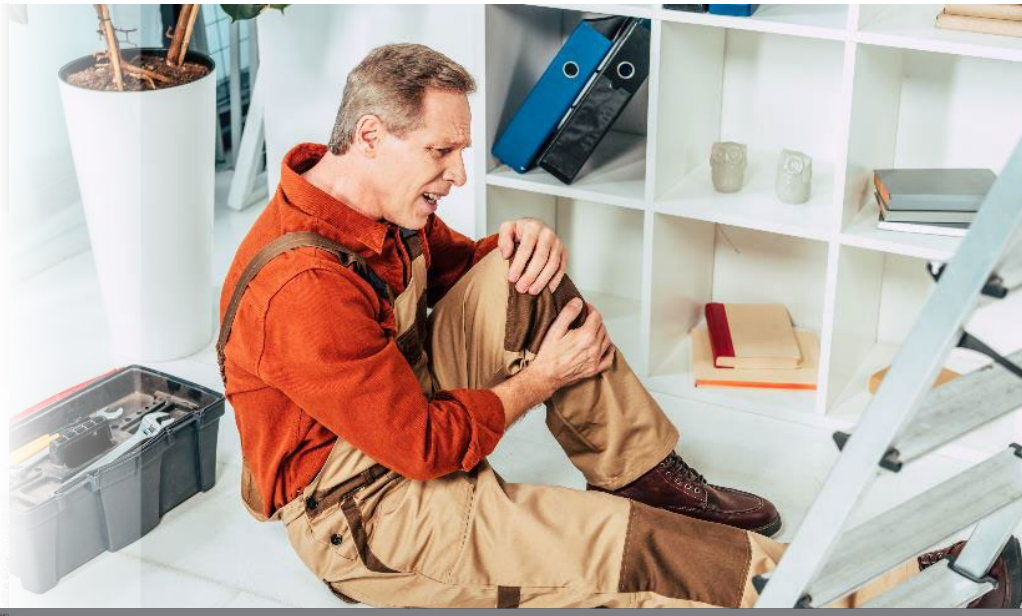

Group Health vs. Workers' Comp trends in healthcare

September 23, 2020

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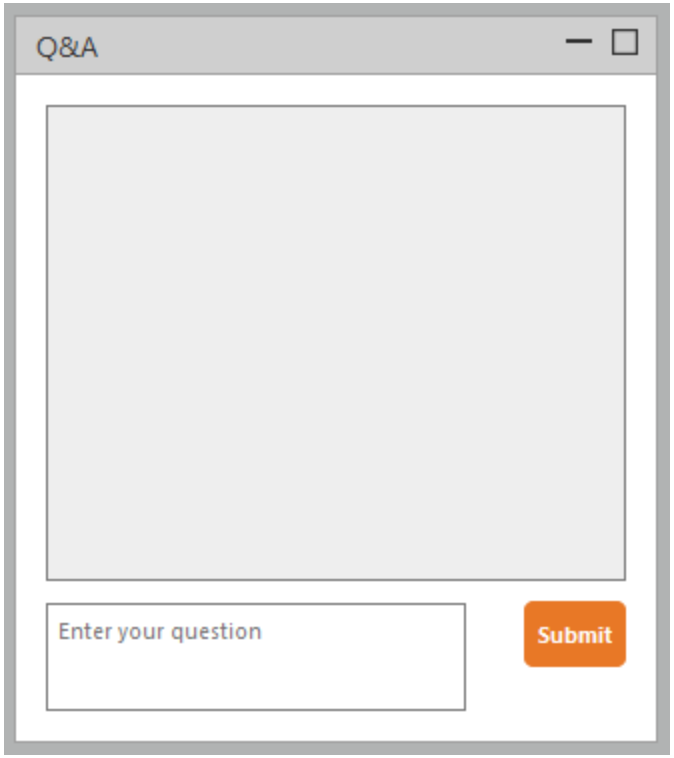
Ask a question

Questions will be answered at the end of the presentation as time allows.



