources for drug price information including AWP are Red Book (Thomson Reuters) and Alchemy (Elsevier Gold Standard). When AWP is supplied by the manufacturer, it is identified by the drug price compendia as suggested wholesale price (SWP). If the manufacturer-labeler does not supply the compendia with an SWP, AWP is calculated by the compendia using a markup applied to the WAC or [direct price (DP)] supplied by the manufacturer-labeler."[12] The markup factor may be lower than 120 percent but not greater than 120 percent; however, a manufacturer may supply an SWP that is greater than a markup of 120 percent.[13] | • Widely available<br>• Exists for most drugs | • Highly inflated as compared to true pharmacy acquisition cost<br>• Pricing changes do not always reflect changes in pharmacy acquisition cost |

[12] Curtiss FR, Lettrich P, Fairman KA. What is the price benchmark to replace average wholesale price (AWP)? J Manag Care Pharm. 2010 Sep;16(7):492-501. doi: 10.18553/jmcp.2010.16.7.492. PMID: 20726678.
[13] Id.

| Benchmark | Definition | Pros | Cons |
|---|---|---|---|
| Wholesale Acquisition Cost (WAC) | WAC is "the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data."[14] | • Widely available<br>• Exists for most drugs<br>• Strong correlation between pricing changes and changes in pharmacy acquisition costs for single-source drugs | • Prices are inflated as compared to true pharmacy acquisition cost<br>• Pricing for multisource drugs does not correlate with pharmacy acquisition cost |
| National Average Drug Acquisition Cost (NADAC) | NADAC is a national pricing benchmark developed and maintained by CMS which is established and updated monthly based on invoice surveys of retail community pharmacies.[15] | • Published by CMS<br>• Publicly available<br>• Reflects pharmacy acquisition cost | • Only available for "covered outpatient drugs" as defined within the Medicaid program<br>• Dependent on provider survey participation |
| Federal Upper Limit (FUL) | FUL is the maximum reimbursement amount allowed for multiple source drugs for which the Food and Drug Administration (FDA) has rated three or more products therapeutically and pharmaceutically equivalent.[16] FUL is calculated as no less than 175 percent of the weighted average AMP.[17] | • Published by CMS<br>• Publicly available | • Not available for single source products<br>• Only available for "covered outpatient drugs" as defined within the Medicaid program<br>• Not always reflective of pharmacy acquisition cost |
| Actual Acquisition Cost (AAC) | A state Medicaid agency's "determination of the pharmacy providers' actual prices paid to acquire drug products marketed or sold by specific manufacturers."[18] | • Reflective of state Medicaid specific pharmacy acquisition costs<br>• Updated timely with changes in pharmacy acquisition costs | • Administrative cost to develop and maintain<br>• Dependent on provider survey participation |

[14] 42 U.S.C. §1395w–3a(c)(6)(B).
[15] Centers for Medicare & Medicaid Services, Methodology for Calculating the National Average Drug Acquisition Cost (NADAC) for Medicaid Covered Outpatient Drugs (2013), *available at* https://tinyurl.com/y55hbg7r.
[16] 42 U.S.C. §1396r–8(e).
[17] Id.
[18] 42 U.S.C. §447.502 (2016).

| Benchmark | Definition | Pros | Cons |
|---|---|---|---|
| Estimated Acquisition Cost (EAC) | Replaced by AAC in 2016, EAC is a state Medicaid agency's "best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size of drug most frequently purchased by providers.[19] Prior to 2016, EAC generally determined by applying a discount to AWP or WAC. | • N/A | • No longer used by state Medicaid agencies for fee-for-service pharmacy reimbursement |
| Maximum Allowable Cost (MAC) | MAC is a price, similar to the FUL, established by a private payer such as a Pharmacy Benefits Manager to reimburse for multi-source brand and generic products. Established and maintained by the Pharmacy Benefits Manager by means of pricing and utilization data.[20] | • Closer to pharmacy acquisition cost than AWP or WAC<br>• Available for most multi-source products | • Administrative cost to develop and maintain<br>• Often developed through methodologies that are not transparent<br>• Generally not utilized for single source drugs |
| Average Sales Price (ASP) | ASP is "the volume-weighted average of the manufacturers' average sales prices for all National Drug Codes assigned to the drug or biological product."[21] | • N/A | • Only available for drugs covered through Medicare Part B<br>• Not reflective of pharmacy acquisition cost |
| Average Manufacturer Price (AMP) | For a covered outpatient drug of a manufacturer, including those sold under a New Drug Application (NDA) approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, AMP is defined as "the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to retail community pharmacies and retail community pharmacies that purchase drugs directly from the manufacturer." | • N/A | • Confidential to CMS and state Medicaid agencies<br>• Updated quarterly and lags by two quarters<br>• Not reflective of pharmacy acquisition cost |

Based on considerations of coverage and availability, several of the above benchmarks can be immediately dismissed as nonviable options for consideration within the context of a workers' compensation system. With respect to coverage, while the ASP benchmark is publicly available from CMS, its coverage is limited to drugs covered by Medicare Part B. Concerning availability, AMP is subject

[19] 42 U.S.C. §447.502 (2007).
[20] Murry L, Gerleman B, Urick B, Urmie J. Third-party reimbursement for generic prescription drugs: The prevalence of below-cost reimbursement in an environment of maximum allowable cost-based reimbursement. J Am Pharm Assoc (2003). 2018 Jul-Aug;58(4):421-425. doi: 10.1016/j.japh.2018.04.018. Epub 2018 May 31. PMID: 29861152.
[21] 42 C.F.R. 414.904(c)(1).

to confidentiality restrictions under federal regulations, such that it is only available to CMS and state Medicaid agencies.[22] Further, MAC prices are typically proprietary to individual payers and not generally shared outside of their respective organizations. Lastly, while state-specific AAC benchmarks are sometimes available publicly, they often lack sufficient detail for use by other payers. Though not relevant to a consideration of coverage or availability, it is also worth noting that state-specific AAC benchmarks are often perceived as valid only within the state in which they are created. As of the time of this writing, Arizona does not maintain a state-specific AAC benchmark.

The EAC approach, while not eliminated on the basis of coverage or availability, requires continuous evaluation to consider the shifting relationships between actual marketplace costs and widely available benchmarks, such as AWP and WAC.

When evaluating the remaining benchmarks as the basis for a payment methodology, NADAC and FUL are both highly available and provide the most transparent reimbursement in relation to acquisition cost. Under the Affordable Care Act, and subsequent regulations promulgated by CMS, the FUL was redefined to be calculated as no less than 175 percent of AMP. If 175 percent of AMP was less than the corresponding NADAC, the FUL would be set equal to the NADAC. However, FULs are only available on multi-source brand and generic products that have a NADAC. Furthermore, there has been no conclusive study on the relationship between acquisition cost and AMP pricing, which undermines the transparency and reliability of the FUL benchmark in reflecting true acquisition cost. Therefore, when choosing between NADAC and FUL as a benchmark to be utilized in a payment methodology, the NADAC has significant advantages in terms of coverage and transparency.

