



WORKERS COMPENSATION PRESCRIPTION DRUG STUDY 2008 UPDATE

KEY FINDINGS

In our previous report, we noted a significant slowdown in the growth of the prescription drug share of workers compensation (WC) medical costs for services provided in 2005. In this report, we see a continued leveling off of the prescription drug share on medical costs in WC through 2006. This slower growth is partly due to the fact that the previously popular Cox-2 inhibitor anti-inflammatory drugs Vioxx[®] and Bextra[®] were removed from the market in late 2004 and early 2005. Will this deceleration in WC prescription drug spending growth continue?

Other key findings:

- Remarkably, utilization has decreased two years in a row
- Removal of the anti-inflammatories Vioxx[®] and Bextra[®] is associated with a drop in the number of prescriptions per claim for claimants who had been getting these drugs; no single drug or handful of drugs stands out as an apparent replacement for Vioxx[®] and Bextra[®]
- The cost share of anti-inflammatories and analgesics dropped five points in the past two years
- Anti-inflammatories comprised 25% of prescription drug costs in 2003. Three years later, the share had fallen 10 percentage points
- Generic use in 2006, when generics were available, was 90%, up slightly from the previous year
- Without approvals of new generics, the maximum additional savings that can be realized from the use of generic equivalents is 12%

This study includes a new analysis of what drugs are replacing the Cox-2 inhibitors, and an expanded discussion of generic drugs.

Updates of prior analyses include:

- Estimates of the prescription drug share of total medical costs by injury year
- Changes in price, utilization, and cost
- Prescribing patterns

DRUG TRENDS IN GENERAL HEALTHCARE

Drug trends in WC are related to drug trends in general healthcare, and growth in spending on prescription drugs in general healthcare has slowed in recent years. The Center for Medicare & Medicaid Services (CMS) reports, as shown in Exhibit 1, that the rate of increase in drug spending for all payers (including Group Health and WC) dropped by almost half from an annual average of 14.0 percent for the period 1996-2003 to an annual average of 7.6 percent for the period 2003-2006 [1].

Annual Changes in National Prescription Drug Expenditures

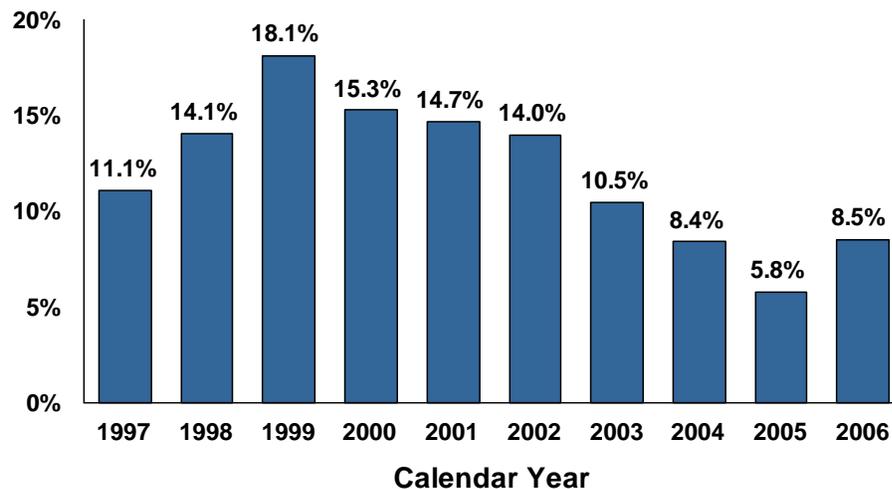


Exhibit 1

PriceWaterhouseCoopers [4] suggests several factors contributing to the recent slower growth in spending on prescription drugs:

- Introduction of fewer blockbuster drugs
- Some blockbuster drugs going off patent
- Transition of some drugs to over-the-counter status
- Acceptance of tiered formularies
- Lower rate of price growth

However, the CMS also reports that in 2006 growth in nationwide prescription drug spending for all payers accelerated for the first time in six years, from a growth rate of 5.8 percent in 2005 to 8.5 percent in 2006 (Exhibit 1). The CMS estimates that nearly half of this growth was due to increased use of prescription drugs as a result of:

- Coverage now available under Medicare Part D,
- New uses for existing drugs,
- Strong growth in several therapeutic classes of drugs, and
- Increased use of specialty drugs.

However, a higher generic dispensing rate in 2006 helped to contain further spending growth [1].

CMS [2] expects prescription drug spending growth to slow to 6.7 percent in 2007, primarily due to slower drug price growth, and accelerate from 2008 through 2017, driven by several factors including:

- A projected leveling off of growth in the generic dispensing rate,
- An expectation of new drugs continuing to come onto the market, and
- Evolving treatment guidelines that call for earlier introductions of pharmacotherapy.^(a)

It will be interesting to see whether these projections hold for WC as well.

STUDY DATA

The data used in this study is derived from claims for injuries that occurred from 1994 to 2006, and services provided from 1996 to 2006, evaluated as of July 1, 2007. The "prescription drugs" included in the data are all drugs identified with a National Drug Code (NDC) or with a carrier specialized drug code. Therefore, not all WC drug costs are included in this study (e.g., we are not able to include drug costs that were bundled with other services and included in codes such as Hospital Revenue Codes, Healthcare Common Procedure Code System (HCPCS), or Current Procedural Terminology (CPT)).

DISCUSSION OF FINDINGS

Trends in the Prescription Drug Share of WC Total Medical Costs

Exhibits 2 and 3 show that up to Service Year 2004, the share of prescription drug dollars within total medical costs for all relative service years increased steadily (service year 2004 is the third point from the right in each line). In Exhibit 2, the first five relative service years, this share declined slightly in Service Year 2005 and has remained relatively flat in Service Year 2006.

One force behind the decline is the removal of Vioxx[®] and Bextra[®] from the market along with a decreased use of Celebrex[®]. These anti-inflammatory drugs were/are used most often in the early years of treatment.

Is the Prescription Drug Share of Total Medical Costs Stabilizing in WC?

