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Industrial Commission of Arizona
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RE: SB 1111 Reimbursement Guidelines for Physician-Dispensed Medications
Public Hearing: August 23, 2018

To the Honorable Members of the Industrial Commission:

Property Casualty Insurers Association of America (PCI) respectfully submits the following comments for the public hearing scheduled to receive testimony for the proposal to amend the 2019/2020 Arizona Physicians' and Pharmaceutical Fee Schedule to address additional reimbursement guidelines for medications dispensed in settings that are not accessible to the general public, including physician-dispensed medications.

Property Casualty Insurers Association of America (PCI) is a national trade association representing nearly 1000 property and casualty insurance companies. PCI members write over $220 billion in annual premium including 35% of the commercial insurance market and 37% of the private workers' compensation insurance market.

PCI submits the following comments for consideration.

I. General Comments and Background Information

Arizona, like most states, recognized the problems associated with physician dispensing of repackaged drugs in the workers' compensation system and adopted regulations to curb the abuses associated with that practice.[1] Unfortunately the abuses associated with physician dispensing of pharmaceuticals remain.

Many jurisdictions, including Arizona, enacted legislation or adopted regulations governing reimbursement for physician-dispensed pharmaceuticals that aimed to reduce the much higher prices paid to physicians than to pharmacies for drugs they dispense. The price-focused reforms limited reimbursement to physicians to a methodology based on the average wholesale price (AWP) assigned by the original manufacturer of the drug product rather the much higher AWP assigned to the drug product by the repackaging company.[2]

The business model of the repackaging/physician-dispensing industry changed in response to the reform legislation and regulations. Physicians are now dispensing new drug strengths of common drugs supplied by the repackaging industry which are assigned a much higher AWP by the original manufacturer than the more common dosages for those drug products.

Examples of these physician-dispensed drug products that have new dosage strengths or formulation include:

- 7.5-milligram cyclobenzaprine HCL (muscle relaxant)

[1] Industrial Commission of Arizona, Arizona Physicians' Fee Schedule, Pharmaceutical Fee Schedule (2009 amendments)
[2] Arizona adopted regulations specify reimbursement based on 85% of AWP of the original manufacturer plus a $7 dispensing fee

- 150-milligram tramadol HCL extended release (opioid pain reliever)
- 2.5-325-milligram hydrocodone-acetaminophen (opioid pain reliever)
- Lidocaine-menthol patches (topical pain relief patches)

According to Workers Compensation Research Institute (WCRI) studies[3], cyclobenzaprine HCL is a commonly prescribed muscle relaxant. Historically, this drug has been prescribed in 5- and 10-milligram strengths. These common strengths are typically reimbursed at $0.35 to $0.70 per pill. However, the new 7.5-milligram dosage is assigned a much higher AWP by the manufacturer of this new drug product which results in a dramatic increase in reimbursement rates to $2.90 to $3.45 per pill. The data on the other listed physician-dispensed drug products show a similar pattern of pricing escalation.

The growing practice of physician dispensing of higher-priced new drug strengths and formulation is a significant cost-driver with no apparent health benefit to the injured worker to justify undermining the physician dispensing reforms adopted in many jurisdictions, including Arizona. In addition, physician dispensing has been associated with worse health outcomes for workers in at least two studies.[4]

The problems encountered by state-administered workers' compensation systems with physician-dispensed drugs are not found in the private health insurance market or public assistance programs which generally do not reimburse for physician-dispensed drugs.

In general, Massachusetts[5], Montana[6], New York[7], Texas[8] and Utah[9] do not allow physician-dispensing of pharmaceuticals.

Indiana restricts reimbursement for physician dispensing to one office visit and drugs for up to 7 days from the date of disablement.[10] Similarly, North Carolina restricts physician-dispensing of Schedule II, III, IV, and V pharmaceuticals to injured workers to an initial 5-day supply commencing with initial treatment following injury.[11] Kansas requires all compounds and physician dispensed medications to be preapproved by the payer.[12]

A Florida statute prohibiting physicians from dispensing Schedule II and Schedule III controlled substances is associated with a reduction in the percentage of injured workers receiving strong opioids and a reduction in the frequency of prescriptions dispensed for strong opioids.[13] However, physician dispensing of high-priced new drug strengths of common drugs in Florida has undermined some of those reforms and has become a new cost-driver in their workers' compensation system.[14]

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[3] WCRI, "A Multistate Perspective on Physician Dispensing, 2011-2014" (July 2017); WCRI, "Physician Dispensing of Higher-Priced New Drug Strengths and Formulation" (April 2016); WCRI, "Are Physician Dispensing Reforms Sustainable" (January 2015)
[4] 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)
[5] MA Title XV, Chapter 94C, Section 9
[6] MCA 37-2-104
[7] NY Education Law Article 137 §6810
[8] TX Occupations Code §158.003
[9] UT ST §58-17b-309
[10] Indiana Code 22-3-3-4.5(c)
[11] North Carolina General Statutes §97-26.2
[12] Kansas 2017 Schedule of Medical Fees (effective January 1, 2017)
[13] FS s. 465.0276; WCRI, "Impact of Banning Physician Dispensing of Opioids in Florida" (July 2013)
[14] WCRI, "Early Impact of Florida Reforms on Physician Dispensing" (July 2016); WCRI, "A Multistate Perspective on Physician Dispensing, 2011-2014" (July 2017)

Prohibiting or imposing appropriate restrictions on physician dispensing of pharmaceuticals can improve return-to-work and health outcomes for injured workers and reduce the risk of dependence and addiction to inappropriate drugs while reducing unnecessary costs in the workers' compensation system.

II. Recommendations

Eligibility for reimbursement for physician-dispensed medications to Arizona injured workers should be limited to a first fill of medications dispensed within seven days of the date of injury and limited to no more than a seven-day supply of appropriate medications that are recognized and recommended by the adopted evidence-based treatment guidelines and pharmaceutical formulary.

Reimbursement for physician-dispensed medications should be based on the NDC code of the lowest priced therapeutically equivalent medication available in the marketplace for the drug(s) dispensed.

Thank you for considering these comments.

Respectfully submitted,

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