Overall the NADAC measures well in terms of transparency, availability, and coverage:

Availability

The NADAC is published weekly on a website maintained by CMS and accessible to the general public. The NADAC rate file can also be acquired through several of the large drug pricing compendia publishers including Medi-Span, which is the source currently adopted by the ICA to obtain AWP pricing. Accordingly, the cost to obtain NADAC pricing for payers, third-party administrators, or pharmacy benefit managers adjudicating workers' compensation pharmacy claims in the current System is minimal. The use of an AAC-based methodology by fee-for-service Medicaid programs is codified within federal regulations and currently there are 40 states that rely on the NADAC. Additionally, although not mandated, a growing number of Medicaid managed care pharmacy programs are using the NADAC as the basis for pharmacy reimbursement. Accordingly, it can be anticipated that the NADAC will continue to be produced by CMS for the foreseeable future.

[22] 42 U.S.C. §1396r–8(b)(3)(D).

Transparency

The transparency of the NADAC is a direct reflection of its methodology. It is closely monitored and updated on a weekly basis in relation to market pricing changes and is recalculated monthly based on an invoice survey of retail community pharmacies. The benchmark is widely utilized and accepted within most state Medicaid pharmacy programs and its adoption into methodologies used by private payers is increasing. The vast majority of pharmacies within the United States are already accepting pharmacy reimbursement based on the NADAC and it has become validated and accepted within the industry.

Coverage

The coverage of the NADAC is fair, but there are still some lapses in coverage for which other benchmarks, including the AWP and WAC provide the most coverage for drug products. Therefore, a sustainable methodology could utilize NADAC, with its inherent transparency, as its primary benchmark with either AWP or WAC as a backup benchmark.

When deciding on a backup benchmark between AWP and WAC, coverage becomes the primary focus. Within most state Medicaid programs today, WAC is the popular choice for a backup benchmark. Though still inflated compared to actual marketplace cost, WAC tends to be closer to acquisition cost as compared to AWP. Medicaid programs are generally limited to products that are "covered outpatient drugs," as defined by federal regulations, and products that are covered tend to have a WAC. Although products used within a workers' compensation system must be reasonable and necessary and some restrictions are in place to limit abuse, a workers' compensation system generally has fewer restrictions on products associated with coverage definitions, formularies, or preferred drug lists as compared to a Medicaid program. Examples of products generally not covered by state Medicaid programs that may be covered within a workers' compensation program, include many private label topical analgesics such as Terocin® lotion and Dendracin® lotion. This results in a larger number of covered products in Arizona's Workers' Compensation System compared to a Medicaid program. These additional products, including many OTC and non-drug items, may not have a WAC price available. Therefore, in the context of a workers' compensation system, the use of both WAC and AWP as backup benchmarks would be ideal. The use of WAC adds a layer of reimbursement transparency and protection in instances where the inflation of AWP is excessive while the use of AWP would help to ensure the most complete drug coverage.

Recognizing that state Medicaid programs needed data from which to develop a backup benchmark approach as part of the requirements for AAC-based reimbursement, CMS began publishing the "NADAC Equivalency Metrics" on a quarterly basis. These metrics present the average relationships between the NADAC and the AWP or WAC. Since the NADAC was developed to be an average of pharmacy acquisition cost, these metrics provide states with guidance on how to adjust AWP or WAC to best estimate acquisition costs from each of these benchmarks. These adjustments, when applied to AWP or WAC, can help to compensate for any deficiencies in terms of their transparency and relationship to pharmacy

acquisition cost. To provide some insight into these relationships, Table 3 below displays information from the NADAC Equivalency Metrics for quarter ending September 2020.

**Table 3: NADAC Equivalency Metrics for Quarter Ending September 2020**

| Drug Type | AWP Mean | AWP Median | WAC Mean | WAC Median |
|---|---|---|---|---|
| Brand Legend Single Source | -20.1% | -20.1% | -4.1% | -4.1% |
| Brand Legend Multi-Source | -21.3% | -20.1% | -5.1% | -4.1% |
| Generic Legend | -79.4% | -86.7% | -45.1% | -50.2% |

The above equivalency metrics suggest that, for brand name drugs, a discount of approximately 20 percent would need to be applied to AWP, and 4 percent to WAC, in order to best estimate pharmacy acquisition costs. Similarly, a discount of at least 80 percent would need to be applied to AWP, and 45 percent to WAC, in order to best estimate pharmacy acquisition costs for generic drugs.

## Additional System Concerns

In recent years, some workers' compensation systems have seen an increase in the use of high cost topical OTC medications. This increase in utilization has occurred simultaneous to a continual decline in the use of opioids for acute pain management following an injury.[23] Private label topical analgesics (PLTAs) in particular, are a driving factor in increased costs to workers' compensation systems due to their high AWPs and, therefore, high reimbursement rates in systems utilizing AWP as their basis for payment. These PLTAs, many of which may be purchased without a prescription (i.e., OTC drugs), contain varying amounts of pain relieving ingredients such as capsaicin, methyl salicylate, menthol, and lidocaine. Further, they vary slightly in strength and/or composition from other commercially available OTC products and are typically marketed as being superior alternatives despite having virtually no clinical evidence of increased efficacy or FDA approval. Finally, these products are not frequently found in many retail outlets but are typically dispensed by physicians and/or independent pharmacies. Examples of PLTAs include Terocin® Lotion, Dendracin® Lotion, and Tru-micin®, which are comparable to OTC products such as BenGay®, Icy Hot®, and Aspercreme®.

As PLTA products are significantly more expensive than their similar OTC or store brand counterparts, workers' compensation systems should consider limiting reimbursement and/or coverage on these select products. Approaches for consideration include, but are not limited to:

(1) Identify products or groups of products with excessive pricing and "map" those products to reference products such as BenGay®, Icy Hot®, and Aspercreme® even if the formulations are not an exact match and provide coverage only for the reference products.

[23] Coventry Sounding Board, Top-Ranking Drug Classes in 2019, Workers Comp Blogwire (June 17, 2020), https://tinyurl.com/y66bn54y.

(2) Implement reimbursement limits based on reference product pricing similar to the ICA's approach for topical compound medication reimbursement limits, per the Pharmaceutical Fee Schedule, for OTC topical products[24].

The above approaches would require periodic manual review and maintenance by pharmacy benefit managers and/or a workers' compensation system to ensure PLTA products are monitored for utilization and appropriate reimbursement.