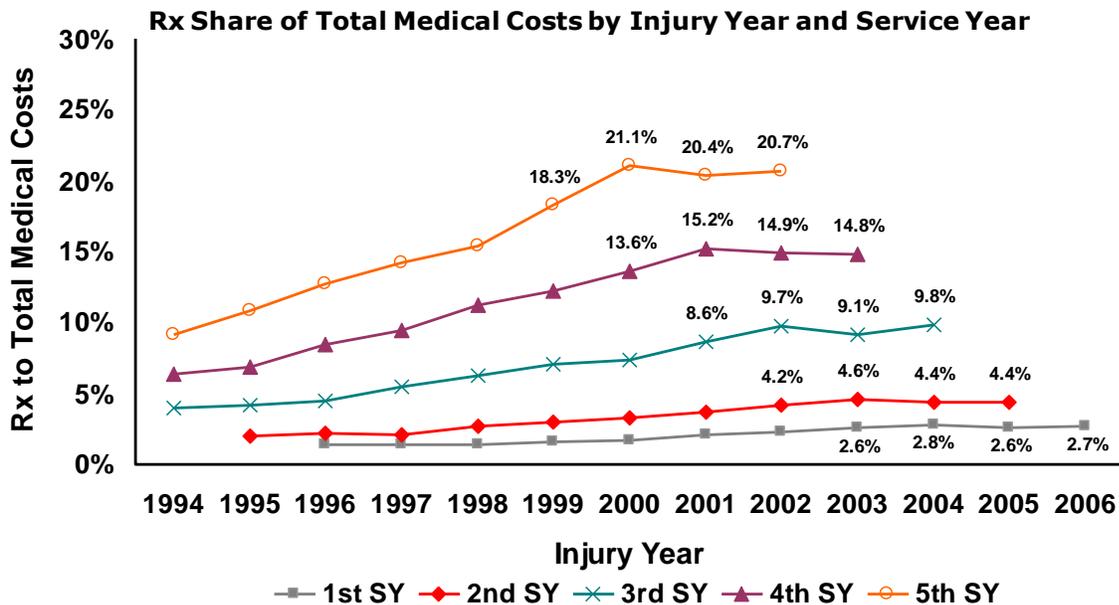


Exhibit 2

In Exhibit 3, the last eight relative service years show that there is generally no leveling off of the share for Service Year 2004 and subsequent. Note the higher proportion of total medical dollars spent on prescription drugs as claims mature.

Is the Prescription Drug Share of Total Medical Costs Stabilizing in WC?

Rx Share of Total Medical Costs by Injury Year and Service Year

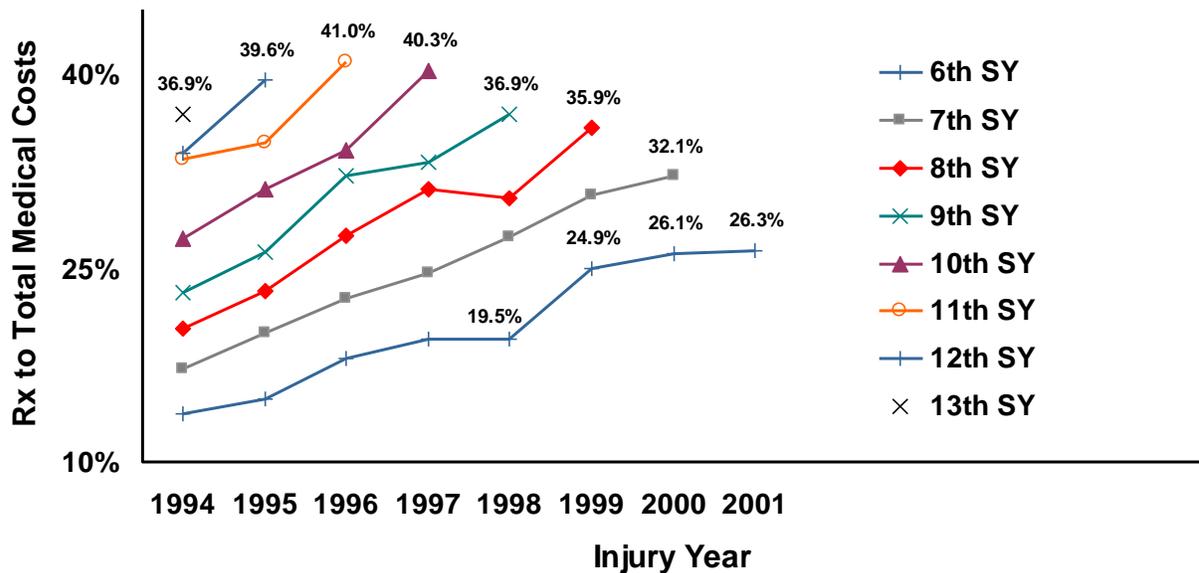


Exhibit 3

Forecasts of the Prescription Drug Share of Total Medical Costs

Previously, we estimated the ultimate prescription drug share of total medical costs for Injury Year 2005 at 18%. In our latest study:

- Shares for early service years emerged as expected and
- Shares for older service years increased more than had been expected.

This prompted a slight revision to our estimate of the drug share for older service years, which in turn contributed to an increase in our Injury Year 2005 forecast to 19%. Due to the leveling off of the share since Service Year 2004, as noted earlier, our Injury Year 2006 forecast is also 19%.

To forecast the ultimate prescription drug share of total medical costs by injury year we essentially apply the patterns shown in Exhibits 2 and 3 to the most recently observed data. Three scenarios, encompassing a wide range of possibilities, were examined:

1. Not Trended--future incremental drug shares for all relative service years remain unchanged from last observed within their respective relative service year
2. Trended--future incremental drug shares for all relative service years follow historical trends
3. Best Estimate--future incremental drug shares for relative service years after the 5th follow historical trends while all other incremental shares remain unchanged from last observed within their respective relative service year

Exhibit 4 displays projections under these three scenarios.

Clearly, the estimated ultimate share is highly dependent on whether one believes the historical trends in incremental drug shares will continue.

Is the Prescription Drug Share of Medical Costs Stabilizing in WC?

