Oral Statement of John W. Ruser
President and CEO
Workers Compensation Research Institute, Cambridge, MA
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Thank you Chairman Cox, Minority Chairman Harkins and members of the House Committee on Labor and Industry for inviting me to talk about some research of the Workers Compensation Research Institute. My name is John Ruser and I am the President and CEO of the Workers Compensation Research Institute or WCRI. WCRI is a not-for-profit public policy research organization located in Cambridge, MA. We provide information to all stakeholders in the various state workers' compensation systems. That information is regularly used in public policy debates. Importantly, WCRI does not take positions on policy nor do we make policy recommendations. We just provide the facts, so that stakeholders can make informed decisions about possible workers' compensation reforms.

Today, I'm going to talk about prescriptions in the Pennsylvania workers' compensation system. I'm going to focus on two aspects. One is the impact of House Bill 1846, which was designed to limit physician dispensing of drugs. The other is trends in prescriptions and the landscape of prescriptions as of the most recent time period for which we have data, that is, the first quarter of 2018.

Let me begin by discussing the regulation of physician dispensing generally and then focus on Pennsylvania. There are two broad approaches that states have implemented to controlling physician dispensing of drugs. These two approaches are price-focused reforms and limiting reforms. Under price-focused reforms, physician-dispensers may dispense drugs, but only at a price related to the average wholesale price of the original National Drug Code or NDC of the drug. Limiting reforms limit the types of drugs that physicians can dispense or limit the dispensing to short time periods.

A number of states, including California and Illinois, regulated physician dispensing by means of price reforms. A WCRI study, *A Multistate Perspective on Physician Dispensing, 2011-2014,* found that after these reforms, physicians dispensed fewer prescriptions, but physician dispensing was still common. The study also found that the prices paid to physicians for common drugs decreased substantially after the reforms in most states. However, we observed increased physician dispensing of higher-priced new strengths and a new formulation in several states, driving up physician prices for several common drugs.

In contrast to the reforms in other states, Pennsylvania's HB 1846, which was effective at the end of 2014, combined both price and limiting reforms. Under the bill, reimbursement cannot exceed 110 percent of the average wholesale price of the original manufacturer's National Drug Code used in the repackaging process. That is the price regulation component of the bill.

In addition, the bill stipulated that there would be no reimbursement to a physician for dispensing over-the-counter strength drugs, while physician dispensing of DEA schedule II drugs, such as Vicodin and Percocet, was limited to a short fill, and physician dispensing of all other prescription strength drugs was limited to a 30-day supply. These were limiting reforms.

At the request of the Pennsylvania Workers' Compensation Advisory Council, WCRI conducted a study of the impact of HB 1846. We compared prescription data for 2 years before the bill became effective, that is, 2013 and 2014, to the 2 years afterwards, that is, 2015 and 2016. We looked at prescriptions filled each year that were filled within the first two years after the injury.

What we found was that fewer prescriptions were dispensed by physicians after the bill became effective and the prices paid to physicians dropped after the reforms went into effect. Please refer to Figure 1. One in 3 prescriptions were physician dispensed pre-reform, while only one in ten prescriptions were physician dispensed after the reform. Further, physician dispensing accounted for around 50 percent of prescription drug costs before the reform, but only 4 percent after the reform. Finally, prices paid to physicians for common drugs decreased by 15 to 81 percent after the reforms.

Looking beyond just physician dispensing, we found that fewer prescriptions overall were dispensed after the reform and drug costs per worker decreased among Pennsylvania injured workers receiving medical care. However, the emergence of some new pharmacies moderated the price reductions from the physician dispensing reforms. These new pharmacies disproportionately dispensed expensive compound drugs, over-the-counter topical analgesics, and new-strength drugs.

Compound drugs are created by mixing individual ingredients together, generally topical creams. Focusing specifically on compound drugs, we saw that the share of prescription costs accounted for by these drugs quadrupled around the time of the physician dispensing reforms. See Figure 2. Compound drugs were only 8 percent of all prescription payments in 2013. That share increased to 43 percent in 2015 before dropping back to 31 percent in 2016. The growth in compounding was fueled by the new pharmacies that dispensed compounds more frequently than existing pharmacies. Importantly, data that I will mention shortly indicate that compounding is no longer a significant share of prescription costs.

Our report on physician dispensing stopped with 2016 data. It is important to know what has happened in Pennsylvania since that time. The data I am going to present to you now are unpublished and preliminary. I am reporting them to give you the most up-to-date picture that I can of prescription drugs in the Pennsylvania workers' compensation system and to provide some comparisons to other states.

We measured prescription payment shares for groups of drugs for prescriptions filled each quarter within the first three years postinjury. We measured the payment shares quarterly from the last quarter of 2014 to the first quarter of 2018, the last quarter for which we currently have data.

Over this time period, there was a change in which drug group had the highest share of prescription payments. While compounds had a high share of all prescription payments early in the time period, that share has dropped substantially in recent quarters. As of the first quarter of 2018, compounds accounted for 7 percent of all prescription payments. And the recent Pennsylvania experience with compounds is not unique. Compounding has dropped in all states where it accounted for a significant share in past years.