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Cara Maxwell, PharmD
Clinical Pharmacist Liaison

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Group Health vs. Workers' Compensation

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Several key differences between Group Health (GH) and Workers' Comp (WC)

	GROUP HEALTH	WORKERS' COMPENSATION
Health care spending	~$3 trillion	~$30 billion

Healthcare in the United States is expensive
2018 data

According to the Centers for Medicare and Medicaid Services

- Healthcare expenses in the U.S. was $11,172 per person
- 17.7% of our Gross Domestic Product and equated to just below $4 Trillion dollars

According to IQVIA

- Nearly 5.8 Billion prescriptions were dispensed in the U.S.
- Cost $344 Billion
- Average cost of $1,044 per person.

17.1% ↓
Opioid use year over year

https://www.iqvia.com/insights/the-iqvia-institute/reports/medicine-use-and-spending-in-the-us-a-review-of-2018-and-outlook-to-2023#:~:text=Americans%20are%20taking%20more%20prescription,by%2015%20million%20since%202014. Accessed September 2020.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet Accessed September 2020

National Healthcare Expenditure (NHE)

2018 data

4.6%
to $3.6 Trillion

$11,172
per person

17.7%
of Gross Domestic Product (GDP).

Medicare	**6.4%** to $750.2 B	**21%** % of total NHE
Medicaid	**3.0%** to $597.4 B	**16%** % of total NHE
Private Health insurance	**5.8%** to $1.243 T	**34%** % of total NHE
Hospital	**4.5%** to $1.191.8 B	Lower than 2017
Physician and clinical services	**4.1%** to $725.6 B	Lower than 2017
Prescription medications	**2.5%** to $335 B	Higher than 2017

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet Accessed September 2020.

Workers' compensation benefit payments
2015 data

Benefit payments	**$61.9B** $0.86 per $100 of covered wages
Medical benefits	**$31.1 B**
Wage loss comparison	**$30.7 B** includes payments to disabled workers and survivors of deceased workers

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet Accessed September 2020.

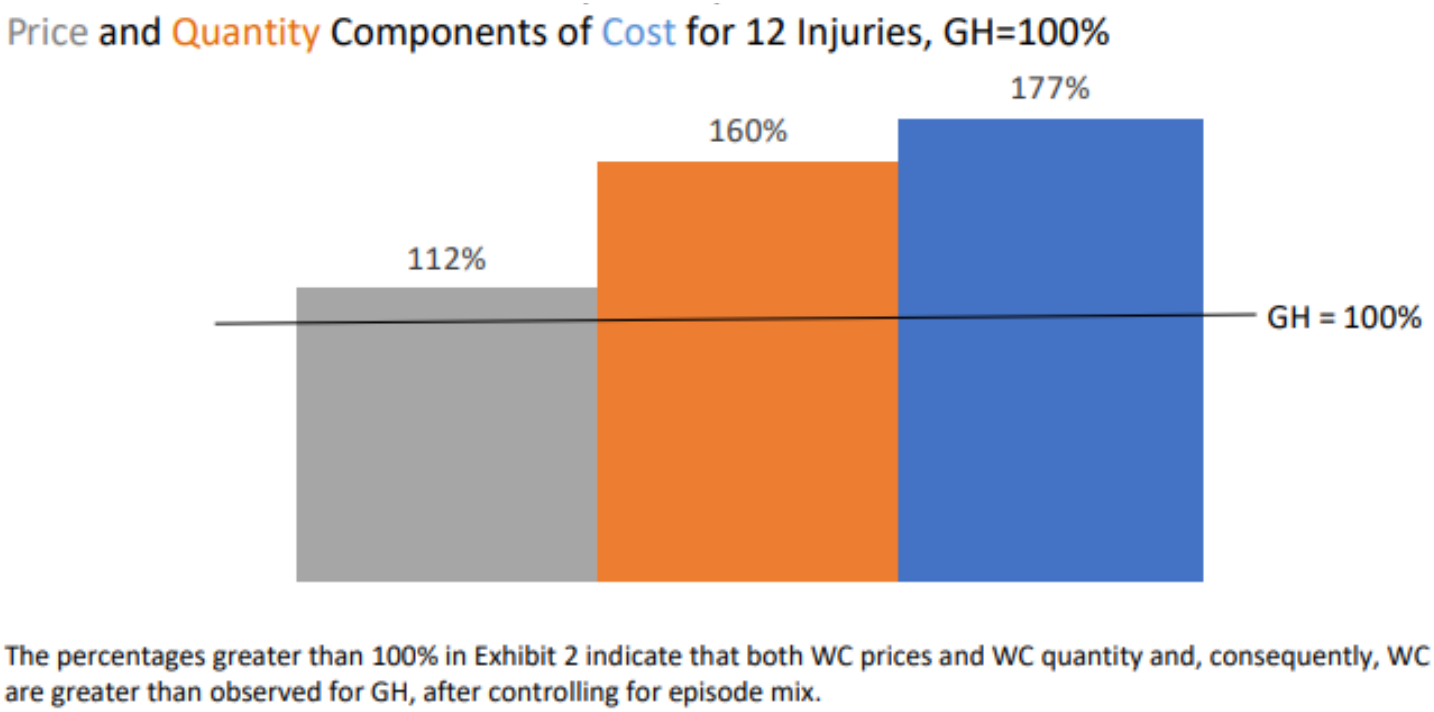
WC pays more than GH to treat comparable injuries