Although changes in reimbursement or coverage for these high cost topical OTC medications would ideally create incentives for the use of lower cost OTC alternatives, payers should also consider the potential for unintended consequences that possible restrictions concerning coverage and/or decreased reimbursement can create. Such consequences could include, but are not limited to, shifts in prescribing patterns to higher cost prescription medications.

[24] Industrial Commission of Arizona, 2020-2021 Fee Schedule Pharmaceutical Guidelines (2020), *available at* https://tinyurl.com/y28ecxz2.

# Analysis

## Data Overview and Limitations

To analyze the potential administrative and financial impacts of a change in the pharmacy reimbursement methodology for the Arizona Workers' Compensation System, Myers and Stauffer received several pharmacy claims data extracts from various payers within the Arizona System. There were a total of six data sets received and utilized, one of which was the Special Fund. Each data set had varying levels of details that included both individual claims and summarized data derived from claims that were aggregated at the National Drug Code (NDC) level. A summary of each data set is presented in Table 4 below.

**Table 4: Summary of Data Sets**

| Data Set | Alias | Detail Level | Time Frame | Notable Attributes |
|---|---|---|---|---|
| 1 | Special Fund | Claim Level | 01/01/2019 – 08/31/2020 | State Funded |
| 2 | Payer A | Claim Level | 01/01/2017 – 09/30/2020 | Self-Insured |
| 3 | Payer B | Claim Level | 09/01/2019 – 08/31/2020 | Self-Insured |
| 4 | Payer C | Claim Level | 01/01/2020 – 08/31/2020 | Self-Insured |
| 5 | Payer D | Aggregated by NDC | 10/01/2019 – 09/30/2020 | Private Insurance |
| 6 | Payer E | Aggregated by NDC | 09/01/2019 – 08/31/2020 | Private Insurance |

## Benchmark Coverage within Reviewed Pharmacy Claims

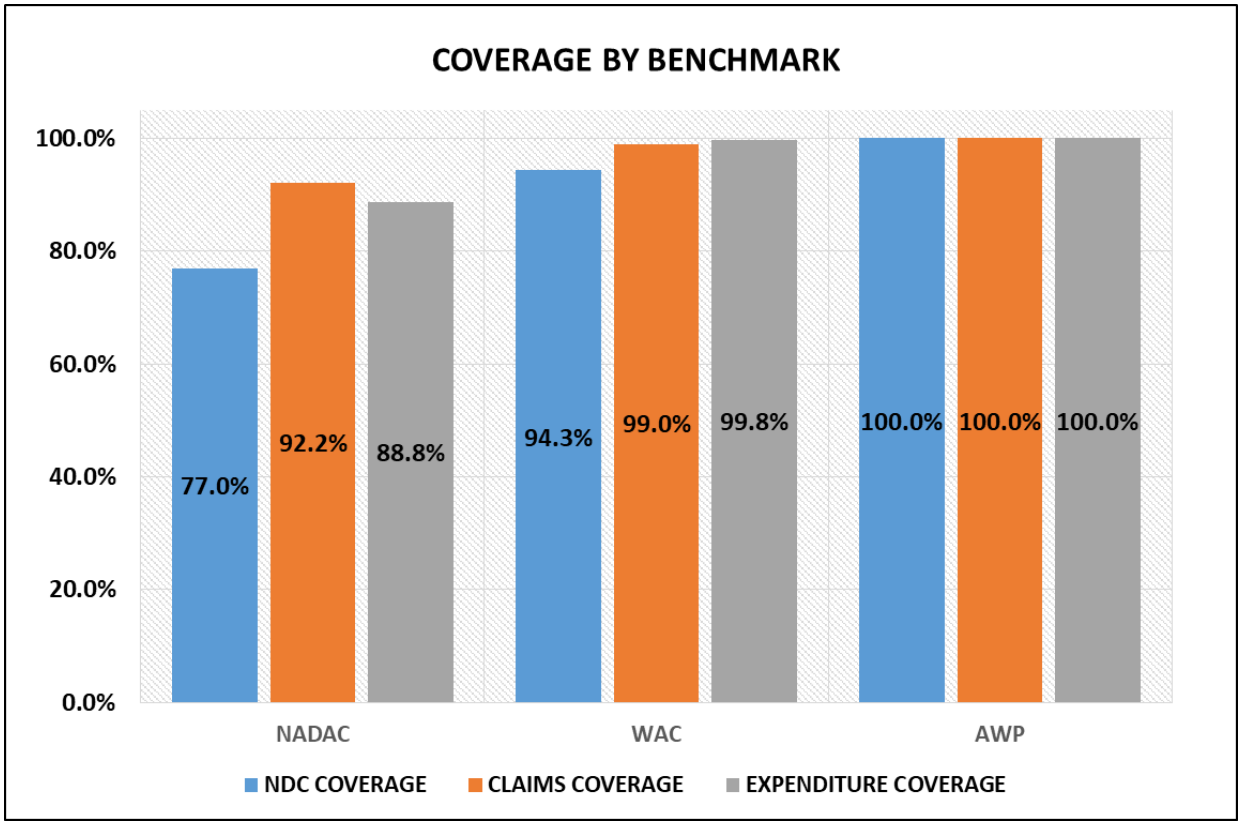
Based on the general evaluation of available pharmaceutical pricing benchmarks, the NADAC received high marks in terms of transparency and availability. Although coverage of the NADAC is good, there are limitations and the use of WAC and/or AWP as a backup potentially represents a means to supplement the NADAC's limitations with respect to coverage. To understand the extent to which the incorporation of the NADAC could benefit the Arizona System, one must assess the coverage of each pricing benchmark in the context of pharmaceutical usage in the current System (i.e., through analysis of the aforementioned data sets). A thorough assessment of benchmark coverage is based on three primary components: (1) percent of total NDCs in the data sets with the pricing benchmark available; (2) percent of total claims in the data sets with the pricing benchmark available; and (3) percent of total expenditures in the data sets with the pricing benchmark available.

The first component, coverage of NDCs, provides perspective into the benchmark's availability with respect to the products dispensed and covered in the System. Analysis of this component of coverage can be an indicator of whether a supplemental or backup benchmark might be necessary. The second component, claims coverage, shows the benchmark's availability with respect to the most highly dispensed products. Analysis of this component of benchmark coverage will demonstrate the extent to which the benchmark is available for the number of claims dispensed. The third component, coverage

based on expenditures, ranks availability of the benchmark based on actual System expenditures. This component is especially important when analyzing the incorporation of a benchmark based on acquisition cost, such as NADAC, as the coverage based on expenditures can provide insight into the potential for eliminating excessive pharmaceutical billing practices.

Based on the pharmacy claims data reviewed by Myers and Stauffer, the total NDC, claim, and expenditure coverage for NADAC, WAC, and AWP was measured and is depicted by Figure 1 below.

