

Methods Currently Being Utilized to Calculate Part D Prescription Drug Costs in MSA Allocations

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CMS Memorandum States the following:

All workers' compensation settlements "that occur on or after January 1, 2006, must consider and protect Medicare's interests when future treatment includes prescription drugs along with the future medical services that would otherwise be reimbursable by Medicare."

CMS Memo December 30, 2005

Beginning January 1, 2006 CMS requires that the following be submitted

- Cover letter identifying separate amounts for:
 - 1) future medical treatment
 - 2) future prescription drug treatment
- Explanation as to how the submitter calculated the future prescription drug treatment amount.

CMS Memo December 30, 2005

“If the cover letter does not include an amount for future prescription drug treatment, and the current treatment records indicate that the claimant has been prescribed drugs and/or may need prescription drugs related to the WC injury in the future, the submitter did not adequately consider Medicare’s interests.”

July 24, 2006

CMS Directive States the following:

CMS will provide in its written opinion the total WCMSA amount that adequately protects Medicare's interests with regard to the claimant's future medical treatment.

However, CMS' written opinion will also note the submitted prescription drug amount. The CMS' written opinion will provide the total WCMSA amount, which is a combination of the future medical treatment reviewed by CMS and the future prescription drug costs noted in the submitters cover letter.

The parties to the WC settlement must note the total WCMSA amount in the final settlement agreement. Once the final settlement agreement is submitted to CMS' COBC, the claimant and all other parties to the WC settlement can rely on CMS' written opinion regarding whether the WC settlement adequately protects Medicare's interests. (Walters, July 2006)

Current CMS MSA Approval Letter language

You proposed that a WCMSA in the amount of \$_____ be available for the purposes of paying for future medical services related to the work injury or disease that would otherwise be reimbursable by Medicare. We *note* that an amount of \$_____ was submitted for future prescription drug treatment.

We have evaluated your proposal to protect Medicare's interests with a WCMSA for future medical expenses related to (claimant's) work injury or disease. We have determined that \$_____ which is a combination of the *reviewed* future medical treatment and the future prescription drug costs that are *noted* in the submitted cover letter, adequately considers Medicare's interests.

Impact of the December 30, 2005 Memorandum

The directive has impacted workers' compensation settlements nationwide

- Future injury related prescription drug treatment otherwise covered by Medicare Part D must now be included in Medicare Set-Aside allocation - even if the claimant is not enrolled in a Part D program
- Increase in MSA Allocation amounts
- Increase in difficulty when settling WC claims

Inclusion of Future Prescription Drug Costs

- CMS has not published guidelines regarding the pricing mechanism that should be used to calculate future Medicare Part D covered prescription drug costs in MSAs
- Guidelines were expected January 1, 2007 but not issued
- The WCRC is not currently reviewing or independently pricing future prescription drug costs
- CMS states it will provide advanced notification when it plans to independently price future Part D drug costs

In the absence of specific policy, professionals have struggled with the most appropriate mechanism to contain the cost of future prescription drugs while still reasonably considering Medicare's interests

Methods being Utilized in the MSA Industry Today

- Cost Calculation Options
- Use of Generic Substitutions
- Pharmacy Utilization Review
- MSA Reduction by Medicare Part D Co-payments & Deductibles
- Other Mechanisms

It is unknown if CMS policy, when issued, will support the use of these methods

Cost Calculation Methods

Injury related prescription drug costs otherwise covered by
Medicare Part D may be calculated at:

- Average Wholesale Price
- Actual Charges
- Another selected method

Cost Calculation Methods

Average Wholesale Price (AWP)

- Intended to represent the average price at which wholesalers sell drugs to physicians, pharmacies, and other customers
- Typically derived from self reported manufacturer data for both branded and generic drugs
- AWP under significant scrutiny due to allegations of manufacturer overcharging for drugs by artificially inflating AWP
 - Bristol-Myers Squibb ordered to pay \$13 Million in June 2007 to resolve a class action law suit filed on behalf of consumers who made co-payments under Medicare Part B for BMS' cancer drugs

Cost Calculation Methods

Actual Billed Amount

- The amount actually billed to, and paid by, the primary payer
- Determined by reviewing the primary payer's medication claim payment ledger
- Enables payers who have negotiated discounted network rates below the WC reimbursement rate and AWP to utilize these rates in calculation of the future prescription drug component of the MSA

Cost Calculation Methods

Workers' Compensation Reimbursement Rate

- The rate determined by WC statute in the state of claim jurisdiction
- Generally a calculation from AWP (+/-)
- Typically higher than the AWP, with some exceptions (CA)