- Quantity differences dominate price differences
- Quantity differences vary principally by type of injury

https://www.ssa.gov/policy/docs/statcomps/supplement/2017/workerscomp.html, Accessed September 2020

According to NCCI for a selected group of injuries

Workers' compensation pays more than group health to treat comparable injuries.



The percentages greater than 100% in Exhibit 2 indicate that both WC prices and WC quantity and, consequently, WC costs, are greater than observed for GH, after controlling for episode mix.

Costs of physician services within the WC and GH insurance systems

QUANTITY DIFFERENCES	PRICE DIFFERENCES
• Dominate over price differences, explaining 80% of the cost difference for a select group of 12 common WC medical conditions • Vary principally by type of injury; all the injuries considered show a higher quantity of services for WC than for GH	More related to the jurisdiction than to the type of injury, due, in part, to the different WC physician fee schedules that apply by state

Traumas to arms and legs consistently have the smaller cost and quantity differences. Chronic or pain-related injuries, such as bursitis and back pain, have larger differences.

Differences between workers' compensation and group health depend on the medical service category

- Evaluation, management, radiology, and physical medicine costs are higher in WC due to the greater quantity of those services, even for states where WC prices are lower than GH
- Higher WC costs for surgery are driven more by higher prices than by quantity
- Quantity and prices for radiology services are higher in WC than in GH; however, technological advances have moved them closer in recent years
- The most pronounced difference between WC and GH is the higher quantity of physical medicine services in WC, which may be partly due to cost sharing in GH

Several key differences between GH and WC

	GROUP HEALTH	WORKERS' COMPENSATION
Health care spending	~$3 trillion	~$30 billion
Benefit structure	• **Defined benefit plan** • Varying levels of coverage • Eligibility determined prospectively • Closed network • Copay/co-insurance/out of pocket costs	• **Undefined benefit plan** • 100% medical cost coverage • Eligibility determined retrospectively • Open network • No copay

Several key differences between GH and WC

	GROUP HEALTH	WORKERS' COMPENSATION
Health care spending	~$3 trillion	~$30 billion
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Clinical focus	• **Primarily medical issues** • Chronic disease • End-of-life care • Health and wellness	• **Primarily physical injuries** • **Pain management and use of opioids** • Manage the immediate need and close claim • Return claimant to work