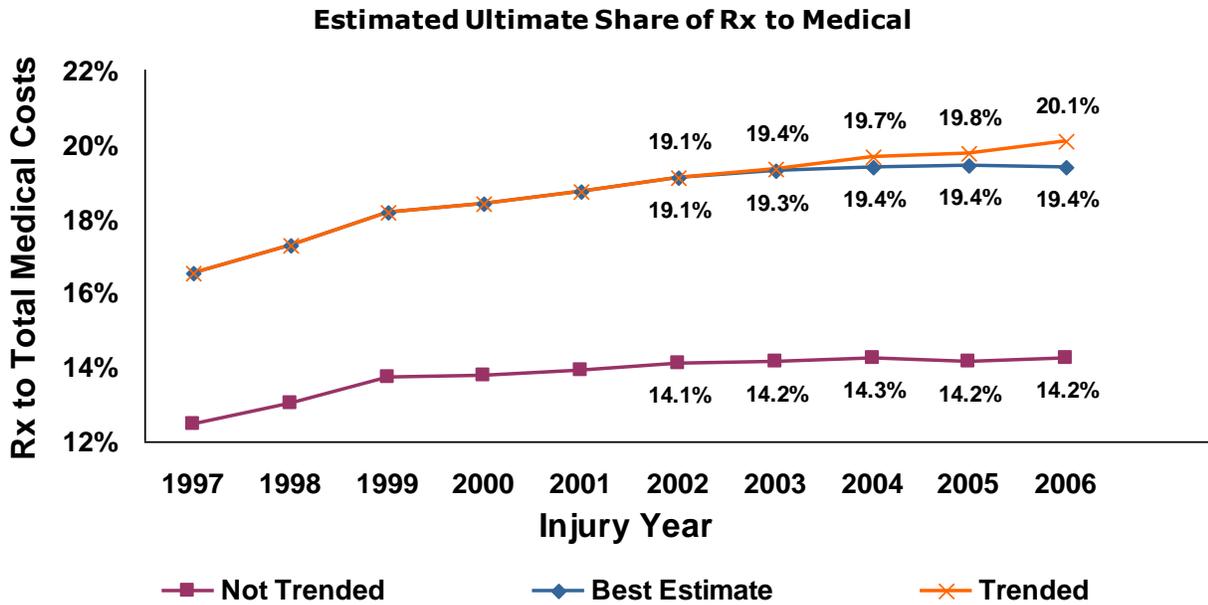


Exhibit 4

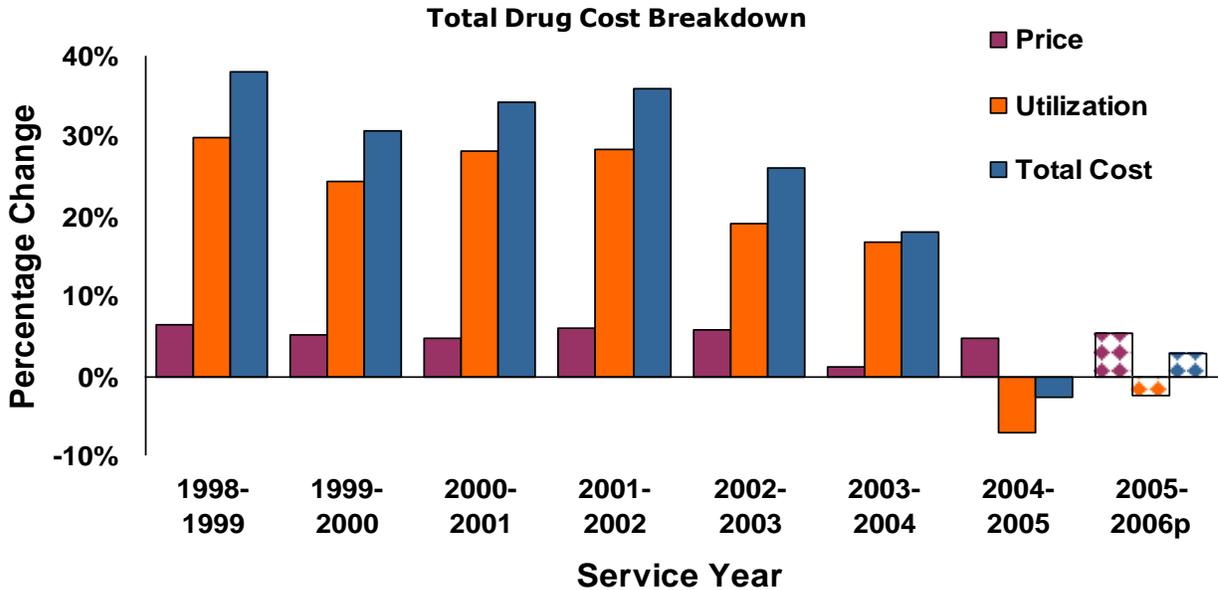
Changes in Price, Utilization, and Cost

The prescription drug cost per claim rose at an annual average rate of 30.4% from Service Year 1998 to 2004, fell slightly in 2005, and rose again slightly in 2006 (preliminary estimate). Recent preliminary data indicates that price change, not utilization change, drove the slight increase in total cost.

Exhibit 5 reveals a noticeable dip in the average price increase from Service Year 2003 to 2004. From 1998 to 2006, the average price increase was 4.9%. The increase is 5.5% when the change from 2003 to 2004 (1.2%) is excluded. This lower-than-normal price increase from 2003 to 2004 is due, in large part, to sizeable price cuts for generic versions of hydrocodone-acetaminophen from various manufacturers. In this exhibit:

- Total cost is the total dollar impact
- Price is the portion of cost change that can be attributed to price changes of the drugs purchased in the previous year
- Utilization is the difference between total cost change and price change, and includes changes in the number of prescriptions per claim and the impact of changes in the mix of drugs prescribed (i.e., from previously used drugs to newer and more costly alternatives)

