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October 10, 2018

Via electronic mail to mro@azica.gov

Industrial Commission of Arizona
c/o Jacqueline Kurth, Manager
Medical Resource Office
P.O. Box 19070
800 W. Washington Street
Phoenix, AZ 85005-9070

Re: **Amended Submission**
Laws 2018, Chapter 101, Section 3 (Senate Bill 1111);
Reimbursement Guidelines for Physician Dispensed Medications;
August 23, 2018 Public Hearing

Dear Members of the Industrial Commission of Arizona:

CopperPoint Mutual Insurance Company ("CopperPoint") is pleased to provide written comments in connection with the Industrial Commission of Arizona's ("Commission") consideration of reimbursement guidelines for medications dispensed by physicians and in settings that are not accessible to the general public ("physician dispensing"). CopperPoint urges the Commission to adopt reimbursement guidelines such as those suggested below as part of the 2019/2020 Arizona Physicians and Pharmaceutical Fee Schedule. Thank you for this opportunity for input.

Background

Medical expenses are the leading cost driver in Arizona's workers' compensation system, and prescription medications account for approximately 20% of those medical costs. Medications that are dispensed by physicians cost substantially more than those obtained at a retail pharmacy. In Arizona, a very small number of medical providers who are engaged in dispensing derive tremendous profits at the expense of injured workers, their employers, and the

workers' compensation system as a whole. Studies have demonstrated that physician dispensing increases the quantity of drugs dispensed, produces longer periods of disability, and results in poor patient outcomes.[1]

While Arizona recently enacted a prohibition on physician dispensing of opioid medications, this addresses only one area of concern. CopperPoint believes that limiting reimbursement for physician dispensing of non-opioid medications will serve to further reduce unnecessary costs and improve health outcomes for Arizona's injured workers.[2]

Physician Dispensing Is Not Necessary For Patient Convenience

The vast majority of injured workers have their prescription drug needs met through the thousands of retail pharmacies that exist throughout Arizona. Indeed, there are currently only a handful of physicians engaging in the practice of dispensing medications to Arizona's injured workers.[3] From July 15, 2017 through July 15, 2018, CopperPoint paid 29 different physician dispensers for medications costing a total of $2,194,437. Significantly, only five of the 29 dispensers were responsible for 95% of all physician dispensing costs. The top three physician dispensers charged CopperPoint $839,439, $628,524 and $460,879, respectively, for a total of $1,928,842. These numbers demonstrate that physician dispensing is not a mainstream practice and that Arizona's injured workers have other options readily available for their prescription medication needs.

Physician dispensing is not more convenient to the patient, especially after the first fill. Physician dispensed refills require another doctor visit, typically only during business hours and on weekdays. By contrast, pharmacies are often available to provide refills before or after regular business hours. CopperPoint analyzed its injured worker claimant population by zip code. A majority of claimants reside in areas with access to multiple pharmacies within a short distance. In fact, most had 50 or more pharmacies within a 15-mile distance, while others had at least five pharmacies in that range. Moreover, this does not take into account the availability of mail order pharmacy services. Mail order pharmacies allow for delivery of a 3-month supply of medications directly to a patient's door.

Physician Dispensing Leads to Higher Costs

Physician dispensing circumvents cost control by avoiding negotiated rates. Retail pharmacies are usually members of networks, which provide medications at much lower costs through negotiated rates. As a result, medications dispensed by physicians cost substantially more than those obtained at most pharmacies.

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[1] Journal of Occupational and Environmental Medicine, "Effect of Physician-Dispensed Medication on Workers' Compensation Claim Outcomes in the State of Illinois" (May 2014); California Workers Compensation Institute, "Differences in Outcomes for Injured Workers Receiving Physician-Dispensed Repackaged Drugs in the California Workers' Compensation System" (February 2013).

[2] The fact that Arizona recently banned physician dispensing of opioids makes non-opioid dispensing reform even more critical. In Florida, after a statute was enacted prohibiting physicians from dispensing Schedule II and Schedule III controlled substances, there was an increase in physician dispensing of higher-priced new-strength drug products. WCRI, "A Multistate Perspective on Physician Dispensing, 2011-2014" (July 2017).

[3] While currently the number of physicians dispensing in Arizona is relatively small, absent reform we can expect the number to grow substantially based upon the experience of other states. *See* ibid.

CopperPoint and most other insurers contract with a third party for their prescription benefit manager (PBM) services. These PBMs typically have hundreds of pharmacies in their networks. In addition, any patient in any location may take advantage of a PBMs mail order prescription services. Network pharmacies generally provide medications at a cost that is well below the Commission's Pharmaceutical Fee Schedule price. Identical medications dispensed from physicians' offices are charged at the full Fee Schedule price, resulting in greater cost to the workers' compensation system.[4]

Physician dispensing of medications also involves a disturbing conflict of interest: physicians are incentivized to prescribe more and costlier mediations to patients for a longer duration of time. Doctors may be motivated by profit to prescribe specific types of medications in unusual dosages that are much higher in price than equivalent medications in normal doses available at pharmacies (or even over the counter). Many special drug dosages and formulations created for physician dispensing appear to be nothing more than an opportunity for increased revenue.