Several key differences between GH and WC

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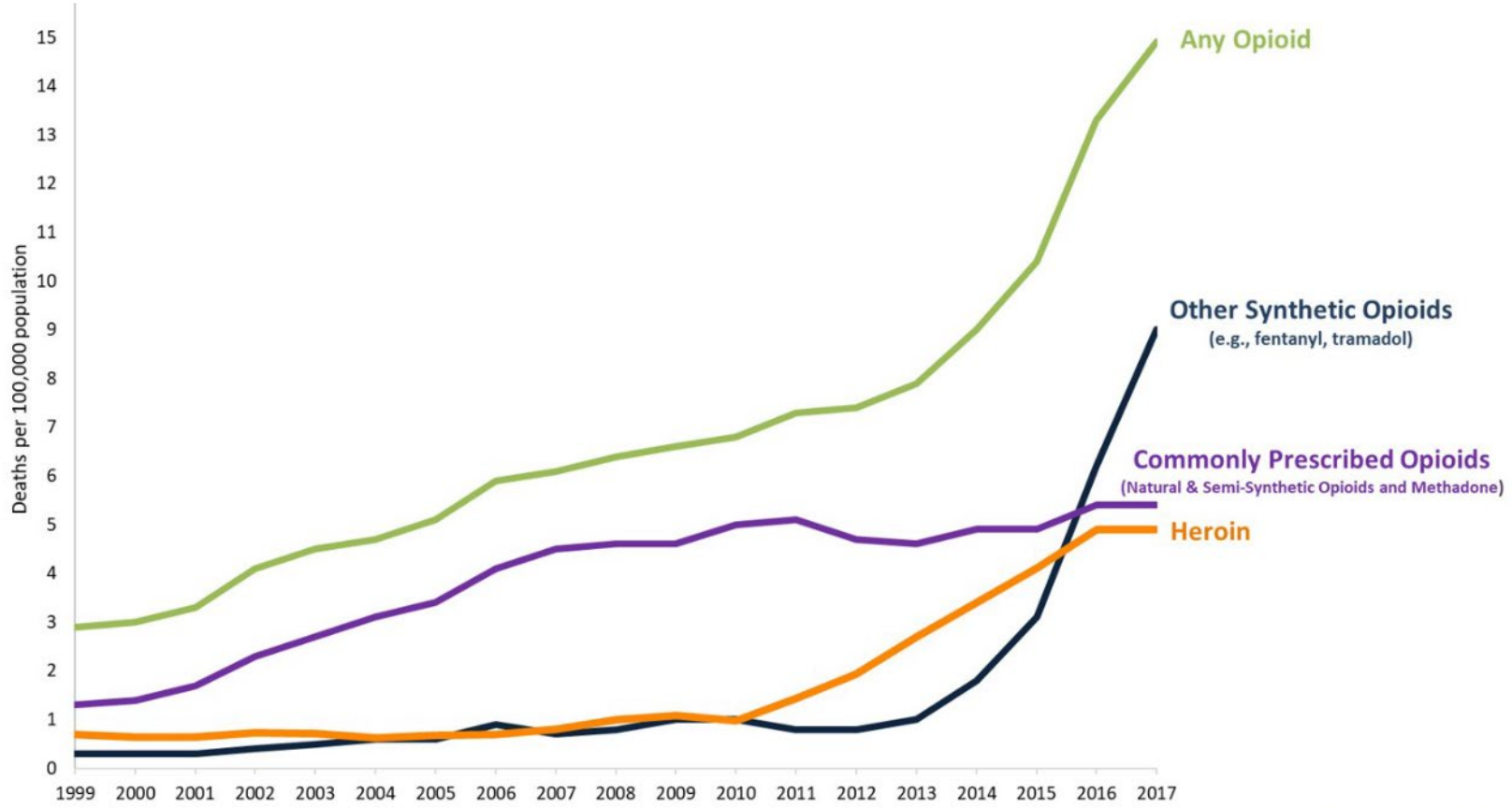
Clinical focus	• Primarily medical issues • Chronic disease • End-of-life care • Health and wellness	• Primarily physical injuries • Pain management and use of opioids • Manage the immediate need and close claim • Return claimant to work
Opioid analgesic spend	**~2.8% of total drug spend**	**~22.3% of total drug spend**

Overdose death rates involving opioids by type, United States 2000-2017



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2018. https://wonder.cdc.gov/.