Surprisingly, Utilization Has Decreased Once Again



p Preliminary

Exhibit 5

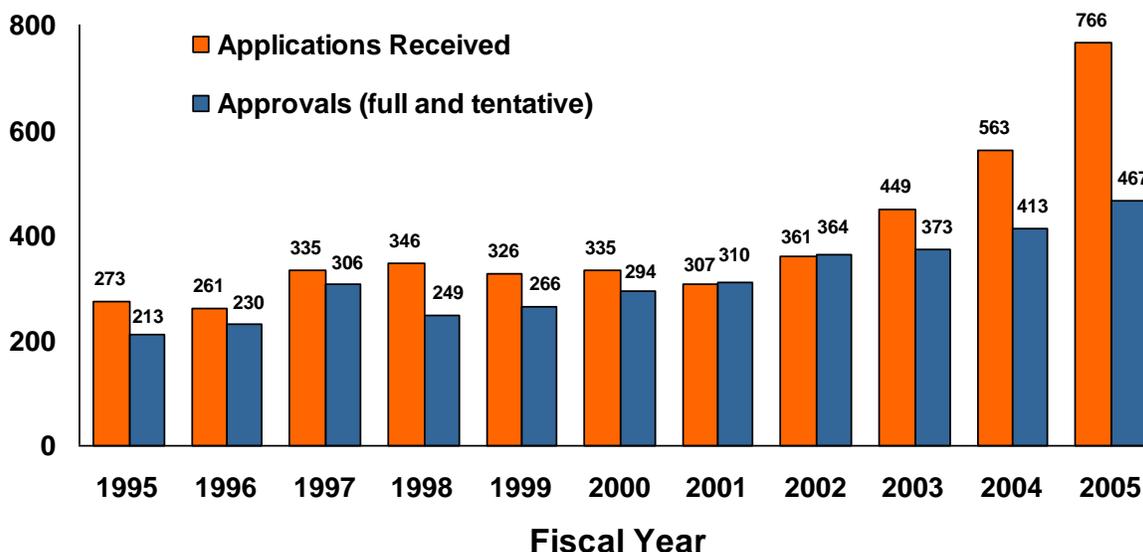
Impact of Generic Drugs

Use of generic drugs, when available and appropriate, is one key to keeping drug costs down. Logically, the more generics available on the market, the greater the potential for additional drug cost savings. Exhibit 6 illustrates the growing number of generic drug applications received by the Food and Drug Administration (FDA) through 2005. While the number of approvals had been increasing, it did not keep pace with the number of applications. The FDA announced in October 2007 that it was adding staff and implementing changes to the generic drug review process to help reduce the growing backlog of applications. At that time, there was a backlog of more than 1,300 applications. The FDA approved 682 generic drug applications in fiscal year (FY) 2007 (a 30% increase from FY 2006), and expects to approve even more in FY 2008 [5].

OxyContin[®], a popular WC drug, has been the subject of some interesting patent battles. In June 2005, a federal appeals court ruled that the patents on OxyContin[®] were not enforceable. In February 2006, the same court vacated its previous ruling. In September 2008, the patent holder for OxyContin[®] granted a generic manufacturer limited rights to produce and sell a generic form of OxyContin[®].

When generic drugs are available, they are used 90% of the time in WC. The additional potential savings from the use of available generics is about 12% based on Service Year 2006 data.

FDA Approval of New Generic Drug Products May Help Keep Costs Down



Source: Statement of Gary Buehler, R.Ph, Director of the Office of Generic Drugs, Food and Drug Administration, before the United States Senate Special Commission on Aging, July 20, 2006

Exhibit 6

Prescribing Patterns

Exhibit 7 lists the top 10 drugs for Service Year 2006, ranked by total amount paid, as well as ranks for earlier time periods. As expected, we see movements in ranks as some brand names are taken off the market and more generics are approved. Some noteworthy changes are:

- Vioxx[®] and Bextra[®], previously in the top 10, were removed from the market in September 2004 and April 2005, respectively.
- Celebrex[®] remains on the market, but lost its 2004 top rank partially due to the expansion, in April 2005, of risk information on the label.
- FDA approved a generic for Oxycontin[®] in March 2004. On August 28, 2006, Purdue (the maker of OxyContin[®]) settled a lawsuit with Endo and Teva (makers of generic OxyContin[®]). Endo and Teva agreed not to produce generics in exchange for Purdue's agreement not to pursue them for damages related to their production of generic OxyContin[®]. Endo continued to sell the generic through December 31, 2006, and Teva through March 31, 2007. In September 2008, Mallinckrodt was granted limited rights to sell a generic OxyContin[®].
- FDA approved a generic for Neurontin[®] (Gabapentin) in September 2003 that climbed the chart rather quickly.
- FDA approved a generic for Mobic[®] (Meloxicam) in July 2006 that pushed Mobic out of the top 10.
- Big climbers include Lyrica[®], Fentanyl, and Tramadol w/Acetaminophen (see Appendix 1).

Actiq[®] continues to rise in the rankings, despite studies indicating a high incidence of off-label use and media reports of abuse and addiction. A generic for Actiq[®] was approved by the FDA in September 2006. It will be interesting to see the effect on Actiq's[®] 2007 ranking.