**Figure 1: Summary of Coverage by Benchmark**




In regard to the pharmacy claims data sets obtained by Myers and Stauffer, there is a NADAC available for approximately 77.0 percent of NDCs dispensed. However, those 77.0 percent of NDCs make up approximately 92.2 percent of the total claims and 88.8 percent of the total expenditures. Alternatively stated, this indicates that the adoption of the NADAC benchmark would result in 92.2 percent of claims reimbursing at a rate based on the NADAC, compared to current pricing based on AWP. Furthermore, 88.8 percent of total expenditures would be subject to payment based on the NADAC, as a result of the transition from an AWP-based methodology to one utilizing the NADAC.

Although the NADAC benchmark would cover a large portion of claims (92.2 percent), there would still be a need for a benchmark to cover the remaining 23.0 percent of NDCs for which there is not currently

a NADAC price. WAC, the backup benchmark of choice in most state Medicaid programs, would help to cover the majority of products at 94.3 percent of NDCs, 99.0 percent of claims, and 99.8 percent of expenditures. However, utilization of AWP, the current benchmark utilized in the ICA's methodology, would ultimately ensure that a pricing benchmark exists for all products covered by the Arizona System. AWP has 100 percent coverage, whether measured by NDCs, number of claims, or expenditures. Accordingly, some combination of WAC and AWP, or solely AWP, would serve as adequate backup benchmark(s) to the NADAC.

## Current Reimbursement Landscape

Under the ICA's current reimbursement methodology, brand and generic drugs are reimbursed at no more than 85 percent of AWP for ingredient cost, plus an additional $7.00 as a dispensing fee (when permitted). It is important to note that until the release of the 2019/2020 pharmaceutical fee schedule, ingredient reimbursement for brand drugs was set at no more than 95 percent of AWP. Because several of the data sets analyzed by Myers and Stauffer have dates of service both before and after the implementation of the current pharmaceutical fee schedule, brand ingredient reimbursement within our analysis might yield values higher than 85 percent of AWP, in the aggregate, for some of the payers. To better understand the potential financial impact of alternative methodologies, one must consider actual current reimbursement as the baseline for measuring potential future changes in the reimbursement methodology. Table 5, below, summarizes the average annual ingredient expenditures by payer and expresses those ingredient expenditures, on average, as a percentage of AWP.

**Table 5: Annualized Ingredient Expenditures by Payer as a Percentage of AWP**

| | Annualized Ingredient Expenditures[25] | | | Ingredient Expenditures as a Percentage of AWP[26] | | |
|---|---|---|---|---|---|---|
| | Brand | Generic | Total | Brand | Generic | Total |
| Special Fund | $266,997 | $297,456 | **$564,453** | 85.5% | 66.2% | **74.1%** |
| Payer A | $717,450 | $1,229,245 | **$1,946,695** | 86.9% | 60.1% | **67.8%** |
| Payer B | $20,020 | $92,073 | **$112,093** | 86.3% | 66.9% | **69.7%** |
| Payer C | $51,265 | $91,308 | **$142,573** | 88.4% | 62.9% | **70.2%** |
| Payer D | $3,076,784 | $4,185,700 | **$7,262,483** | 83.5% | 54.3% | **63.7%** |
| Payer E | $442,193 | $617,381 | **$1,059,574** | 84.8% | 62.8% | **70.4%** |

[25] Note: "Annualized Ingredient Expenditures" was calculated by dividing the total ingredient expenditures by the total number of months represented in the data set to arrive at an average monthly expenditures. This amount was then multiplied by 12 to estimate an annualized amount.
[26] Note: "Ingredient Expenditures as a Percentage of AWP" was calculated by dividing the actual Annualized Ingredient Expenditures by an alternative ingredient calculation based on 100 percent of AWP for each payer.

In the aggregate, current ingredient expenditures for brand drugs is in the range of 83.5 percent to 88.4 percent of AWP (i.e., a range of AWP minus 11.6 percent to AWP minus 16.5 percent). Although not reflected in Table 5, when specifically analyzing claims which were incurred after the implementation of the 2019/2020 fee schedule with its payment reductions for brand drugs, expenditures were reduced, in the aggregate, to a range of 81.1 percent to 84.5 percent of AWP (i.e., a range of AWP minus 15.5 percent to AWP minus 18.9 percent). These ranges of payment compare favorably to the NADAC Equivalency Metrics in Table 3 which suggest that pharmacies' average acquisition cost for brand drugs is approximately AWP minus 20 percent.

Analysis of ingredient reimbursement for generic drugs indicates that current expenditures are in the range of 54.3 percent to 66.9 percent of AWP (i.e., a range of AWP minus 33.1 percent to AWP minus 45.7 percent). Compared to the current upper limit for payment of generic drugs, 85 percent of AWP, most payers are reimbursing significantly less, in the aggregate. There are two primary factors which likely contribute to this trend:

(1) AWP has been demonstrated to be highly inflated for generic drugs and it is possible that pharmacies' billed charges may be less than 85 percent of AWP thus causing claims to be paid at the lower amount of billed charges instead of 85 percent of AWP; and/or

(2) Most insurers contract with pharmacy benefit managers who have negotiated contracts with pharmacies allowing for lower reimbursement rates for generic drugs. These contracted rates for generic drug reimbursement are often referred to as MAC rates.

However, when comparing the current levels of generic ingredient reimbursement within the pharmacy claims reviewed to the NADAC Equivalency Metrics in Table 3, these levels of average reimbursement are higher than the best estimate of pharmacies' average acquisition cost for generic drugs. The NADAC Equivalency Metrics suggest that pharmacies' average acquisition cost for generic drugs is AWP minus 79.4 percent. Although Myers and Stauffer's experience has shown that there can be substantial variability with respect to how acquisition cost compares to AWP for generic drugs, when considering the high utilization of generic products within the Arizona Workers' Compensation System, there remains substantial potential for achieving more appropriate reimbursement for pharmaceuticals.

## Modeled Methodologies

Myers and Stauffer evaluated available pricing benchmarks and assessed the current levels of ingredient reimbursement within the Arizona Workers' Compensation System as compared to estimates of pharmacy acquisition cost. Based on this analysis, Myers and Stauffer recommends that a reimbursement benchmark derived primarily from NADAC coupled with WAC and/or AWP as a backup benchmark could provide the ICA with the most viable option. This option would address excessive billing practices while continuing to provide for appropriate reimbursement and ensure injured workers will have unimpaired access to needed medications. The adoption of the NADAC as the basis for the primary benchmark into the reimbursement methodology would not adversely impact payers. In an

effort to reduce the amount of administrative burden incurred through the implementation of a new reimbursement methodology while preserving injured workers' access to medications, the methodologies described in Table 6 were considered in order to create fiscal impact models as compared to the methodology of the ICA's current pharmaceutical fee schedule. These models were intended to demonstrate varying levels of ingredient reimbursement, while maintaining the current $7.00 dispensing fee.