www.cdc.gov
Your Source for Credible Health Information

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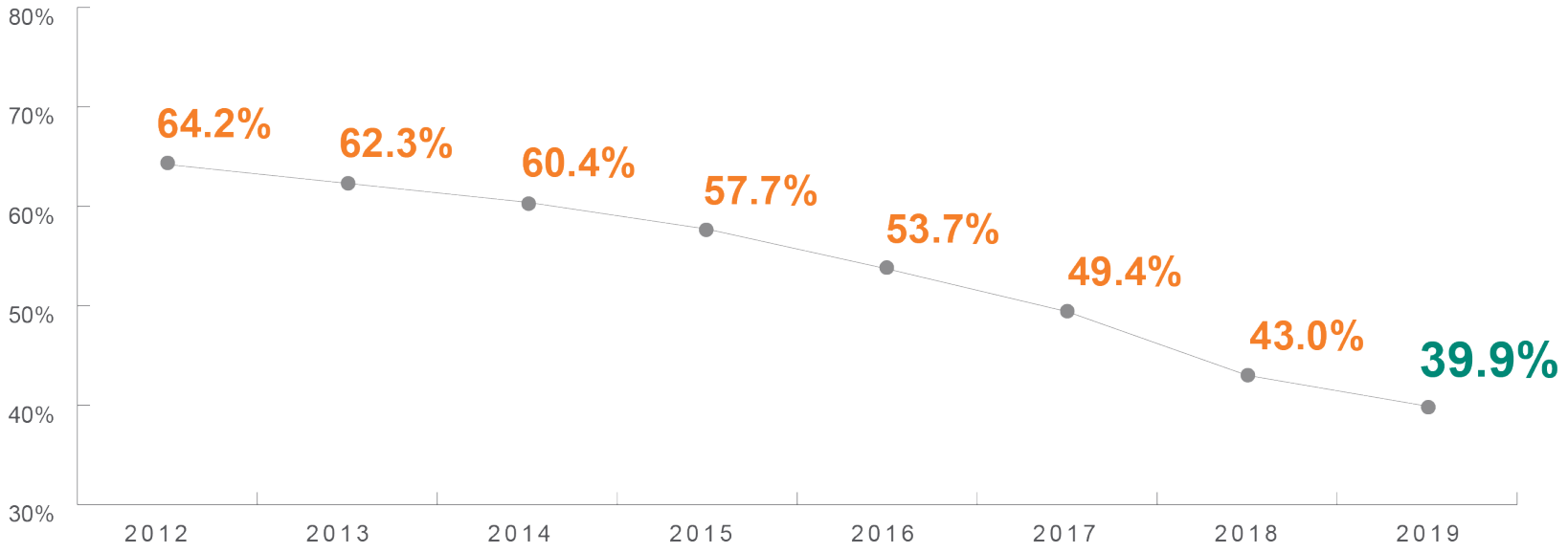
Percentage of injured workers with opioid scripts



Source:
Optum Workers' Comp and Auto No-Fault book of business 2019 trend data

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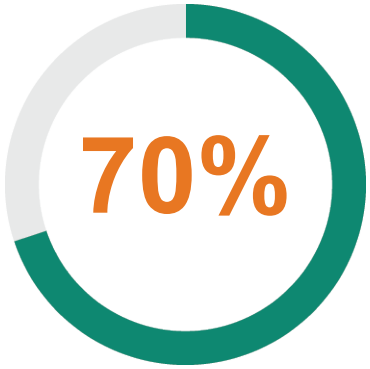
Opioid analgesics are shockingly easy to obtain

of U.S. citizens have leftover opioids in their home



of misused opioid prescriptions come from a friend or relative

of patients who overdose receive an opioid prescription within 10 months

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Several key differences between GH and WC

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Benefit structure	• Defined benefit plan • Varying levels of coverage • Eligibility determined prospectively • Closed network • Program costs often at PMPM • Copay/co-insurance/out of pocket costs	• Undefined benefit plan • 100% medical cost coverage • Eligibility determined retrospectively • Open network • Program costs at a claimant level • No copay
Clinical focus	• Primarily medical issues • Chronic disease • End-of-life care • Health and wellness	• Primarily physical injuries • Pain management and use of opioids • Manage the immediate need and close claim • Return claimant to work
Opioid analgesic spend	~3% of total drug spend	~35% of total drug spend
Characteristics	• Health care reform • Mandated benefits • **Administrative efficiency** • Utilization management	• **Opioid analgesic use and diversion** • Limited ability to direct care • Increasing severity of injuries • Network / utilization management

