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Workers Compensation
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Commissioner Thomas B. Considine
CEO
National Council of Insurance Legislators
2317 Route 34, Suite 2B
Manasquan, New Jersey 08736

Dear Commissioner Considine,

I am writing to address certain statements regarding WCRI data that are contained in the Maryland State Medical Society's (MedChi) resolution 5-18 that opposes NCOIL's Model Act regarding physician dispensing. The resolution states that "the work product of WCRI was totally discredited by the Maryland Workers' Compensation Commission" (MWCC) and "the full details of the Maryland Workers' Compensation Commission's repudiation of WCRI data may be found at www.physiciansresearchinstitute.org by clicking on 'Insurance Funded Studies.'"

The Physicians Research Institute (PRI) website raises the following as evidence that WCRI skewed conclusions and provided erroneous data regarding physician dispensing in Maryland.

> The WCRI "studies" maintained that doctor dispensing of medicines constituted 40 percent of all workers' compensation dispensed medicine and was rising. However, MWCC reported that doctor dispensing was 15.7 percent and was, in fact, declining. WCRI based its conclusions on a review of approximately 12 percent of all claims in any given year while MWCC reviewed 92 percent of all claims. In other words, WCRI had skewed its conclusions by limiting the claims it reviewed.

There are a couple of reasons why WCRI estimates of the frequency and cost of physician dispensing exceed those from MWCC:

1. Physician dispensing is more frequent earlier in a claim and the WCRI study focused on early claims experience. In the WCRI study that is the focus of the PRI website (*Physician Dispensing in the Maryland Workers' Compensation System*, WCRI study number WC-13-22, dated September 2013), we looked at claims occurring in a given year with on average 12 months of experience. That is, we looked at dispensing in the first year of a claim. The MWCC looked at the frequency of physician dispensing for all claims in a given calendar year, without regard to the year the claim originated. The MWCC data include substantially more mature claims experience with lower frequencies of physician dispensing.

2. The WCRI study included claims with more than 7 days away from work. The MWCC included all claims including many less severe ones.

Why did the WCRI study limit the claims in the way that it did? The main focus of the study was to make interstate comparisons of physician dispensing and so we strove to have a comparable set of claims in all of the states studied. We wanted to make apples to apples comparisons across the states. We frequently

examine only claims with more than 7 days away from work, both because these account for most of the system costs and as a way of controlling for the impact of differences across states in waiting periods for income benefits (7 days is the longest waiting period). Also, states differ in the distribution of maturities of claims. We hold constant those maturities by focusing on an average 12 months of experience.

PRI compares estimates produced from two sets of claims with very different scopes. When we replicated the data and methods used by the MWCC on the data used in our Maryland study, we estimated that 16.7 percent of prescriptions were dispensed at physicians' offices, in comparison to the MWCC estimate of 15.7 percent. Hence, when we use similar methods and scope restrictions on different data sets, we get similar results.

We conclude that the MWCC numbers are correct for what they describe and the WCRI numbers are correct for what they describe. Some may ask which approach produces more relevant numbers. The answer depends on what question is being asked. The MWCC approach may uncover a change in trend before the WCRI approach (if the underlying mix of cases does not change). The WCRI approach provides more meaningful interstate comparisons (which is our hallmark).

I would like to address a couple of other issues raised by the PRI website. One has to do with the coverage of data. The data used in the WCRI study came from payors in Maryland that represented 37 percent of the claims in the state workers' compensation system. In the study, which covers multiple years, we included 16,860 claims with more than seven days of lost time that had prescriptions filled and paid for by a workers' compensation payor, and we included more than 120,000 prescriptions received by these claims. The claims covered injuries from October 1, 2007 to September 30, 2011, and prescriptions filled through March 31, 2012. It is worth noting that difference in the sample sizes was not a material contributor to the different results between WCRI and MWCC—not surprising since statistically one gets only very small improvements in precision by increasing the sample size above the 37 percent level that WCRI used.

The PRI website places the WCRI study under "Industry Funded Research." WCRI funding comes from diverse membership—insurers, employers, state governments in the US, Canada, Australia, and New Zealand, as well as managed care companies and a growing number of organizations that advocate for injured workers. WCRI does not take positions on the issues it researches; rather, it provides information obtained through studies and data collection efforts, which conform to recognized scientific methods. Objectivity is further ensured through rigorous, unbiased peer review procedures.

Finally, the PRI website fails to mention another important finding in the WCRI report. For claims with injuries occurring from October 1, 2010 to September 30, 2011, and prescriptions filled through March 31, 2012, the prices paid to physician-dispensers were often more than double the prices paid for the same drugs dispensed at a pharmacy. For example, the average price per pill for Ibuprofen (brand name Motrin) was $0.57 when dispensed by a physician and $0.25 when dispensed at a pharmacy, a difference of 130 percent. In a more recent report (*A Multistate Perspective on Physician Dispensing, 2011-2014*, WCRI study number WC-17-30, dated July 2017), WCRI showed that the per-pill price differential in Maryland between physician- and pharmacy-dispensed generic drugs had narrowed substantially between service years 2011 and 2014, but that the differential still remained above 100 percent in 2014. WCRI has not updated the study to provide more recent results.

I hope this explains the different results obtained by WCRI and MWCC and clarifies that WCRI did not skew the data to provide a particular industry-desired finding.

I would also like to mention that while the focus of the PRI website was on WCRI's work on physician dispensing in Maryland, physician dispensing is frequent in a number of states. WCRI research has studied those other states and the impact of physician dispensing reforms that were implemented in some of them. A WCRI report showed, across 26 states, the percentages of prescriptions dispensed by physicians in 2014 for all medical claims with a date of injury within two years of the fill date (*A Multistate Perspective on Physician Dispensing, 2011-2014*). The highest percentage was 44 percent in Illinois, Florida, and California, while Maryland was fourth at 38 percent. In the three highest states, the percentage of total prescription payments for physician dispensed prescriptions was even higher, at 64 percent for Illinois, 58 percent for Florida and 54 percent for California.

A number of states have implemented price controls on physician dispensed drugs, capping the prices of these drugs at amounts tied to their average wholesale price. The WCRI study referenced in the previous paragraph showed that these reforms resulted in a decrease in the frequency of physician dispensing and a decrease in the physician share of prescription drug costs, with the exception of California, Florida, and Illinois. In these three states, the drop in frequency of physician dispensing was offset by new drug strengths and a new drug formulation that were dispensed by physicians at much higher prices.

Finally, recent WCRI research examined the impact of the 2014 Pennsylvania physician dispensing law that put in place both price controls and quantity limits for physician dispensing (*Monitoring Physician Dispensing Reforms in Pennsylvania*, WCRI report number WC-18-20, dated May 2018). This law resulted in a dramatic drop in the frequency and cost share of physician dispensed drugs. However, coincident with the enactment of the law, new pharmacies appeared in Pennsylvania that predominantly dispensed high-priced compound drugs and topical analgesics. It is unclear if the appearance of the new pharmacies was caused by the physician dispensing law or only coincident with it.

Please don't hesitate to contact me with any questions. Also, please feel free to share this letter as you deem appropriate.

Sincerely,

John W. Ruser, Ph.D.
President and CEO