**Table 6: List of Modeled Ingredient Methodologies**

| Model Name | Description |
|---|---|
| Option 1: NADAC Primary | Brand: NADAC primary; if no NADAC, AWP minus 15 percent<br>Generic: NADAC primary; if no NADAC, AWP minus 40 percent |
| Option 2: NADAC plus Two Percent Primary | Brand: NADAC plus two percent primary; if no NADAC, AWP minus 15 percent<br>Generic: NADAC plus two percent primary; if no NADAC, AWP minus 40 percent |
| Option 3: Alternative AWP Discounts | Brand: AWP minus 15 percent<br>Generic: AWP minus 40 percent |
| Option 4: NADAC plus Two Percent Primary with "Lesser of" Backup | Brand: NADAC plus two percent primary; if no NADAC, Lesser of AWP minus 15 percent or WAC<br>Generic: NADAC plus two percent primary; if no NADAC, Lesser of AWP minus 40 percent or WAC minus 20 percent |

Options 1, 2, and 4 utilize NADAC as the primary benchmark. While Option 1 models straight NADAC, Options 2 and 4 add a two percent markup to NADAC to account for no change in the $7.00 dispensing fee. Further explanation of this rationale is included in the evaluation of Option 2 below. For all Options, the discounts applied to WAC and AWP were derived by considering their relationship to acquisition cost via the NADAC Equivalency Metrics (Table 3), the current payment levels from payers in the AZ System (Table 5), and the goal of the ICA to reduce excessive billing practices while still maintaining sufficient access to care for injured workers. Based on these variables, WAC and AWP minus 15 percent was modeled for brand drugs, while WAC minus 20 percent and AWP minus 40 percent was modeled for generic drugs. Additionally, discounted WAC and AWP will only be utilized when NADAC is not available which may be indicative of a new drug available in the marketplace or a lowly utilized drug in the marketplace. Both of these examples could potentially limit the number of manufacturers in the marketplace and thereby impact provider acquisition cost. Finally, similar to the rationale behind Options 2 and 4 of adding a two percent markup to NADAC, the modeled discounted WAC and AWP takes into consideration no change to the $7.00 dispensing fee.

In an effort to standardize the output, each data set was repriced for each option and presented as an estimated percent reduction in ingredient expenditures compared to current expenditures. Table 7 below presents the estimated percentage reductions in ingredient expenditures by brand and generic products for each payer.

**Table 7: Estimated Percentage Reduction in Ingredient Expenditures by Payer**

| | Special Fund | Payer A | Payer B | Payer C | Payer D | Payer E |
|---|---|---|---|---|---|---|
| **Option 1: NADAC Primary** | | | | | | |
| Brand | -4.1% | -7.3% | -6.8% | -8.3% | -3.8% | -4.3% |
| Generic | -85.9% | -60.0% | -85.1% | -66.9% | -76.0% | -75.9% |
| **Total** | **-47.2%** | **-40.5%** | **-71.1%** | **-45.8%** | **-45.4%** | **-46.0%** |
| **Option 2: NADAC plus Two Percent Primary** | | | | | | |
| Brand | -2.9% | -5.7% | -5.1% | -6.9% | -2.1% | -2.9% |
| Generic | -85.6% | -59.7% | -84.9% | -66.5% | -75.7% | -75.6% |
| **Total** | **-46.5%** | **-39.8%** | **-70.6%** | **-45.1%** | **-44.5%** | **-45.3%** |
| **Option 3: Alternative AWP Discounts** | | | | | | |
| Brand | -0.6% | -2.2% | -1.5% | -3.9% | 1.7% | 0.3% |
| Generic | -9.4% | -0.1% | -10.3% | -4.6% | 10.6% | -4.5% |
| **Total** | **-5.2%** | **-0.9%** | **-8.8%** | **-4.3%** | **6.8%** | **-2.5%** |
| **Option 4: NADAC plus Two Percent Primary with "Lesser of" Backup** | | | | | | |
| Brand | -3.8% | -6.0% | -5.2% | -7.1% | -2.4% | -3.4% |
| Generic | -85.7% | -60.7% | -85.1% | -68.2% | -76.3% | -76.0% |
| **Total** | **-47.0%** | **-40.5%** | **-70.9%** | **-46.3%** | **-45.0%** | **-45.7%** |

Of the four options, Option 1 (NADAC Primary) would result in the greatest reduction of ingredient expenditures in the aggregate. The addition of NADAC as the primary benchmark, combined with a more aggressive discount from AWP for generic products as a backup benchmark, would allow most claims to pay at a rate that is much closer to actual pharmacy acquisition cost. As presented in Table 7, the largest percentage decrease in reimbursement would apply to generic products with modeled reductions ranging by payer from 60.0 percent to 85.9 percent of current expenditures. For brand products, modeled ingredient expenditures were reduced between 3.8 percent and 8.3 percent depending on the payer. In the aggregate, Option 1 would reduce total expenditures for ingredient reimbursement between 40 percent and 50 percent. Notably, the modeled reduction in ingredient expenditures for the Special Fund under this reimbursement option was 47.2 percent.

Similar to Option 1, the reimbursement methodology associated with Option 2 (NADAC plus Two Percent Primary) would also reduce total expenditures for ingredient reimbursement on the order of 40 percent to 50 percent. The only difference between Option 1 and Option 2 is the addition of a two percent markup to NADAC rates. A significant rationale for this proposed markup stems from the lack of any proposed adjustment to the dispensing fee. When NADAC rates are utilized within the context of a Medicaid fee-for-service pharmacy program, dispensing fees are required to be determined based on a state's analysis of the costs incurred by pharmacies to dispensing prescriptions.[27] Dispensing fees set in this manner tend to be slightly higher than the current $7.00 dispensing fee utilized by the ICA. Since a

[27] See 42 CFR § 447.502 and 42 CFR § 447.518(d).

workers' compensation system is not under the same obligations of a Medicaid program to set dispensing fees in the same manner, Myers and Stauffer has not proposed a change to the current dispensing fee incorporated within the ICA pharmaceutical fee schedule. However, the two percent markup to the NADAC rates could be beneficial with respect to ensuring pharmacy participation in the System, while still reducing incentives for excessive billing practices.