Top 10 Drugs for 2006

Most Prescribed Based on Total Dollars Paid in WC

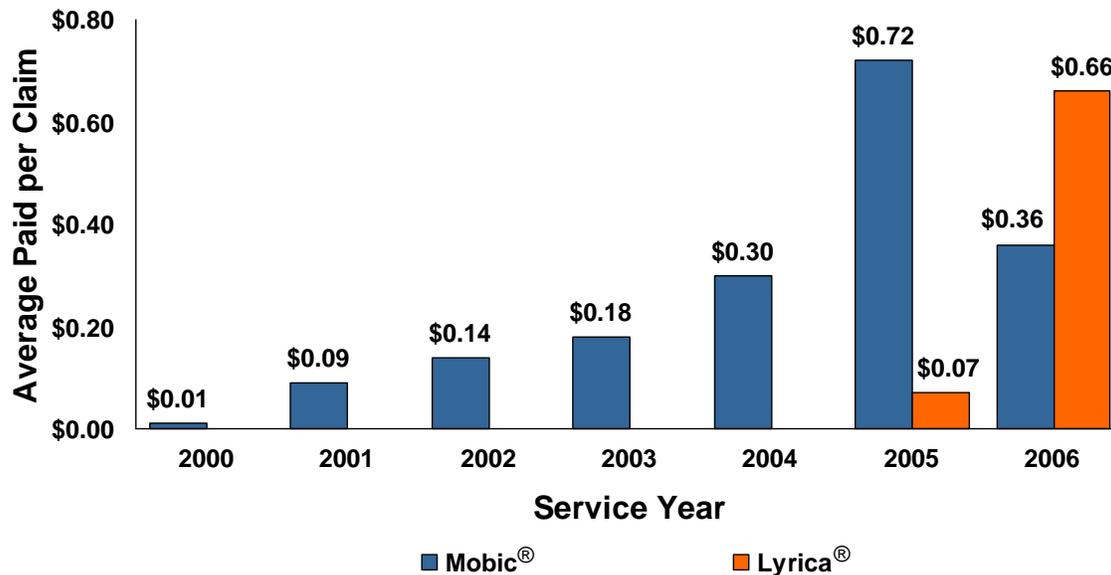
DRUG NAME	FDA APPROVAL	RANKING			
		2006	2005	2004	2002-2006
HYDROCODONE/ACETAMINOPHEN	7/85	1	1	3	1
LIDODERM®	3/99	2	6	11	6
GABAPENTIN	9/03	3	2	38	13
CELEBREX®	12/98	4	5	1	2
OXYCODONE HCL	<1/82, 3/04	5	9	27	17
CARISOPRODOL	<1/82	6	4	6	4
ACTIQ®	11/98	7	11	16	19
SKELAXIN®	4/64	8	7	9	7
OXYCONTIN®	12/95	9	3	2	3
NAPROXEN	3/94	10	10	10	8

Exhibit 7

Previously, we reported a significant increase in the total prescription drug costs for the anti-inflammatory drug Mobic® in Service Year 2005. Exhibit 8 shows that the increase turned out to be short-lived. Mobic's® average paid per claim in Service Year 2006 was half the amount in Service Year 2005. This fall was driven by the approval of a generic in July 2006 and the FDA's announcement of additional safety advisories for meloxicam (Mobic's® active ingredient). These advisories include a "black-box"^(b) warning on cardiovascular (CV) and gastrointestinal (GI) risks and additional "warnings" language about potential CV, GI, renal, and skin problems associated with the drug [6].

Exhibit 8 also shows that Lyrica® continues to ascend the prescription drug chart. Lyrica® was first approved on December 30, 2004 for the treatment of nerve pain caused by diabetes and the shingles. On June 21, 2007, Lyrica® became the first FDA approved drug for the treatment of fibromyalgia. Will the Service Year 2007 data show a continued rise in rank?

Mobic's[®] Rise Has Subsided While Lyrica[®] Is Growing



Mobic's[®] rankings in 2006, 2005, and 2004 are 20, 8, and 22, respectively
 Lyrica's[®] rankings in 2006, 2005, and 2004 are 11, 60, and 1269, respectively

Exhibit 8

The Fall of the Big Three

Exhibits 9 and 10 illustrate the effects of recent events regarding Cox-2 inhibitors:

- September 2004—Merck & Company voluntarily withdrew Vioxx[®] from the market
- April 2005—At the request of the FDA, Pfizer voluntarily suspended sales of Bextra[®]
- April 2005—The FDA allowed Pfizer to keep Celebrex[®] on the market, but with expanded risk information included on the label

Anti-Inflammatories Continue Their Market Share Decline (Percentage of Total WC Prescription Drug Costs)

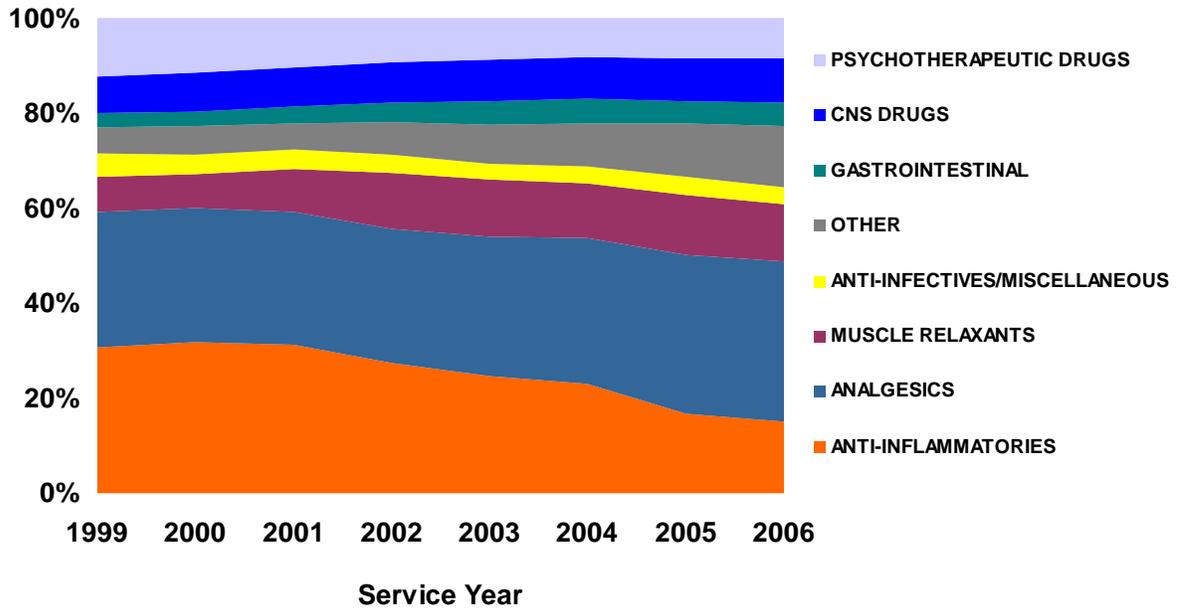
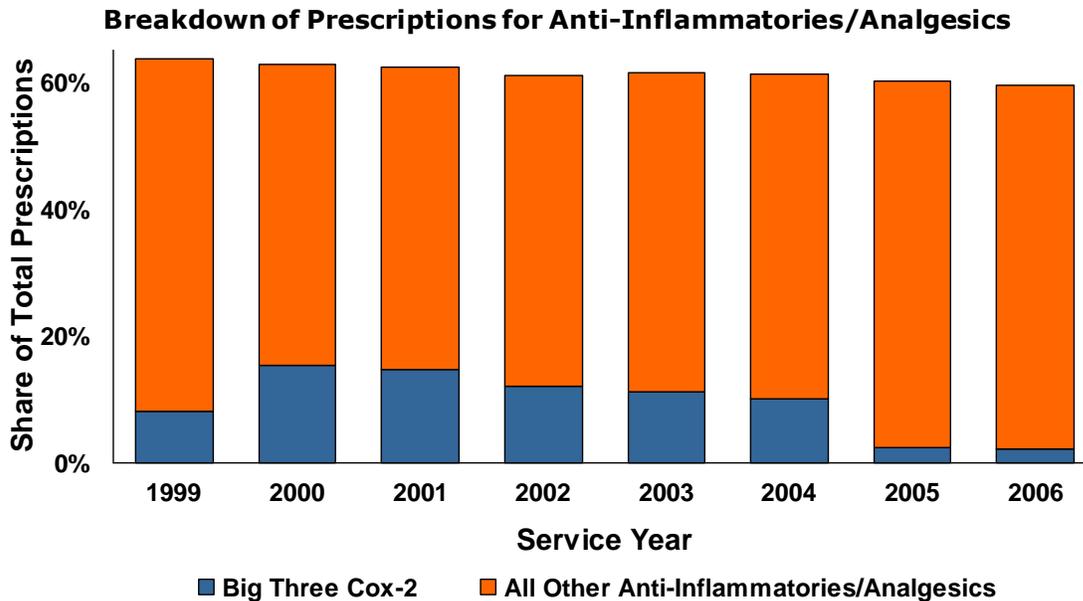