CopperPoint data reveals numerous examples of excessive costs associated with physician dispensing of specially formulated and non-customary dosage medications, including: (1) a charge for $3,327.17 for a specially formulated Menthoderm Ointment, when a comparable muscle rub product is available over the counter for $52.61, (2) a per-pill charge of $9.26 for a 150 mg tablet of Tramadol, when the combined average wholesale price for 100 mg and 50 mg tablets is just $4.50;[5] (3) a per-pill charge of $41.53 for a specially formulated 8 mg tablet of Ondansetron, when the price for the generic formulation is just $.94; and (4) a per-pill charge for a special formulation of Duloxetine DR 30 mg of $7.54 when the price for the customary formulation is $.20.[6]

According to CopperPoint data, the average medication cost per prescription for the top three physician dispensers is $546. The average medication cost per prescription dispensed by pharmacies over the same period of time was less than half that amount, or $221.

Physician dispensing of medications is associated with not only higher pharmaceutical costs, but higher overall claim costs and higher indemnity/wage replacement costs.[7] CopperPoint data shows that for 2017, the average cost of a claim involving physician dispensing was $4,280, compared to $2,370 for a claim not involving physician dispensing.

Physician Dispensing Lacks Clinical Controls and Jeopardizes Patient Outcomes

Physician dispensing bypasses clinical safeguards that carriers have in place to ensure that injured workers are receiving the prescription drugs best suited for treating their injuries. Most retail pharmacies are connected to the PBM electronically, so this clinical review can happen instantaneously and any outliers can be immediately identified. Formulary edits by the PBM also help ensure the use of generics

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[4] The text of this paragraph has been amended to excise certain specific references to CopperPoint's PBM, considered by said PBM to represent proprietary information. These amendments attempt to retain the substance contained within the original submission, while alleviating concerns regarding sensitive trade information expressed by the PBM.

[5] Over a one-year period of time, CopperPoint spent a total of $143,601 for Tramadol ER prescriptions dispensed by physicians.

[6] Over a one-year period of time, CopperPoint spent a total of $189,970 for Duloxetine DR 30 mg prescriptions dispensed by physicians.

[7] *See* Journal of Occupational and Environmental Medicine (May 2014), "Effect of Physician-Dispensed Medication on Workers' Compensation Claim Outcomes in the State of Illinois."

or less expensive, therapeutically equivalent medications. When medications are dispensed from physician offices, these clinical safety controls and utilization protocols do not exist.

In addition, physician dispensing raises patient safety concerns because physicians may not be aware of an injured worker's complete prescription history. This can lead to negative drug interactions. By contrast, pharmacists are trained to identify the composition, effects, proper dosages, and interaction of drugs. Pharmacists are best positioned to advise patients on how and when to take their medications and to spot potentially harmful drug interactions.

Physician dispensaries are also limited in types and supplies of medications available. Given the financial incentives that exist, a physician may therefore prescribe and dispense the medication on hand, rather than a more efficacious medication that is available at the local pharmacy.

Finally, we note that Arizona's Medicaid program (AHCCCS) recognizes the importance of clinical controls for delivering better outcomes and helping achieve overall lower claim costs. AHCCCS generally does not reimburse for drugs dispensed by a physician. Instead, "AHCCCS contracts with a pharmacy benefit manager (PBM) to provide and administer clinically appropriate pharmaceutical services and manage the medication formulary."[8]

CopperPoint Recommendations

In light of these concerns, we respectfully suggest the following concepts as the Commission considers adopting reimbursement guidelines for medications dispensed outside the pharmacy setting:

1. Any reimbursement restrictions should apply not only to medications dispensed by physicians in their offices, but to all medications dispensed in settings that are not accessible to the general public.

2. Any reimbursement for medications dispensed in non-pharmacy settings should be limited to circumstances where all of the following apply:
    a. The medication dispensed is for not more than an initial, one-time limited supply of medication. (We suggest a 14-day supply limit is appropriate.)
    b. The medication is dispensed within a short period of time after the employee first seeks medical treatment for the injury. (We believe a 72-hour limit is sufficient to provide access in emergent circumstances.)
    c. The medication conforms to formulas and dosages that are customarily available when the medication is dispensed by a licensed pharmacist in a pharmacy setting that is available to the general public.

In summary, CopperPoint believes that the adoption of these reimbursement guidelines is essential to a sustainable system that provides quality medical treatment to injured workers in a safe and cost-effective manner.

[8] https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS Chap12Pharmacy.pdf

Thank you for your consideration of these comments.

Sincerely,

Mark A. Kendall
Vice President, Legal Services