August 5, 2021

Mr. Charles Carpenter
Industrial Commission of Arizona
P.O. Box 19070
800 W. Washington Street
Phoenix, AZ 85005-9070

Dear Mr. Carpenter,

Please accept the following as our comments on the recent Staff Proposal of the 2021-2022 Physicians' & Pharmaceutical Fee Schedule. We appreciate the Commission's efforts to both monitor and address medical costs in the workers' compensation system. In support of these efforts, we are sharing insights about the anticipated impact of modifying the reimbursement methodology for outpatient pharmaceuticals. While we are in support of the overall intent to better control drug costs, we are strongly opposed to the adoption of the NADAC benchmark, which we anticipate will have an adverse negative impact on pharmacy benefit managers like Healthesystems, who are integral to ensuring injured workers are able to receive medically necessary medications quickly and easily and in the safest and most cost-effective way possible.

Why NADAC misses the mark in workers' compensation

While AWP is not a perfect benchmark, it remains the most robust, viable and sustainable for our industry. For these reasons, we recommend retaining AWP-based methodologies for all outpatient drug reimbursement. Regarding NADAC, 22% of all medications dispensed in Arizona do not have a NADAC price according to the Myers & Stauffer 2020 White Paper on Pharmaceutical Reimbursement. The "missing" 22% are medications where no NADAC is reported, because they relate to "non-covered drugs" in the Medicaid program.

Many of the medications without a NADAC price are well known and commonly dispensed medications that are brought to market in new, but not novel, formulations or strengths, and include oral drugs, topical analgesics, and patches. These fall into the category of medications that are prescribed mainly to generate profit rather than to serve patients' medical needs in the most cost-effective manner. They are the major contributing cause of unmanaged and inflated drug costs in workers' compensation claims. These are often formulated, manufactured, and marketed only for injured workers and are rarely prescribed by physicians outside of the workers' compensation setting. They are almost always dispensed by pharmacies who do not participate in any PBM network. These drugs do not deliver better medical outcomes for patients. Adopting NADAC will not impact this "prescribed for profit" category of medications, since they are not covered in the Medicaid system and therefore do not have a NADAC price.

Other states have addressed the costs associated with these "profit over patient" medications by placing reimbursement, supply and quantity limits on OTC topical analgesics and patches. The ICA Staff has also proposed this approach in its 2021-2022 Physicians' and Pharmaceutical Fee Schedule. We support this step to apply quantity limits, limits on the days' supply and payment caps, and the rates proposed by the ICA seem

reasonable to this end. We further recommend the ICA staff explore how MCG Health, publisher of the state adopted treatment guidelines and ODG Formulary, may further address the concerns on the safety, efficacy, and cost effectiveness of these new, but not novel formulations and strengths of medications. This will help to determine what changes are necessary going forward to ensure appropriate care at a more reasonable cost.

Why In-Network vs Out-of-Network Pharmacies Makes a Difference

What we know from our own data is that the new, but not novel, formulations and strengths as described above are coming from out-of-network pharmacies. These entities and the manufacturers that work closely with them are in the business of exploiting any loophole in the workers' compensation fee schedule or regulations. In any other payer setting, this kind of "profit over patient" pattern of behavior would place the participating pharmacy at risk of being removed from the network. However, the current regulatory framework prevents most employers and carriers from steering patients into a network, so there is no recourse for the payer to eliminate these bad actors from the equation. Arizona employers are paying the bill and get no better outcomes for their injured workers to offset those increased costs.

Often out-of-network pharmacies refuse to participate in networks because the terms of network agreements incentivize participating pharmacies to buy and dispense medications that are widely available, at a low cost. The economics of pharmacy network agreements ensure patients have broad access to many pharmacies within their community and that these pharmacies adhere to standards that not only protect the patient, but offer value and savings to the employer, carrier or other purchasers. With more than 1,400 Arizona licensed in-state pharmacies, the vast majority participate in our pharmacy network. There is no lack of options for injured workers to receive their medications at a reasonable cost.

If the Commission were to move forward as proposed with NADAC, we ask the Commission to take the following points into consideration:

Multiple backup methodologies add complexity and risk for providers and payers

There is some additional operational and regulatory risk associated with incorporating multiple "backup" calculation methods as it relates to pharmacy reimbursement. As currently proposed, when there is no NADAC, the ICA has designated multiple backup formulas using percentages of Average Wholesale Price, Wholesale Acquisition Cost and Generic Equivalent Acquisition Price (GEAP) as benchmarks to arrive at the fee schedule rate. Multiple methods add complexity that will not only be challenging to implement but will likely create more confusion for the provider in understanding the expected reimbursement, resulting in fee disputes which the ICA may be called upon to resolve. Specifically, we suggest strike through on Section III(F) 1(b) and (c.) and replace with *"If the medication is not listed in NADAC, the maximum payable is (XX % of AWP per unit) x (number of units dispensed)."*

Timing & Technology Impact

We anticipate any fee schedule which is adopted that includes changes in benchmark, methodologies and payment caps will require time and IT resources to implement correctly. If the final version of the fee schedule were to be published in mid to late August and become effective on October 1st, this will only allow payers and their PBMs, at most, 30-45 days to evaluate and update current contracts and to implement this business and technology change. Given the complexity of the proposal, the brevity of this timeline is highly challenging. We

would recommend a minimum of 120 days from date of adoption to effective date to allow for the necessary changes to occur in the PBM/payer/pharmacy marketplace.

Future Considerations for Better Cost Containment and Quality of Care

A more direct approach to addressing the cost drivers in pharmacy services is to make some legislative and/or regulatory change which gives employers and payers the ability to manage their pharmacy costs more comprehensively. Requiring injured workers to choose from within a broad network of providers, as designated by their carrier or claims administrator, is an approach that could be studied to determine its potential benefit to Arizona's injured workers and employers. Networks are delivering savings, and this is why they are so prevalent in all medical benefit programs, including commercial and government healthcare plans. This type study might support a public policy change which would enable the purchaser, (i.e., the employer, carrier, or third-party administrator) to reduce unnecessary spend in pharmacy that comes with using out of network pharmacies. More robust use of pharmacy networks will improve overall care and reduce costs and provide better data to allow employers & carriers to detect wasteful, questionable, or abusive patterns of prescribing or billing. The more "in-network" dispensing that occurs, the greater the clinical oversight on the injured worker's overall drug regimen.

While the Myers & Stauffer report suggests a NADAC-based reimbursement structure could deliver 40-50% savings, it failed to consider how PBMs, like Healthesystems are working with payers to reduce costs via their participating network pharmacy agreements. PBM networks are just one piece of how PBMs deliver value to the market. Across the multiple payer categories in the Myers & Stauffer report, current medication spend in Arizona is somewhere between 5-30% below the current fee schedule; however, PBMs deliver savings to the system and to employers, well beyond these reported expenditures. Not only do PBMs reduce drug costs via network discounts, but we also identify and reduce overutilization and inappropriate prescribing through real time review of transactional data, minimizing fraud, waste, and abuse in the system. These additional "soft" savings are often overlooked but add significant benefit to the injured worker, while reducing their employers' claim costs.

If there are any questions in relation to our comments, please do not hesitate to reach out to me directly. Healthesystems stands ready to assist the Commission leadership and staff in any additional fact finding that may be useful in advancing initiatives which improve patient care while simultaneously controlling costs.

Sincerely,

Sandy Shtab
AVP, Advocacy & Compliance
813-868-2264
sshtab@healthesystems.com