Option 3 (Alternative AWP Discounts), which mirrors the ICA's current methodology for brand drugs at AWP minus 15 percent but utilizes a larger discount from AWP for generic drugs (i.e., AWP minus 40 percent), would realize a more modest reduction of expenditures of up to 8.8 percent to a slight cost of up to 6.8 percent depending on the payer. Although Option 3 would have the least financial impact, it would have the smallest level of administrative impact with respect to implementation by the various payers within the System since it is based on AWP only. Notably, as evidenced in Table 5, most private payers within the System are already paying in the range of AWP minus 35 percent to AWP minus 45 percent for generic drugs in the aggregate. Therefore, cost reduction would be minimal. Furthermore, the reimbursement methodology would still be subject to ongoing changes in AWP prices which may continue to distort the relationship between reimbursement levels and the cost incurred by pharmacies to acquire drugs.

Finally, Option 4 (NADAC plus Two Percent Primary with "Lesser of" Backup) would realize a comparable reduction in expenditures to that of Option 1 and Option 2, in the 40 to 50 percent range. The addition of WAC for brand drugs and a discounted WAC for generic drugs, in combination with a discounted AWP for both brand and generic drugs, as a "lesser of" backup benchmark would provide an additional layer of support in instances where AWP is highly inflated and drugs could be subject to excessive billing practices. Similar to Option 2, Option 4 utilizes NADAC plus two percent as the primary benchmark. However, for the backup benchmark, Option 4 utilizes the lesser of AWP minus 15 percent or WAC for brand drugs, and the lesser of AWP minus 40 percent or WAC minus 20 percent for generic drugs. Compared to Option 2, the "lesser of" backup methodology would result in a slightly larger reduction of expenditures. This reduction would be realized on the 23 percent of drugs that do not have a current NADAC price, and would be subject to payment by the lesser of a discounted AWP or WAC benchmark. Similar to the comparison between Option 1 and Option 2, a two percent markup on NADAC would generate less reduction in expenditures on the 77% of drugs with a NADAC price. Thus, the primary benefit of Option 4 would be the added support of utilizing WAC in addition to AWP as a backup benchmark to hedge against the potential for excessive billing for drugs that fall outside of coverage of the NADAC.

# Recommendations

The reimbursement methodology within the ICA's current pharmaceutical fee schedule utilizes an ingredient reimbursement based on 85 percent of AWP. However, research suggests that this amount can be substantially higher than a pharmacy provider's actual cost to acquire drugs. A representation of pharmacy acquisition cost, as compared to AWP, was presented by the NADAC Equivalency Metrics in Table 3. According to those metrics, the average acquisition cost for brand legend products is approximately 80 percent of AWP (i.e., AWP minus 20 percent). The average acquisition cost for generic legend products is approximately 20 percent of AWP (i.e., AWP minus 80 percent). When comparing these metrics to the actual ingredient reimbursement amounts that payers in the Arizona Workers' Compensation System are currently reimbursing, average reimbursement for brand drugs is relatively close to acquisition cost, ranging from 81.1 percent to 84.5 percent of AWP (i.e., a range of AWP minus 15.5 percent to AWP minus 18.9 percent). With respect to the current reimbursement for generic drugs, the average payments from payers within the System are considerably less than the threshold set within the ICA's current pharmaceutical fee schedule (i.e., 85 percent of AWP). On average, payments for generic drug products range from 54.3 percent to 66.9 percent of AWP (i.e., a range of AWP minus 33.1 percent to AWP minus 45.7 percent). Even though actual practice for generic drug reimbursement is less that the amount specified in the pharmaceutical fee schedule, these amounts are still relatively high in comparison to the average acquisition cost which is estimated by the NADAC Equivalency Metrics to be approximately 20 percent of AWP.

To assist the ICA in addressing concerns of pharmacy payments that may be excessive compared to pharmacy providers' actual acquisition cost while still maintaining a level of payment necessary to ensure widespread access to necessary medications for injured workers, Myers and Stauffer presented and evaluated several alternative pharmacy pricing benchmarks. This evaluation of available benchmarks considered the coverage, transparency, and availability of each benchmark. This process narrowed the focus to the NADAC, serving as the primary reimbursement benchmark, and used in tandem with AWP as a backup benchmark. The NADAC was considered the best overall solution for a primary benchmark as it is most reflective of pharmacy acquisition cost (i.e., transparency). NADAC is publicly available, routinely maintained and anticipated to be produced for the foreseeable future (i.e. availability). The benchmark would cover a large portion (77 percent) of drug products currently utilized in the System (i.e. coverage). AWP, or WAC in combination with AWP, were determined to be the best options for backup benchmarks to NADAC. AWP provides 100 percent coverage of the drug products currently utilized in the Arizona Workers' Compensation System and it is the benchmark utilized within the current methodology. WAC would provide coverage for approximately 94 percent of drug products and 99 percent of claims within the current System and would supplement AWP in providing more transparent reimbursement on drug products with excessively inflated AWPs. However, given the concerns over transparency of WAC and AWP, especially for generic drugs, Myers and Stauffer has

recommended that a discount be applied to both WAC and AWP in each of the reimbursement options that were modeled.

Based on the assessment of the current System, the evaluation of alternative benchmarks, and considering the ICA's goal to manage System expenditures by eliminating excessive billing practices and aligning reimbursement to a level that is reflective of pharmacy providers' true acquisition cost, Myers and Stauffer modeled the following four ingredient reimbursement options:

(1) For brand drugs, NADAC as the primary benchmark with AWP minus 15 percent as a backup benchmark; for generic drugs, NADAC as the primary benchmark and AWP minus 40 percent as a backup benchmark.

(2) For brand drugs, NADAC plus two percent as the primary benchmark with AWP minus 15 percent as a backup benchmark; for generic drugs, NADAC plus two percent as the primary benchmark and AWP minus 40 percent as a backup benchmark.

(3) AWP minus 15 percent for brand drugs and AWP minus 40 percent for generic drugs.

(4) For brand drugs, NADAC plus two percent as the primary benchmark with the lesser of AWP minus 15 percent or WAC as a backup benchmark; for generic drugs, NADAC plus two percent as the primary benchmark with the lesser of AWP minus 40 percent or WAC minus 20 percent as a backup benchmark.

For all of these reimbursement options, a change to the current dispensing fee of $7.00 was not recommended. The current dispensing fee utilized by the ICA compares favorably to the dispensing fees used within other workers' compensation systems of other states. Furthermore, the current fee of $7.00 is higher than the dispensing fees often utilized within commercial pharmacy plans. Although state Medicaid programs which incorporate the NADAC tend to have dispensing fees that are slightly higher than the current dispensing fee used by the ICA, a workers' compensation system is not subject to the same requirements for dispensing fees as a state Medicaid program. However, a significant rationale for the proposed markup to NADAC incorporated into the second and fourth options described above (i.e., NADAC plus two percent) is intended to help ensure stakeholder acceptance of a NADAC-based reimbursement methodology despite a dispensing fee that is slightly less than those typically used within a Medicaid pharmacy reimbursement methodology.