Several key differences between GH and WC

	GROUP HEALTH	WORKERS' COMPENSATION
Health care spending	~$3 trillion	~$30 billion
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Clinical focus	• Primarily medical issues • Chronic disease • End-of-life care • Health and wellness	• Primarily physical injuries • Pain management and use of opioids • Manage the immediate need and close claim • Return claimant to work
Opioid analgesic spend	~3-5% of total drug spend	35% of total drug spend
Characteristics	• Health care reform • Mandated benefits • Administrative efficiency • Utilization management	• Opioid analgesic use and diversion • Limited ability to direct care • Increasing severity of injuries • Network / utilization management
Regulatory dynamics	• **Federal government influences** • Uncertainty due to health care reform	• **State-based legislation and direction** • Approved guidelines and formularies

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Case studies combining GH and WC data

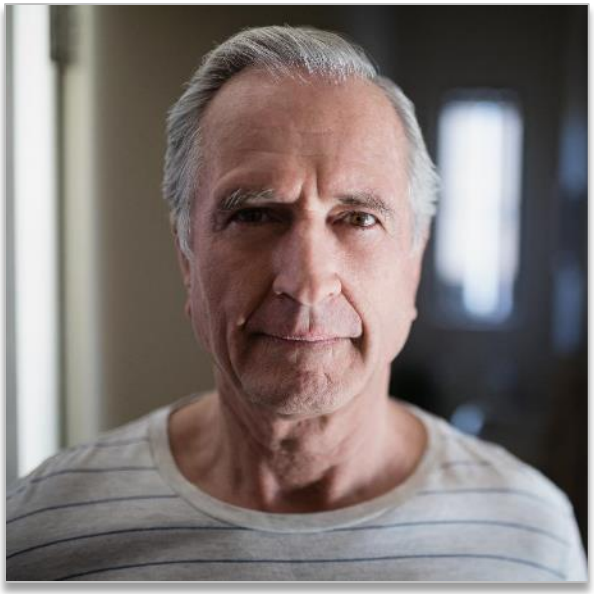
OPTUM®

Case study 1

A 65-year-old-male with a date of injury ten months ago.

Fracture to his right femur and ribs also resulting in pain in his back and lower extremities.

Pre-existing co-morbidities:
Diabetes mellitus, hyperlipidemia, hypertension, GERD, osteoarthritis of the left knee, and insomnia.



Upon discharge from the hospital, the following medications were filled for a 30-day supply:

- Cyclobenzaprine 10 mg tab #90 - Dr. Smith
- Fentanyl 12 mcg patch #4 (MED=45) - Dr. Smith
- Oxycodone 5 mg tab (MED=225) - Dr. Smith
- Trazodone 50 mg tab #15 - Dr. Copeland
- Sertraline 25 mg tab #90 - Dr. Copeland
- Ondansetron 4 mg ODT #180 - Dr. Smith
- Atorvastatin 40 mg tab #30 - Dr. Patel
- Atenolol 100 mg #30 - Dr. Patel
- Gabapentin 600 mg tab #90 - Dr. Copeland
- Omeprazole 40 mg cap #30 - Dr. Copeland
- Zolpidem 10 mg tab #30 – Dr. Patel
- Diclofenac/cyclobenzaprine/gabapentin/ketamine/bupivacaine compounded pain cream #120 - Dr. Copeland

Focus and concerns for Case 1

GROUP HEALTH

- Effects on pre-existing conditions
- Support/caregiver
- Nutrition/weight management
- Diabetes management
- Verify if ACEI/ARB had been trialed for hypertension or if contraindicated
- Indication for gabapentin
- Pain management
- Omeprazole, advanced age and recent fracture
- Appropriateness/continued need for several Beers Criteria medications
- Dose appropriateness of medications
- Adverse effects from medications
- Coordination of care between multiple providers

