NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS COMPENSATION INSURANCE COMMITTEE
NCOIL ANNUAL MEETING, PHOENIX, ARIZONA
FRIDAY, NOVEMBER 17, 2017
4:30 P.M. - 5:45 P.M.

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Committee met at the Sheraton Grand Phoenix Hotel in downtown Arizona on Friday, November 17, 2017 at 4:30 pm.

Representative Marguerite Quinn of Pennsylvania, Chair of the Committee, presided.

Other members of the Committee Present were:

Rep. Matt Lehman, IN
Rep. Peggy Mayfield, IN
Rep. Joseph Fischer, KY
Rep. Michael Webber, MI
Rep. Lois Delmore, ND
Rep. George Keiser, ND
Asw. Maggie Carlton, NV
Asw. Pamela Hunter, NY
Asm. Andrew Garbarino, NY
Rep. Michael Henne, OH
Rep. Bill Botzow, VT

Other legislators present:

Rep. David Santiago, FL
Rep. Tom Oliverson, TX
Sen. Jerry Klein, ND

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 13, 2017, meeting held in Chicago, IL.

DISCUSSION OF IMPACT OF DIRECT DISPENSE PROGRAMS ON STATE WORKERS' COMPENSATION SYSTEMS

Rep. Marguerite Quinn (PA) introduced Ms. Kathy Fisher, Assistant Director of External Engagement and Ms. Dongchun Wang, Economist, both of the Workers' Compensation Research Institute (WCRI).

Ms. Fisher reported on a study published in July 2017 regarding Physician Dispensing in 26 states. The key question addressed in the 2017 study was "*Did Reforms Achieve their Intended Goals?"* There were two main categories of reforms: price-focused reforms, which target higher-priced, repackaged drugs, capping reimbursement at the AWP; and limiting reforms, which limit the types of drugs that can be dispenses or limit dispensing to a short time frame. Rep. Quinn noted that the costs are usually never

seen by the employee on the front end but rather the costs are seen on the back end which is the root cause of pharmacy inflation.

When assessing whether the reforms met intended goals, the following areas were looked at: prices of the drugs; frequency of physician dispensing; cost Sharing (physician-dispensed drugs relative to all prescription costs); and patterns. The study compared measures between states that have had reforms with those that have not had reforms or with states where WCRI observed pre-reform data.

Ms. Fisher continued by saying that the overall findings concluded that prices of many of the most common physician-dispensed drugs decreased. Physicians dispensed fewer prescriptions in 2014 than in 2011. A combination of decreased prices and frequency reduced the cost share of physician-dispensed drugs in many states. CA, FL and IL were exceptions. Ms. Fisher went on to say that despite decreases, there was an increase in the physician dispensing of the higher-priced, new drug costs strengths, which was enough to offset the decreases in those states. Dispensing was still common in several states. Further, despite the decrease in dispensing, the percentage of total pharmaceutical costs in those states was 54 – 64%. There was a noticeable shift in pattern of dispensing from opioids to non-opioids as a result of the limiting reforms.

Ms. Fisher discussed the prices of frequently dispensed drugs in post-reform states – overall, there was a decrease. Decreases of up to 39% per pill were reported. The study therefore concluded that price-focused reforms were effective. Prices were more static or increased in non/or pre-reformed states. In contrast, price increases as high as 42% were reported. MD and NC were exceptions. Physicians dispensed fewer prescriptions in 2014 in most states. Cost share of physician-dispensed drugs to all prescription costs changed little or increased in CA, FL and IL. A decrease in cost share of over 30% were seen in CT, IN, KY and SC. Unsurprisingly, cost share also increased in some non- and pre-reform states. In Illinois, California and Florida, physician dispensing of higher priced, new drug strengths/formulations, of certain existing drugs: 7.5 mg Cyclobenzaprine HCL (Flexeril), 150 mg extended release Tramadol HCL (Ultram), 2.5-325 mg Hydrocodone-Acetaminophen (Vicodin) and Lidocaine-menthol (new formulation of pain patch). The increased dispensing of those new, higher-priced drugs offset the other reductions in CA, FL and IL. Accordingly, that calls into question the effectiveness of price-focused reforms in those States. Ms. Fisher noted that those new drug strengths are rarely seen filled at pharmacies.

Rep. David Santiago asked if the increase in total payments was because those drugs were physician dispensed as opposed to pharmacy dispensed. Ms. Fisher responded affirmatively stating that the cost increased when dispensed by the physician because the higher-priced, new drugs are not being filled at pharmacies.

Rep. Santiago asked what the strategy was that CA, FL and IL used to work around the reforms. Ms. Fisher responded that the reforms were aimed at just repackaged drugs that were already in existence and that the new drugs are being packaged by generic manufacturers.

Ms. Wang added that if you look at cyclobenzaprine HCL (Flexeril) there are commonly three different strengths. Two existing strengths are 5mg and 10 mg and the new strength is 7.5 mg. Before the 7.5 mg strength came to market, in FL, most of the physicians dispense 10 mg but when the new dosage came out in the market, if you look

at the curve, you can see a steep increase for the new strengths. The high frequency plus the higher prices offset the reduction for the existing drugs. Notably, the 7.5 mg was rarely prescribed to be filled at a pharmacy which suggests that some dispensing physicians had an economic incentive.

Mr. Paduda added that the supply chain for physician dispensing is incredibly adaptable and they can figure out a way of making money. He stated that if repackaging was cut-off, the same supply chain would look for another way of selling the product. In this case, be creating a new strength of the drug, i.e. 7.5 mg, the manufacturer is able to set any price they want and under the fee schedule, which is 112% of AWP in FL, the payer has to pay that as the legal requirement.