The fiscal impact of each reimbursement option was modeled to measure the impact on current expenditures and assess the risk of creating access issues. Based on the estimated percentage reduction in expenditures, Option 1, Option 2, or Option 4 has the potential to reduce current System expenditures in the range of 40 to 50 percent in the aggregate. This modeled reduction in expenditures would be the direct result of realigning reimbursement with actual costs incurred by pharmacies to acquire medications. Such an alignment would also help to curb excessive billing practices. The majority of expenditure reduction would be realized through the use of the NADAC and its closer alignment to the costs that pharmacies actually pay for generic drugs. Option 3, which was based entirely on AWP

and was presented to provide an approach with the least amount of administrative burden for payers, would have a less significant impact even though it applied a 40 percent reduction to AWP for generic drugs as opposed to the current reduction from AWP of 15 percent.

Considering the primary goal of the ICA to eliminate excessive billing practices by better aligning the pharmaceutical fee schedule with a reimbursement methodology more reflective of pharmacy providers' actual acquisition costs while maintaining access for injured workers, Myers and Stauffer would recommend that the ICA consider an approach which adopts the NADAC as the primary benchmark, but also contemplates a modest markup factor as a means of preserving pharmacy participation and ensuring access for injured workers. This approach was modeled in Option 2 (i.e., NADAC plus Two Percent Primary) and Option 4 (i.e., NADAC plus Two Percent Primary with "Lesser of" Backup). For Option 2, the incorporation of NADAC plus 2 percent as a primary benchmark with a discounted AWP as a backup benchmark would introduce minimal administrative burden associated with implementation and would align reimbursement to a level more reflective of pharmacy providers' actual acquisition costs. The use of the NADAC has already been generally accepted by pharmacy providers as an appropriate reimbursement benchmark so its use incurs minimal risk for creating access issues for workers covered in the System. Similar to Option 2, Option 4 would also align reimbursement to a level more reflective of pharmacy providers' actual acquisition costs. Though the addition of a third pricing benchmark could add administrative complexity, the incorporation of WAC, in addition to AWP as the lesser of backup reimbursement, would further aid the ICA in successfully limiting excessive billing practices.

# Appendix A: Other System Methodologies

| System | Reimbursement Methodology | Source |
|---|---|---|
| **State Systems with AWP as Primary Benchmark** | | |
| Arizona | Brand: 85 percent of AWP plus $7.00 Dispensing Fee<br>Generic: 85 percent of AWP plus $7.00 Dispensing Fee | https://tinyurl.com/y28ecxz2 |
| Alabama | Brand: AWP plus 5 percent plus $9.64 Dispensing Fee<br>Generic: AWP plus 5 percent plus $12.51 Dispensing Fee | https://tinyurl.com/y3ljrx99 |
| Alaska | Brand: AWP plus $5.00 Dispensing Fee<br>Generic: AWP plus $10.00 Dispensing Fee | https://tinyurl.com/y6avskz7 |
| Arkansas | Brand: AWP plus $5.13 Dispensing Fee<br>Generic: AWP plus $5.13 Dispensing Fee | https://tinyurl.com/7v9tvql |
| Colorado | Brand: AWP plus $4.00 Dispensing Fee<br>Generic: AWP plus $4.00 Dispensing Fee | https://tinyurl.com/tma2yht |
| Connecticut | Brand: AWP plus $5.00 Dispensing Fee<br>Generic: AWP plus $8.00 Dispensing Fee | https://tinyurl.com/y4dlw684<br>https://tinyurl.com/y6pygorl |
| Delaware | Brand: AWP minus 31.9 percent plus $3.29 Dispensing Fee<br>Generic: AWP minus 38.0 percent plus $4.10 Dispensing Fee | https://tinyurl.com/yxfltmu3 |
| Florida | Brand: AWP plus $4.18 Dispensing Fee<br>Generic: AWP plus $4.18 Dispensing Fee | https://tinyurl.com/yxs35c35 |
| Georgia | Brand: AWP plus $4.43 Dispensing Fee<br>Generic: AWP plus $6.63 Dispensing Fee | https://tinyurl.com/yyamp22q |
| Hawaii | Brand: AWP plus 40 percent<br>Generic: AWP plus 40 percent | https://tinyurl.com/y64h78we |
| Idaho | Brand: AWP plus $5.00 Dispensing Fee<br>Generic: AWP plus $8.00 Dispensing Fee | https://tinyurl.com/y4bq2nmx |
| Kansas | Brand: AWP minus 10 percent plus $3.00 Dispensing Fee<br>Generic: AWP minus 15 percent plus $5.00 Dispensing Fee | https://tinyurl.com/y6fzgmdu |
| Kentucky | Brand: AWP plus $5.00 Dispensing Fee<br>Generic: AWP plus $5.00 Dispensing Fee | https://tinyurl.com/yya52gg6 |
| Louisiana | Brand: AWP plus 10 percent plus $10.99 Dispensing Fee<br>Generic: AWP plus 40 percent plus $10.99 Dispensing Fee | https://tinyurl.com/y2q6j4q5 |
| Michigan | Brand: AWP minus 10 percent plus $3.50 Dispensing Fee<br>Generic: AWP minus 10 percent plus $5.50 Dispensing Fee | https://tinyurl.com/y66s4ph2 |