Exhibit 9

Exhibit 9 reveals a relatively sharp decrease in market share for anti-inflammatories (which includes Cox-2 inhibitors), and some increase in analgesics and “Other” from Service Years 2004 to 2005. The effects of the negative news regarding Cox-2 inhibitors and the withdrawal of Vioxx[®] and Bextra[®] from the market are even more clearly displayed in Exhibit 10. During that same time period, the Big Three’s share of total anti-inflammatories/analgesics prescriptions dropped significantly.

The Once Popular Cox-2 Painkillers Are Now a Small Share of Prescriptions



Big Three Cox-2 is Vioxx®, Bextra®, and Celebrex®

Note: Total prescriptions includes all drugs, not just anti-inflammatories and analgesics.

Exhibit 10

What is Replacing the Cox-2 Inhibitors?

To determine which drug or drugs are replacing the Cox-2 inhibitors we:

- Identified claims with heavy Cox-2 inhibitor use* in the first service year of an injury,
- Looked at the third service year for these claims, and
- Looked for any difference in drug use patterns in the third service year before and after the removal of Vioxx® and Bextra®

We found that:

- The total number of prescriptions went down and
- Only Mobic®, Meloxicam, and Lyrica® showed significant increases

* more than 25% of the total prescriptions are one or more of Vioxx®, Bextra® and Celebrex® in the first 12 months of injury

The data did not provide any clear evidence to answer the question: What are previous users of Cox-2 inhibitors now being prescribed? Some studies suggest some of the Vioxx® and Bextra® users switched to Celebrex® or Mobic®. Others indicate a portion of users opted to receive no prescription pain relievers or switched to conventional (non-coxib) non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., naproxen, aspirin, or ibuprofen). This might explain the drop in average prescriptions per claim for heavy Cox-2 inhibitor anti-inflammatories/analgesics displayed in Exhibit 11. If the patient has gastrointestinal problems, he or she might be prescribed a gastroprotective agent as well as a NSAID.

Note: Heavy Cox-2 inhibitor total is the average total number of prescriptions per claim for Heavy cox-2 inhibitor users

Prescriptions per Claim for Heavy Cox-2 Users Are Down

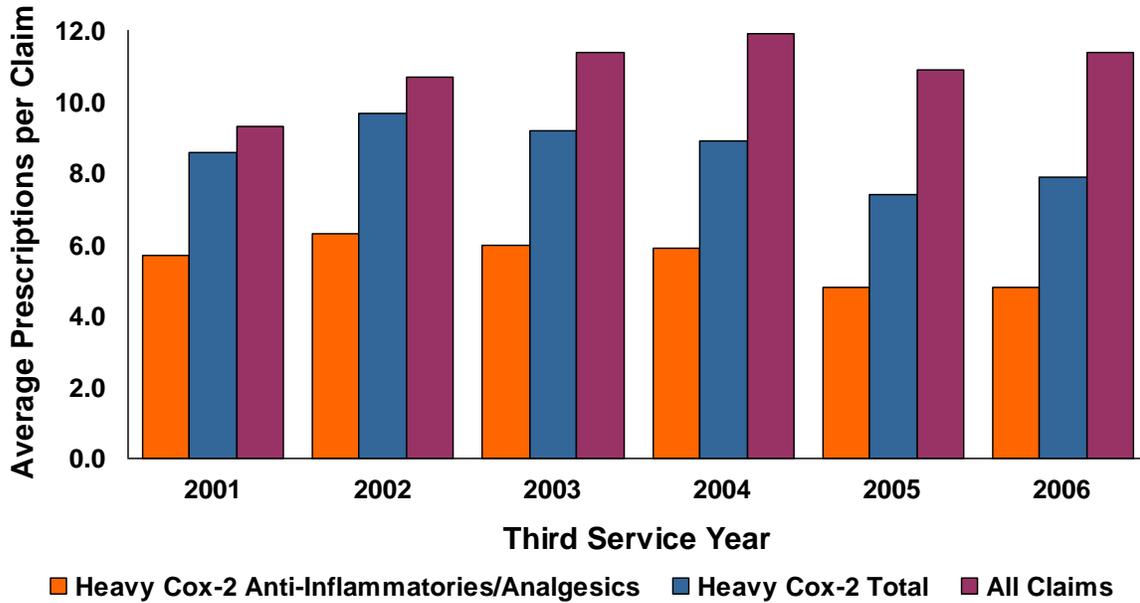


Exhibit 11

Exhibit 12 shows the drug shares of total prescriptions in the third service year for claims with heavy Cox-2 inhibitor use. Despite the expanded warnings of risks associated with its use, Celebrex[®] remains a significant share of total prescriptions. Shares for many other drugs increased, including Ibuprofen, Cyclobenzaprine, Lyrica[®], and Tramadol.