As compounds began to decline, the share of all payments accounted for by dermatologicals began to increase. Dermatologicals include both prescription and over-the-counter strength

products, including Lidoderm, Lidopro, Terocin, Pennsaid, among others. In the fourth quarter of 2015, when compounds were at their peak, dermatologicals accounted for 10 percent of all drug payments. That share increased over the next couple of years, and dermatologicals have continued to have the highest payment share of any drug group since 2017. In the most recent quarter, dermatologicals were one third of all prescription payments. These dermatologicals are often dispensed by the new pharmacies that previously engaged in dispensing compounds.

Like its experience with compounding, Pennsylvania's experience with dermatologicals is not unique. Dermatologicals account for a growing share of drug payments in a number of states, most notably Delaware. In our data, we see that dermatologicals accounted for more than 20 percent of prescription payment shares in 11 of 27 study states in the first quarter of 2018.

Pennsylvania and many other states have been taking steps to reduce the dispensing of opioids both in workers' compensation and in the general health system. These steps are reflected in the declining shares of payments for opioids in all 27 states that we studied, including Pennsylvania. In Pennsylvania, opioids accounted from 16 to 17 percent of all prescription payments in the first half of 2015; that share dropped to 10 to 11 percent in the first half of 2018.

In sum, HB 1846 substantially reduced physician dispensing, but new pharmacies appeared coincident with the bill that first dispensed compounds and now often dispense dermatologicals. In the most recent data available to us, dermatologicals account for the highest share of prescription payments, while the payment share for compounds has dropped substantially. The payment share for opioids has also dropped, reflecting measures to control opioid prescribing.

Thank you to the Committee for this opportunity to share our research findings.

I look forward to addressing your questions.

Figure 1.