Focus and concerns for Case 1

GROUP HEALTH	WORKERS' COMPENSATION
• Effects on pre-existing conditions • Support/caregiver • Nutrition/weight management • Diabetes management • Verify if ACEI/ARB had been trialed for hypertension or if contraindicated • Indication for gabapentin • Pain management • Omeprazole, advanced age and recent fracture • Appropriateness/continued need for several Beers Criteria medications • Dose appropriateness of medications • Adverse effects from medications • Coordination of care between multiple providers	• Pre-existing vs. compensable conditions • Compound prescribed for injury or pre-existing osteoarthiritis? • Gabapentin prescribed for diabetic peripheral neuropathy or neuropathic pain related to the injury? • Coordination of care (multiple providers) • Physician dispensed medications • Opioid use and provider knowledge of opioid treatment guidelines • Use of appropriate non-pharmacologic therapy

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Case study 2

A 29-year-old-male with a crush injury to his finger/hand resulting index finger amputation 11 months ago.

Prescribed medications:

- Oxycodone 5mg #120
- Alprazolam 0.5mg #14
- Lisinopril 20mg #30

Initially, the adjuster approved the Lisinopril following discharge from the hospital. Upon further review, the Lisinopril was prescribed for hypertension that was not diagnosed until the claimant was seen for the injury sustained to his finger/hand.

Additional information:

- Healthy adult that did not frequent a physician office
- No routine physicals
- He did not know how to access his group health benefits

Focus and concerns for Case 2

GROUP HEALTH CLAIM

- Chronic disease management – blood pressure monitoring, medication adherence
- Establishing primary care, routine health checks
- Support system/caregiver
- Initial wound care
- Behavioral health needs
- Coordination of care for needs associated with crush injury/plan exclusions

Focus and concerns for Case 2

GROUP HEALTH CLAIM	WORKERS' COMPENSATION CLAIM
• Chronic disease management – blood pressure monitoring, medication adherence • Establishing primary care, routine health checks • Support system/caregiver • Initial wound care • Behavioral health needs • Coordination of care for needs associated with crush injury/plan exclusions	• Compensability of Lisinopril and HTN • Long term use of benzodiazepines and opioids • Use of appropriate non-pharmacologic therapy • Return to work timeline

Case study 3

A 59-year-old-female with a knee injury six months earlier. Increasing doses of opioids were noted on the claim after a period of stable short acting opioid doses (three times daily). Requests for long acting opioids were received but there had been no recent surgery or known aggravation to injury to suggest the need for such a change.

Medication Regimen:

- Hydrocodone/APAP 10/325 mg #90
- Docusate sodium 100 mg #30
- Diclofenac Gel 1% #100 gms

Requested Medications – awaiting authorization or denied

- Ibrance 125 mg #21
- Zoledronic Acid 4 mg - IV
- Fentanyl 25 mcg TDM #10

Review of the medical records indicated the claimant had been diagnosed with breast cancer that had spread to her liver, bones and brain. Increasing pain complaints were determined to be due to her cancer progression, not her knee injury.

Following discussion with the provider, the pain medications were transitioned to her oncologist and group health benefits due to the etiology and progression of the pain.

Focus and concerns for Case 3

GROUP HEALTH CLAIM

- Ibrance
  - specialty medication
  - confirm indicated for type of cancer and cancer stage, appropriate adjunct medications prescribed
  - Tiered medication, adherence and lower tier formulary alternatives if applicable
- Complications of malignancy – treatment plan verification. Confirm cancer responsive to treatment or progressed to palliative care
- Adverse effects of medication/toxicity
- Nutritional needs
- Pain management
- Patient support system, emotional well being for patient and family/care givers
- Short term/long term disability benefits, availability of catastrophic illness health benefits
- Advanced directives, end of life care