Cost Calculation Methods

Lowest Attainable Cost

- Involves a search for the lowest cost at which a particular drug can be attained
- Search can be limited to a claimant's geographical location or may include suppliers who deliver by mail to the claimant's location
- Some national pharmacy networks now offer discounted pharmacy programs to claimants for use with MSA accounts post settlement

Generic Substitutions

- Brand-name drugs are substantially more expensive than generic equivalents
- When utilizing this method, brand name drugs are substituted with generic equivalents whenever available

Pharmacy Utilization Review

- Utilized in cases that appear to fall outside standard practice guidelines without documented justification
- Independent licensed pharmacist will review medical records, prescription drug utilization and prescribing patterns paying close attention to the following:
 - Multiple drugs in same class
 - Use of contraindicated drugs
 - Potential drug interactions
 - Availability of less expensive alternatives
- May provide the necessary documentation to support the allocation projection

Reduction by Co-Payments & Deductibles

- The most controversial of the methods used when projecting Part D Rx drug costs in MSAs
- Customers often have internal protocols regarding the use of this method
 - Use on all cases
 - Use not permitted on any case
 - Cases with certain dollar thresholds for Rx drugs
 - Use at claims discretion as needed

Reduction by Co-Payments & Deductibles

Argument for the use of the reduction method

- The MSA is for injury related medical and prescription drug expenses that are otherwise covered by Medicare, therefore co-payments and deductibles should not be included in the MSA since this amount is not otherwise covered by Medicare
- More defensible than other methods currently being used (arbitrary cut off, “mini MSA” with limited future projection period)
- If the claimant exhausts the funds in the MSA account and turns to Medicare Part D for coverage, the claimant will be required to pay the Medicare co-payments and deductible amounts from the non-MSA funds. If the co-payment and deductible amounts are included in the MSA funds, the claimant would not have these funds available for co-payments and deductibles.
 - This applies to cases where the MSA is funded via a structure with annual payments that may result in a temporary depletion situation

Reduction by Co-Payments & Deductibles

Argument opposing the use of the reduction method

- CMS has not historically allowed future Medicare Part A and B medical costs to be reduced by co-payment and deductible amounts and therefore it is anticipated that CMS will not support this method when policy is issued
- This method may complicate administration if CMS determines the claimant must utilize the non-MSA funds to pay the equivalent of the Part D deductible and co-payments each year before the MSA funds can be utilized for Part D Rx drug costs
- If CMS does not allow this method when policy is made, MSA cases in the submission pipeline may be significantly increased

2008 Part D Annual Deductibles and Co-Pays At a Glance

- a. \$275 deductible
 - Deduct 100% of the first \$275 of Rx costs

- b. 25% co-pay
 - Deduct 25% of annual RX costs between \$275 -\$2,510
 - Maximum deduction is \$558.75

- c. 100% co-pay (*donut hole*)
 - Deduct 100% of annual RX costs between \$2,510-\$5,726.25
 - Maximum deduction is \$3,216.25

- d. 5% co-pay
 - Deduct 5% of annual RX costs over \$5,726.25
 - No Maximum

Utilizing Co-Pays & Deductibles in MSA Allocations

Case Example

- CL has a 10 year life expectancy
- CL has future Part D costs of \$58,000
- Applying the co-pay and deductible formula

Sample Reduction Using Co-Payments & Deductibles

The example case below involves a claimant with a 10 year life expectancy and future Part D costs of \$58,000

Step 1 - Calculate the total estimated future prescription drug costs otherwise covered by Medicare for the claimant's life expectancy (or commutation period if less than life expectancy)

- \$58,000

Step 2 - Divide the total estimated prescription drug cost in Step 1 by the life expectancy to obtain the annualized prescription drug cost

- \$58,000 total Rx drug cost divided by 10 year life expectancy = \$5,800

annualized cost

Step 3 - Calculate the total annual deduction allowance in each coverage category as shown on the following slide

Coverage Category	Formula	Example of annual deductions in a case with annual Rx drug costs of \$58,000
a. Deductible	Deduct 100% of the first \$275 of annual Rx drug costs here (Maximum deduction of \$275)	\$275
b. 25% Co-pay	Deduct 25% of annual Rx drug costs between \$275 and \$2,510 (Maximum deduction of \$558.75)	\$558.75
c. 100% Co-pay	Deduct 100% of annual Rx drug costs between \$2,510 and \$5,726.25 (Maximum deduction of \$3,216.25)	\$3,216.25
d. 5% Co-Pay	Deduct 5% of all annual Rx drug costs over \$5,726.25 (No maximum deduction)	\$3.69 (5% of \$73.75)
Total Annual Deduction	Add deductions in coverage categories a-d to obtain total annual deduction	\$4,053.69