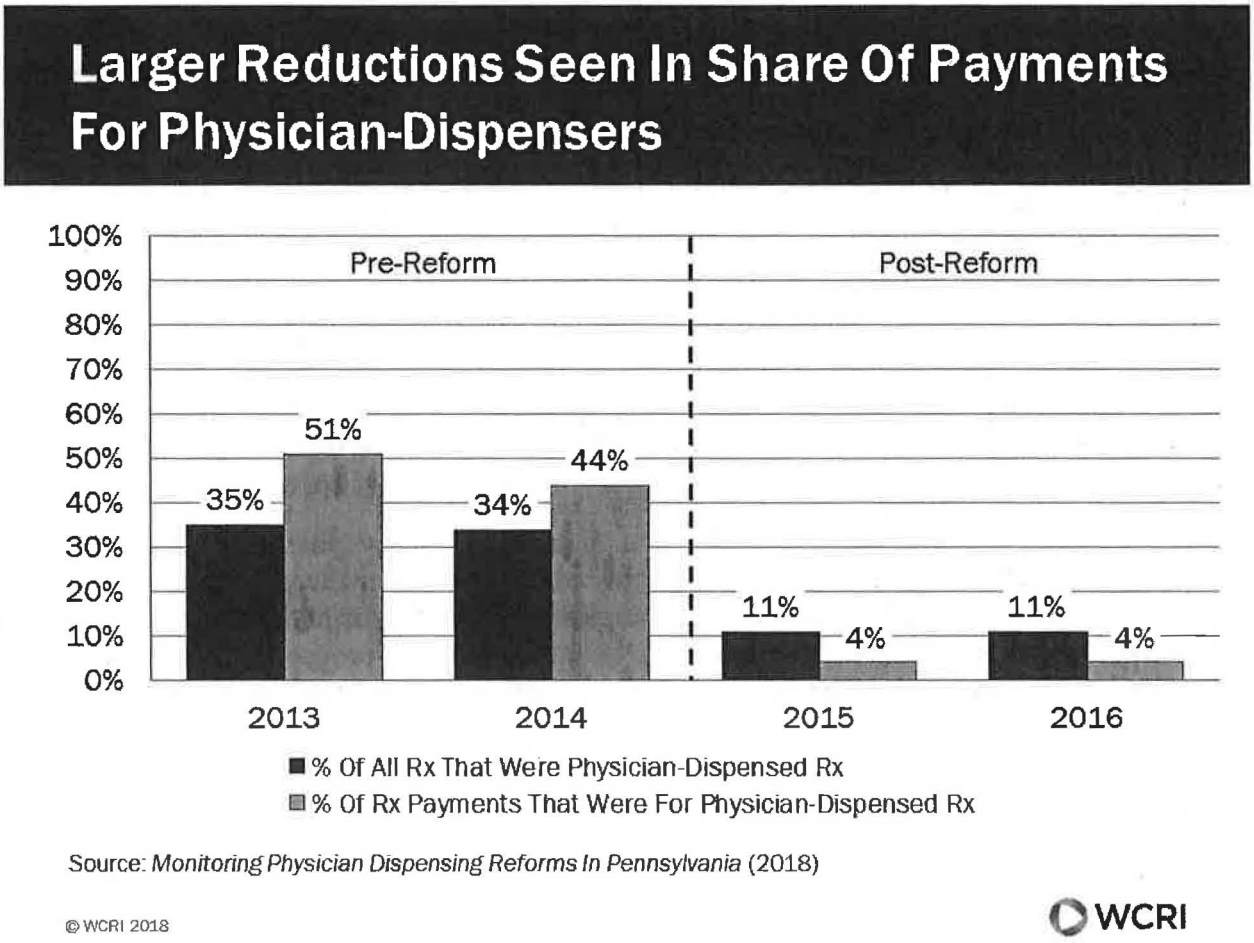
Larger Reductions Seen In Share Of Payments For Physician-Dispensers
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Pre-Reform
Post-Reform
35%
51%
34%
44%
11%
4%
11%
4%
2013
2014
2015
2016
% Of All Rx That Were Physician-Dispensed Rx
% Of Rx Payments That Were For Physician-Dispensed Rx
Source: Monitoring Physician Dispensing Reforms In Pennsylvania (2018)
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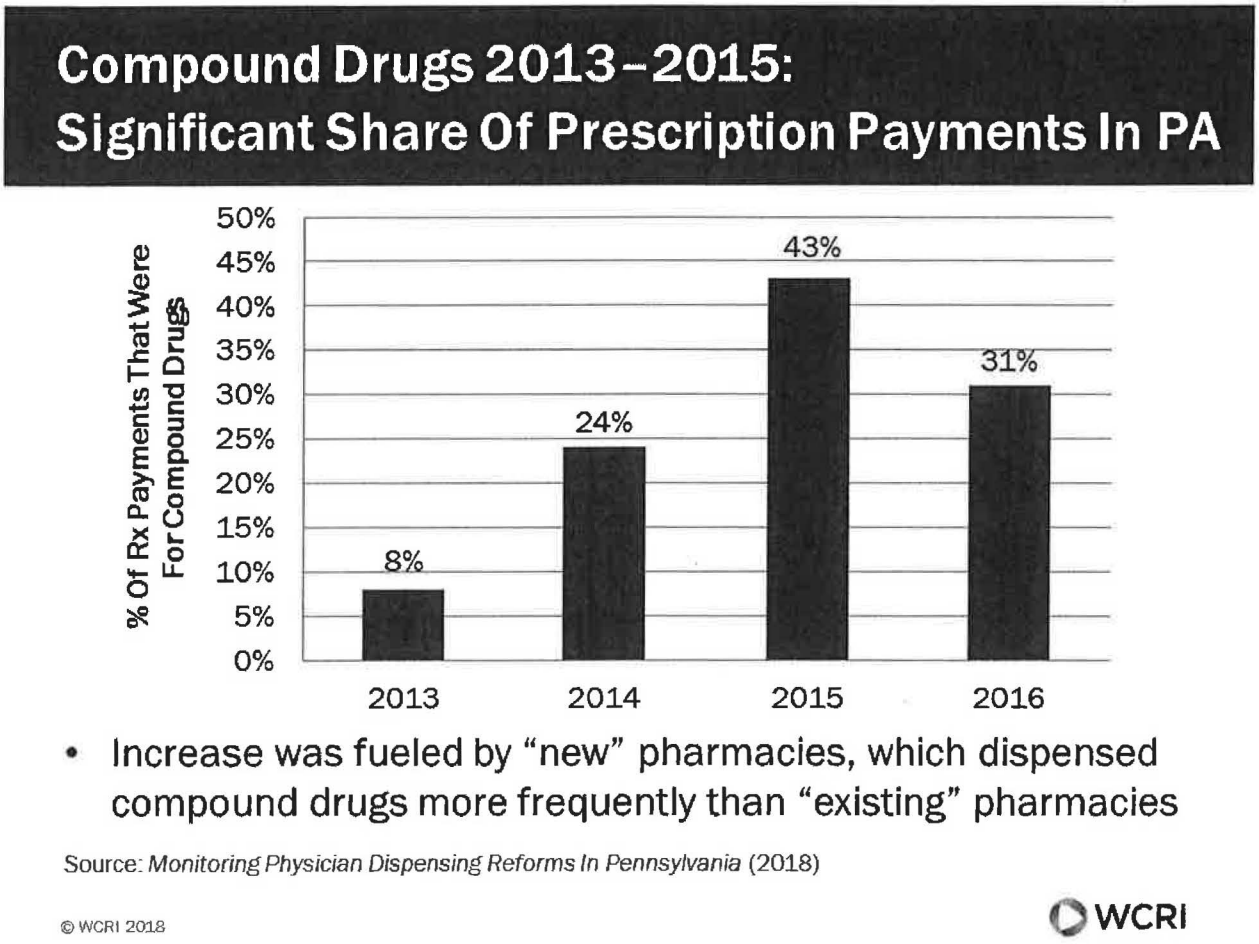
Figure 2.


Compound Drugs 2013–2015:
Significant Share Of Prescription Payments In PA
% Of Rx Payments That Were For Compound Drugs
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
8%
24%
43%
31%
2013
2014
2015
2016
• Increase was fueled by "new" pharmacies, which dispensed compound drugs more frequently than "existing" pharmacies
Source: Monitoring Physician Dispensing Reforms In Pennsylvania (2018)
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