Shares for Claims With Heavy Cox-2 Use

Percentage of Prescriptions

DRUG NAME	THIRD SERVICE YEAR					
	2006	2005	2004	2003	2002	2001
1 HYDROCODONE/ACETAMINOPHEN	17.1%	16.8%	14.8%	15.2%	12.7%	8.5%
2 CELEBREX®	11.8%	10.1%	11.4%	11.7%	13.6%	18.6%
3 IBUPROFEN	3.8%	3.5%	1.7%	2.3%	2.0%	1.2%
4 CYCLOBENZAPRINE HCL	3.4%	2.9%	2.4%	2.2%	2.3%	1.7%
5 LYRICA®	3.4%	0.2%	0.0%	0.0%	0.0%	0.0%
6 TRAMADOL HCL	3.1%	3.6%	2.4%	2.5%	1.6%	0.0%
7 NAPROXEN	3.0%	2.9%	1.9%	1.6%	1.3%	0.9%
8 MOBIC®	2.8%	5.4%	1.0%	0.9%	1.4%	1.0%
9 TRAMADOL/ACETAMINOPHEN	2.6%	1.6%	0.0%	0.0%	0.0%	0.0%
10 PROPOXYPHENE NAPSYLATE/ACETA.	2.5%	3.6%	3.4%	4.1%	3.9%	3.4%

Exhibit 12

EMERGING ISSUES

Finding Alternative to Average Wholesale Price (AWP)

Twenty-eight states have WC prescription drug fee schedules that are based on average wholesale price (AWP) according to a WCRI study [8]. The controversy over the use of AWP as a benchmark for prescription drug reimbursement is not new. Few will disagree that the use of AWP as a pricing mechanism is flawed, but the challenge has always been finding a suitable alternative. The federal government addressed the issue several years ago by passing the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The Act mandated that, beginning in 2005, payments for physician-administered Part B drugs are based on the drug's average sales price^(c) (ASP). Until 2005, Medicare's method of paying physicians for Part B drugs was based on the drug's average wholesale price (AWP) [7].

First DataBank (publisher of Blue Book AWP) has announced that it will stop publishing AWP information in two to three years. Although there are other companies that publish prescription drug AWP (e.g., Thompson Medical Economics Red Book), will this information be sufficiently available in the future?

Repackaged Drugs in WC

A relatively new issue to WC is physician-dispensed prescription drugs, commonly known as repackaged drugs. These are drugs purchased in bulk and repackaged into individual prescription sizes for physician dispensing [3]. This issue received significant attention in California after the passage of Senate Bill 228 in 2003, which included changes in prescription drug reimbursement. The new legislation required workers compensation to use the MediCal pharmacy fee schedule, which did not cover repackaged drugs. As a result, higher fees were allowed for repackaged drugs. The California legislature has since corrected this.

In addition to potential price differences, there is concern that physician-prescribing behavior might also lead to increased utilization, or over-prescribing, further increasing costs.

Estimates are that seven to 10 percent of physicians dispense prescription drugs [9].

With the exception of a few states, most with prescription drug fee schedules require that physician-dispensed prescription drugs are reimbursed at the same price as drugs dispensed by retail pharmacies. There are some reports that physician-dispensed prescription drugs (repackaged prescription drugs) are increasing in some areas of the country, so this may be an area for increased monitoring by states.

FUTURE RESEARCH

Possible areas of future research include

- Where do narcotics occur in the life of a claim?
- What impact do physician-dispensed drugs have on WC costs?
- Why is the share of prescription drugs still increasing on older relative service years, while it has leveled off in earlier relative service years?

NCCI will continue to monitor and report on prescription drugs and other important issues that affect the WC industry.

CREDITS

Barry Lipton, John Robertson, Satya Arya, and Gina Cooper of Actuarial and Economic Services, Barry Llewellyn of Regulatory Services, and James Bonk of Data Quality Research, contributed to this study.

APPENDIX 1

Top 50 Prescribed Drugs by Total Paid in WC Service Year 2006

Drug Name	Percentage of Total Rx Paid	Rank
HYDROCODONE W/ACETAMINOPHEN	6.27%	1
OXYCODONE HCL	3.81%	5
ACTIQ®	3.13%	7
OXYCONTIN®	2.90%	9
TRAMADOL HCL	2.31%	13
FENTANYL	1.87%	15
DURAGESIC®	1.68%	18
OXYCODONE W/ACETAMINOPHEN	1.61%	19
PROPOXYPHENE NAPSYLATE W/APAP	1.03%	25
KADIAN®	0.94%	26
TRAMADOL HCL-ACETAMINOPHEN	0.89%	28
AVINZA®	0.88%	29
PERCOCET®	0.87%	30
ENDOCET®	0.77%	32
MORPHINE SULFATE	0.66%	38
ULTRAM® ER	0.50%	46
ANALGESICS SUBTOTAL	30.13%	
CELEBREX®	3.85%	4
NAPROXEN	2.64%	10
IBUPROFEN	1.77%	16
MOBIC®	1.47%	20
ETODOLAC	0.94%	27
NABUMETONE	0.73%	34
MELOXICAM	0.72%	35
PIROXICAM	0.63%	40
DICLOFENAC SODIUM	0.62%	41
NAPROXEN SODIUM	0.50%	45
ANTI-INFLAMMATORY SUBTOTAL	13.89%	
CEPHALEXIN	1.04%	24
ANTIINFECTIVES SUBTOTAL	1.04%	
LOVENOX®	0.47%	47
ANTITHROBOTIC SUBTOTAL	0.47%	
GABAPENTIN	3.88%	3
LYRICA®	2.59%	11
TOPAMAX®	1.12%	23
NEURONTIN®	0.44%	48
CENTRAL NERVOUS SYSTEM DRUGS SUBTOTAL	8.03%	
RANITIDINE HCL	2.11%	14
NEXIUM®	0.72%	36
PREVACID®	0.53%	43
GASTROINTESTINAL SUBTOTAL	3.36%	
CARISOPRODOL	3.68%	6
SKELAXIN®	3.10%	8
CYCLOBENZAPRINE HCL	2.56%	12
TIZANIDINE HCL	1.27%	22
MUSCLE RELAXANTS SUBTOTAL	10.61%	
CYMBALTA®	1.43%	21
EFFEXOR XR®	0.84%	31
LEXAPRO®	0.64%	39
PROVIGIL®	0.55%	42
WELLBUTRIN XL®	0.53%	44
ALPRAZOLAM	0.43%	49
ZOLOFT®	0.42%	50
PSYCHOTHERAPEUTIC DRUGS SUBTOTAL	4.84%	
AMBIEN®	1.75%	17
AMBIEN CR®	0.75%	33
LUNESTA®	0.67%	37
SEDATIVE/HYPNOTICS SUBTOTAL	3.17%	
LIDODERM®	4.23%	2
SKIN PREPERATIONS SUBTOTAL	4.23%	