Sample Reduction Using Co-Payments & Deductibles

Step 4 - Subtract the total annual deduction allowance amount from Step 3 from the total annualized estimated drug cost from Step 2 to obtain the total adjusted annual drug cost amount

- \$5,800 minus \$4,053.69 = \$1,746.31

Step 5 - Multiply the total adjusted annual drug cost by the life expectancy to obtain the total drug cost of prescription drugs to be included in the MSA

- \$1,746.31 multiplied by 10 year life expectancy =
\$17,463.10

Sample Reduction Using Co-Payments & Deductibles

- Utilizing this method, the MSA Part D projection was reduced from \$58,000 to \$17,463.10
- Total reduction of \$40,536.90

Reduction Using Co-Payments & Deductibles

Showing the Math

- CMS has indicated that the submitter should indicate how the future Part D Rx costs were calculated
- Some submitters clearly show the amount of reduction taken and others do not
- CMS temporarily added the deductible and co-payment reductions back into to MSA Part D projections in cases where the reduction amount was disclosed causing significant push back from the industry. Currently, CMS has ceased this activity.

Other Methods

- Rated Age
- Professional Judgment
- Intervention with Prescribing Physician
- Exclusion of Drugs not Covered Under Medicare Part D

Mechanisms for Containing Future Prescription Drug Costs

Rated Age

- The reduction of a claimant's life expectancy through the use of a rated age can significantly reduce the number of years over which the Part D Rx drugs will be projected and thus, decrease the total MSA amount
- A rated age may be utilized whether or not the MSA will be funded by structured payments

Mechanisms for Containing Future Prescription Drug Costs

Professional Judgment

- Professionals completing MSA allocation projections should use their best professional judgment to project future prescription drug use with supporting documentation
- It is a generally accepted practice that if a definitive medical procedure, surgery, or treatment program is projected for the future, the assumption is that the procedure, surgery or program will be successful and the future medications are adjusted accordingly

Mechanisms for Containing Future Prescription Drug Costs

Intervention with Prescribing Physician

- Utilized when the anticipated future use of prescribed drugs is not apparent based upon review of the medical records
- May be appropriate to obtain this information in writing from the prescribing physician so that drugs are not projected over the entire life expectancy inappropriately
- Should not be utilized without express consent from the referral source

Mechanisms for Containing Future Prescription Drug Costs

Exclusion of Drugs not Otherwise Covered by Medicare

- The MSA allocation should only include future injury related Rx drugs that are otherwise covered by Medicare B or D
- Drugs covered under Part B are currently being reviewed by the WCRC (inhalants, injectibles)
- While inpatient drugs are not covered under Part D, Many inpatient drugs are covered under Part B
- Of the drugs excluded from Part D plans, barbiturates and benzodiazepines are the most common encountered in treatment of WC injuries

Mechanisms for Containing Future Prescription Drug Costs

The following drugs are excluded from Part D plans

- Drugs used for anorexia, weight loss, or weight gain
- Drugs used to promote fertility
- Drugs used for cosmetic purposes or hair growth
- Drugs used for the symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- **Non-prescription drugs**
- Inpatient drugs
- **Barbiturates & Benzodiazepines**

- Until CMS issues policy, it is unknown how many of the methods discussed will be accepted by CMS in the future
- Policy statements can be issued at any time
- Some feel use of some of these methods may be the only way to settle some WC claims

Examples of Barbiturates

- Amytal Sodium
- Butisol Sodium
- Luminal
- Luminal Sodium
- Nembutal Sodium
- Phenobarbital
- Seconal Sodium
- *Fiorinal* (Butalbital)
- *Fioricet* (Butalbital)
- ESGIC
- Bellaspas
- Bel-tabs
- Spastrin
- Eperbel-S
- Ergocaff-PB
- Mebaral
- Meridia
- Butisol Sodium

Examples of Benzodiazepines

- *Ativan (Lorazepam)*
- *Dalmane (Flurazepam)*
- *Valium (Diazepam)*
- Diastat
- Dizac
- Doral
- Estazolam
- Gene-xene
- *Halcion (Triazolam)*
- *Klonopin (Clonazepam)*
- Ceberclon
- *Librium (Chlordiazepoxide)*
- Midazolam HCL
- Niravam
- Oxazepam
- Paxipam
- Poxi
- Prosam
- Serax
- *Restoril (Temazepam)*
- Tranxene (Clorazepate)
- Versed
- *Xanax (Alprazolam)*

Questions?