| System | Reimbursement Methodology | Source |
|---|---|---|
| Minnesota | Brand: AWP minus 12 percent plus $3.65 Dispensing Fee or $5.14 for paper claims<br>Generic: AWP minus 12 percent plus $3.65 Dispensing Fee or $5.14 for paper claims | https://tinyurl.com/y4gmtalz |
| Mississippi | Brand: AWP plus $5.00 Dispensing Fee<br>Generic: AWP minus 5 percent plus $5.00 Dispensing Fee | https://tinyurl.com/y6pumksl |
| Montana | Brand: AWP minus 10 percent plus $3.00 Dispensing Fee<br>Generic: AWP minus 25 percent plus $3.00 Dispensing Fee | https://tinyurl.com/y4yq98hn |
| Nevada | Brand: AWP plus $11.75 Dispensing Fee<br>Generic: AWP plus $11.75 Dispensing Fee | https://tinyurl.com/y5t8x752 |
| New Mexico | Brand: AWP minus 10 percent plus $5.00 Dispensing Fee<br>Generic: AWP minus 10 percent plus $5.00 Dispensing Fee | https://tinyurl.com/y57qlmcr |
| New York | Brand: AWP minus 12 percent plus $4.00 Dispensing Fee<br>Generic: AWP minus 20 percent plus $5.00 Dispensing Fee | https://tinyurl.com/y469r6aq |
| North Carolina | Brand: AWP minus 5 percent<br>Generic: AWP minus 5 percent | https://tinyurl.com/y6oyq59h |
| Ohio | Brand: AWP minus 15 percent plus $3.50 Dispensing Fee<br>Generic: AWP minus 15 percent plus $3.50 Dispensing Fee | https://tinyurl.com/y5jpx4ob |
| Oklahoma | Brand: AWP minus 10 percent plus $5.00 Dispensing Fee<br>Generic: AWP minus 10 percent plus $5.00 Dispensing Fee | https://tinyurl.com/y3m35qzb |
| Oregon | Brand: AWP minus 16.5 percent plus $2.00 Dispensing Fee<br>Generic: AWP minus 16.5 percent plus $2.00 Dispensing Fee | https://tinyurl.com/y6g42dtz |
| Pennsylvania | Brand: AWP plus 10 percent<br>Generic: AWP plus 10 percent | https://tinyurl.com/y4as4fsv |
| Rhode Island | Brand: AWP minus 10 percent<br>Generic: AWP minus 10 percent | https://tinyurl.com/yym62gfq |
| South Carolina | Brand: AWP plus $5.00 Dispensing Fee<br>Generic: AWP plus $5.00 Dispensing Fee | https://tinyurl.com/yytefg58 |
| Tennessee | Brand: AWP plus $5.10 Dispensing Fee<br>Generic: AWP plus $5.10 Dispensing Fee | https://tinyurl.com/yybv34nf |
| Texas | Brand: AWP plus 9 percent plus $4.00 Dispensing Fee<br>Generic: AWP plus 25 percent plus $4.00 Dispensing Fee | https://tinyurl.com/y47tljcs |

| System | Reimbursement Methodology | Source |
|---|---|---|
| Vermont | Brand: AWP plus $3.15 Dispensing Fee<br>Generic: AWP plus $3.15 Dispensing Fee | Source Link |
| Washington | Brand: AWP minus 10 percent plus $4.50 Dispensing Fee<br>Generic: AWP minus 50 percent plus $4.50 Dispensing Fee | https://tinyurl.com/y6sp67d3 |
| Wisconsin | Brand: AWP plus $3.00 Dispensing Fee<br>Generic: AWP plus $3.00 Dispensing Fee | https://tinyurl.com/y2durrky |
| Wyoming | Brand: AWP minus 10 percent plus $5.00 Dispensing Fee<br>Generic: AWP minus 10 percent plus $5.00 Dispensing Fee | https://tinyurl.com/y3dv5bdc |
| **State Systems with Alternative Benchmarks** | | |
| California | NDCs Covered by Medi-Cal<br>Brand & Generic: Lessor of NADAC (WAC if no NADAC), MAIC, FUL, or Usual and Customary Charge (U&C) plus $13.20 Dispensing Fee for pharmacies with less than 90,000 claims per year or $10.05 for pharmacies with more than 90,000 claims per year.<br>NDCs Not Covered by Medi-Cal<br>Brand: Lessor of AWP minus 17 percent, MAC, FUL, or U&C plus $7.25 Dispensing Fee<br>Generic: Lessor of AWP minus 17 percent, MAC, FUL, or U&C plus $7.25 Dispensing Fee | https://tinyurl.com/y2x3jtmd<br>https://tinyurl.com/y48u8brx |
| Massachusetts | Brand & Generic Single-Source: Lessor of FUL, MMAC, AAC, or U&C plus $10.02 Dispensing Fee<br>Brand & Generic Multi-Source: Lessor of MMAC, AAC, or U&C plus $10.02 Dispensing Fee | https://tinyurl.com/y5zr96my |
| North Dakota | Brand: WAC plus 8 percent plus $4.00 Dispensing Fee<br>Generic: Lesser of MAC plus 5 percent or WAC plus 8 percent plus $5.00 Dispensing Fee | https://tinyurl.com/y2knwgk7 |
| **State Systems with No Fee Schedule** | | |
| District of Columbia | Brand: Paid at U&C<br>Generic: Paid at U&C | https://tinyurl.com/y3wodrh4 |
| Illinois | Licensed Pharmacy: Insurer pays all necessary and reasonable costs<br>Outside of Licensed Pharmacy: AWP plus $4.18 Dispensing Fee for Brand & Generic | https://tinyurl.com/y2wkzk6m |
| Indiana | Reimbursement for repackaged medications dispensed (other than retail/mail pharmacy) use AWP of original manufacturer. If NDC not determined, max reimbursement is lowest cost generic for prescribed/dispensed medication. Doctors dispensing medications from their office(s) are only entitled to receive reimbursement for medications dispensed during the first seven days from DOI. | https://tinyurl.com/y64ac4lv |

| System | Reimbursement Methodology | Source |
|---|---|---|
| Iowa | Brand: Paid at U&C<br>Generic: Paid at U&C | https://tinyurl.com/yxugvmwl |
| Maine | Brand: Paid at U&C<br>Generic: Paid at U&C | https://tinyurl.com/y63pmj2b |
| Maryland | The MD WCC MFG has never priced durable medical equipment (DME), prescriptions/pharmaceuticals (Rx) or dental procedures; however, medical providers should bill what is usual and customary: "An insurance carrier may base the assigned value on nationally recognized and published relative value studies, or on the values assigned for services involving similar work and resources." Providers are supposed to have one price for all patients regardless of what they get paid by different payers. | https://tinyurl.com/y6jnpjgc |
| Missouri | Brand: Paid at U&C<br>Generic: Paid at U&C | https://tinyurl.com/y3m8n5z9 |
| Nebraska | Brand: Paid at actual charge<br>Generic: Paid at actual charge | https://tinyurl.com/y5kpr6t8 |
| New Hampshire | Brand: Paid at reasonable value<br>Generic: Paid at reasonable value | https://tinyurl.com/y5xhcgrb |
| New Jersey | Brand: Paid at U&C<br>Generic: Paid at U&C | https://tinyurl.com/yyunfev6 |
| South Dakota | Brand: Not to exceed U&C<br>Generic: Not to exceed U&C | https://tinyurl.com/y2yzq3kz |
| Utah | Brand: Paid at U&C<br>Generic: Paid at U&C | https://tinyurl.com/y325zhpz |
| Virginia | Brand: Use prevailing community rate<br>Generic: Use prevailing community rate | https://tinyurl.com/y2sobpl9 |
| West Virginia | Brand: Paid at U&C<br>Generic: Paid at U&C | https://tinyurl.com/y6c5ebdr |
| **Federal System** | | |
| U.S. Department of Labor - Office of Workers' Compensation | Brand: 85 percent of AWP plus $4.00 Dispensing Fee<br>Generic: 75 percent of AWP plus $4.00 Dispensing Fee | https://tinyurl.com/y3y6o43f |