Focus and concerns for Case 3

GROUP HEALTH CLAIM	WORKERS' COMPENSATION CLAIM

• Ibrance
  • specialty medication
  • confirm indicated for type of cancer and cancer stage, appropriate adjunct medications prescribed
  • Tiered medication, adherence and lower tier formulary alternatives if applicable
• Complications of malignancy – treatment plan verification. Confirm cancer responsive to treatment or progressed to palliative care
• Adverse effects of medication/toxicity
• Nutritional needs
• Pain management
• Patient support system, emotional well being for patient and family/care givers
• Short term/long term disability benefits, availability of catastrophic illness health benefits
• Advanced directives, end of life care
	• Compensability of increased opioid doses
	• Providing care convenient to patient
	• Continued definition of what is cancer related vs. injury related (anti-emetics, pain therapy, etc)
	• Overall claimant well being

Combining GH and WC data

Benefits of combining group health and workers' comp information

1. Focus on the whole patient and their medical and prescription history
2. Achieve faster return to work and/or a better quality of care for the patient
3. Build stronger relationship with the client
4. Foster engagement with prescriber
5. Identify and reduce fraud, waste, and abuse issues, and take appropriate action
6. Enhance the client's pharmacy program
7. Apply correct benefit at onset, reduces subro or dispute of responsible entity

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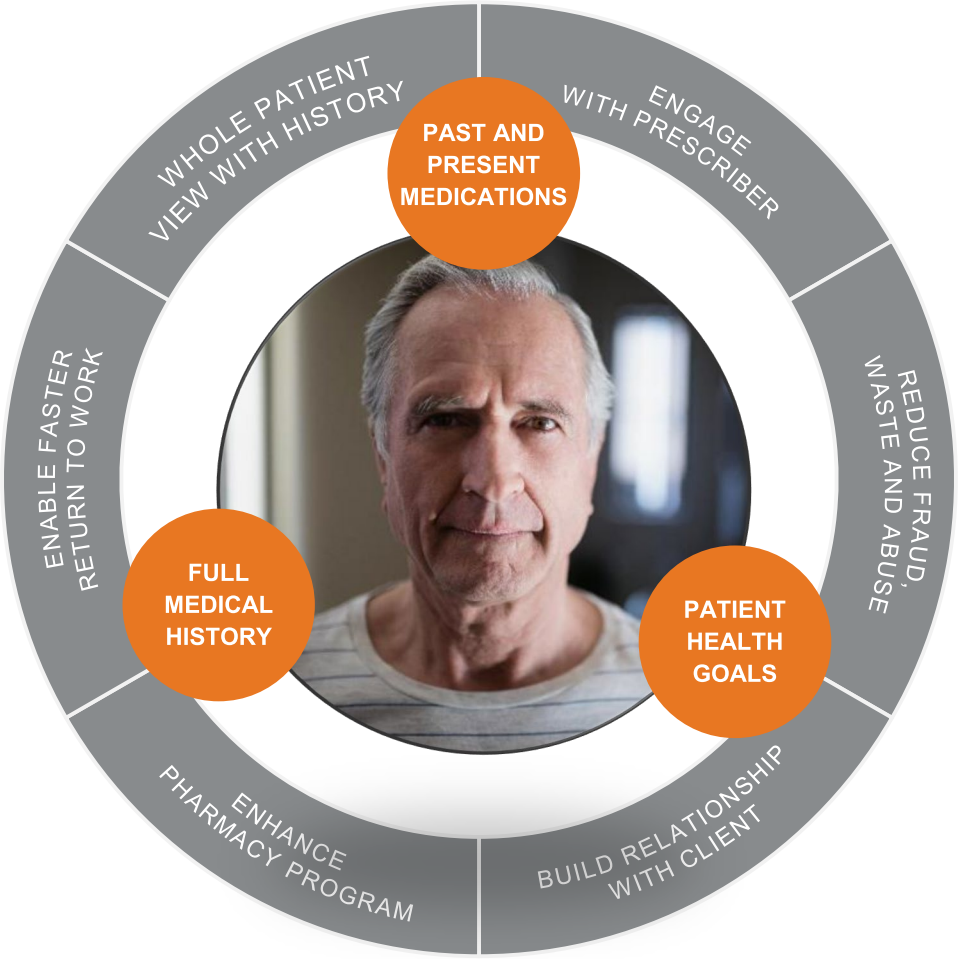
A holistic health approach to improves the safety and efficacy of care



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