APPENDIX 2

2006 Top 10 Prescription Drugs in WC

- 1. Hydrocodone/Acetaminophin** (hye dreo KOE done)/(ah see ta MIH no fen)- (generic form of Vicodin[®]) is a narcotic analgesic used to relieve moderate to severe pain.
- 2. Lidoderm[®]** (LYE doe derm) is used to relieve the pain associated with sunburn; insect bites; poison ivy; poison oak; poison sumac; minor cuts; scratches; and burns; sores in the mouth; dental procedures; hemorrhoids; and shingles (herpes infection).
- 3. Gabapentin** (ga bah PEN tin) (generic form of Neurontin[®], approved in 2003) is used in the treatment of some types of seizures and the management of postherpetic neuralgia (nerve pain caused by the herpes virus or shingles).
- 4. Celebrex[®]** (SELL-eh-breks) is a nonsteroidal anti-inflammatory drug (NSAID) used to treat pain or inflammation caused by many conditions, such as arthritis, ankylosing spondylitis, and menstrual pain. It is also used in the treatment of hereditary polyps in the colon.
- 5. Oxycodone HCL** (ox i KOE done hydrochloride) is a narcotic pain reliever used to treat moderate to severe pain. The extended-release form of this medication is prescribed for around-the-clock treatment of pain.
- 6. Carisoprodol** (kar eye soe PROE dole) (generic form of Soma[®]) is a muscle relaxant used to treat injuries and other painful musculoskeletal conditions.
- 7. Actiq[®]** (AK-tik) is a narcotic pain medicine used to treat "breakthrough" cancer pain that is not controlled by other medicines.
- 8. Skelaxin[®]** (skell-AX-in) is a muscle relaxant used to treat skeletal muscle conditions such as pain or injury.
- 9. OxyContin[®]** (Ox i kon' tin) is a controlled-release narcotic painkiller prescribed for around-the-clock relief of moderate to severe pain.
- 10. Naproxen** (na prox' en) (generic form of Naprosyn[®]) is a nonsteroidal anti-inflammatory drug (NSAID) used to treat pain or inflammation caused by conditions such as arthritis, ankylosing spondylitis, tendinitis, bursitis, gout, or menstrual cramps.

Source: Drugs.com

Note: These drugs might also be used for purposes other than those listed

NOTES

- ^a The treatment of disease, especially mental disorders, through the use of medications.
- ^b A black box warning appears on the label of a prescription medication to alert consumers and healthcare providers about safety concerns, such as serious side effects or life-threatening risks. A black box warning is the most serious medication warning required by the U.S. Food and Drug Administration.
- ^c The MMA defined ASP as the average sales price for all U.S. purchasers of a drug, net of volume, prompt pay, and cash discounts; charge-backs and rebates. Certain prices, including prices paid by federal purchasers, are excluded, as are prices for drugs furnished under Medicare Part D. CMS instructs pharmaceutical manufacturers to report data to CMS—within 30 days after the end of each quarter—on the average sale price for each Part B drug sold by the manufacturer. For drugs sold at different strengths and package sizes, manufacturers are required to report price and volume data for each product, after accounting for price concessions. CMS then aggregates the manufacturer-reported ASPs to calculate a national ASP for each drug.

REFERENCES

- [1] Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Expenditure Accounts 2006 Highlights.
<http://www.cms.hhs.gov/NationalHealthExpendData/downloads/highlights.pdf>
- [2] Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Expenditure Projections 2007-2017. <http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf>
- [3] Barbara O. Winn, "Paying for Repackaged Drugs Under the California Workers' Compensation Official Medical Fee Schedule," Rand Institute for Civil Justice and Health, May, 2005.
- [4] "Behind the Numbers, Healthcare cost trends for 2008," PricewaterhouseCoopers' Health Research Institute, 2007.
- [5] "FDA To Speed Generic Drug Application Reviews," Kaiser Daily Health Policy Report, The Henry J. Kaiser Foundation, October 05, 2007.
http://kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=48018.
- [6] Janis Kelly, "Black box added to Mobic label," Medscape Medical News, October 27, 2005.
<http://www.medscape.com/viewarticle/538384>.
- [7] "Medicare Part B Drugs CMS Data Source for Setting Payments Is Practical but Concerns Remain," Testimony Before the Subcommittee on Health, Committee on Ways and Means, House of Representatives, U.S. Government Accountability Office, Statement of A. Bruce Steinwald Director, Health Care, July 13, 2006. <http://www.gao.gov/new.items/d06971t.pdf>
- [8] Richard A. Victor, Petia Petrova, "The Cost and Use of Pharmaceuticals in Workers' Compensation: A Guide for Policymakers," Workers Compensation Research Institute, June, 2006.
- [9] Jason Clark, CompSource Oklahoma, "Prepackaged Drugs in Workers' Compensation," American Association of State Compensation Insurance Funds, July, August, September, 2006.

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