Ms. Fisher stated that the FDA will review and approve an array of strengths but only a few strengths are manufactured. When the drug goes off-patent and it's open to the generic market, the manufacturers can go back through the various strengths without going back to the FDA for approval.

Ms. Fisher noted that there was a shift in pattern of dispensing as a result of limiting reforms. In KY, there was a 12% decrease in dispensing of opioids. In FL, 2011 legislation banned physicians from dispensing Schedule II and III opioids. Ms. Fisher also noted that there were physician dispensing reforms enacted after the study period in states such as Pennsylvania, Kansas and North Carolina.

The NCOIL Model Act on Workers' Compensation Pharmaceutical Reimbursement Rates incorporates elements of many state reforms. The Model ties reimbursement to the original manufacturer's NDC number. It provides for states with fee schedules and it provides for alternatives if the NDC number is not available and looks for the average wholesale price of therapeutically equivalent drugs and also contains a limiting reform provision which limits the dispensing of repackaged or OTC drugs to one week in all of workers' compensation.

Ms. Fisher concluded by saying that fewer prescriptions were dispensed by physicians in all post-reform and most non-and pre-reform states. Reimbursement rules in many states did help to reduce prices. However, increased physician dispensing, of higher priced new strengths, offset or even outweighed those price reductions. This was especially seen in CA, FL and IL. Finally, it was observed that a shift in dispensing patterns from opioids to non-opioids were observed as a result of limiting reforms.

Mr. Paduda added that the opioid issue is critical and stated that several states have banned or limited physician dispensing of opioids and, after those implementations opioid prescriptions dropped dramatically. He went on to say that these opioids drugs should not have been prescribed to begin with and that they were being prescribed only to make money. He further stated that, in his opinion, banning physician dispensing of opioid drugs would be a good first step.

Rep. Santiago asked if the NCOIL Model legislation would solve FL's problem. Ms. Fisher responded by stating that it would not because it does not address the new strength drugs. Mr. Paduda added that the only way to stop the egregious profiteering is to allow employers to direct fulfillment of drugs to specific pharmacy networks which is already in place in a number of states – NY, MN, OH.

Rep. Quinn added that when she was the prime sponsor of the PA legislative reform bill in 2014, her research led her to physician dispensing websites where profit calculators were being advertised to physicians to embrace the practice of physician dispensing. It was a convenience for physician's patients but it focused on a mathematical formula for the profit level.

Rep. Oliverson (TX) stated that he felt this problem was much bigger than "greedy" doctors and that healthcare providers are graded on their ability to treat pain effectively which can set the wrong incentives for providers to over-prescribe certain drugs. He noted that he was not discounting anything that had been said but asked if there was any data available on the grading and treatment of pain management.

Mr. Padua responded by stating that the treatment of acute pain is fundamentally different from treating chronic pain. Opioids for surgical purposes may be the best first-line of defense. However long-term usage is dangerous, expensive and creates stronger pain the longer the patient uses them. Solid clinical studies show that non-opioids prescriptions can lead to the same results as opioids. He went on to say that long-term use of opioids is counter-productive and eventually leads to hyperalgesia.

DRUG COMPOUNDING: ANALYZING THE PREVALENCE OF COMPOUND MEDICATIONS IN THE WORKERS COMPENSATION INSURANCE INDUSTRY

Mr. Paduda stated that drug compounding is driven by a lot of the same financial motivations as physician dispensing. He went on to say that the physician examines and diagnoses a patient's complaint, and, if appropriate, prescribes a drug or treatment. There is no conflict of interest if the physician does not profit from the prescription. The patients, free of any undue influence by the prescriber, takes the prescription to the pharmacy of their choice and the pharmacist fills the prescription.

Mr. Paduda went on to describe that "compounding" is the preparation, mixing, assembling, packaging, or labeling of a drug – typically used for patients with allergies, specific medical conditions/limitations, and children. There are different types of compound drugs and compounding kits. He reported that many compounds are typically used for patients who are allergic to a binder or who have difficulties swallowing pills or unable to take an oral medication.

In some cases, compounding takes the form of compounding custom dosage forms of medications for patients with special needs which have very little oversight. There is no FDA approval process – it is a State regulated industry. Mr. Paduda also noted that in many cases, compounding has not proven effective. Many compounds are not medically necessary and duplicative and risky – many compounds contain multiple, similar drugs and are expensive. Many states have no effective controls or limits on price or number of scripts with compounds. Some questionable marketing practices are directly related to consumer advertising and or 1099 sales forces.

In workers' compensation, the primary issue is "topicals" – creams, gels, or ointments that are applied to the skin. And the use of "compounding kits" continues to increase in the workers' compensation population. These compounding kits are marketed to compounding pharmacies as a convenience to save time, decrease waste and improve compliance, reproducibility and accuracy. They essentially allow the physician to get around bans on compounds. These products typically are submitted by the dispensing

pharmacy for processing through the PBM using the product NDC, rather than as a compound. This action bypasses the pharmacy-benefits managers and many state workers' compensation requirements for review of appropriateness of compounds. Most states have no effective control on price of compounding drugs.

Mr. Paduda spoke about some potential solutions stating that there can be specific reimbursement limits per script. He went on to say that there are also limits per ingredient (API) which can be tied into the pricing limit and that there is a cap on the number of ingredients in a particular medication and the total cost per script which puts them all together. There are actions that by-pass some of these requirements. For example, if there is a limit of three ingredients, the physician now gives multiple scripts to equal the six ingredients in the original script. Ohio is fortunate because they have the "golden rule" and it is a monopolistic state for comp. They have a limit of paying up to $300 per month on scripts so they are very effective in reducing costs. Another potential solution is "retrospective review" – if the script is prescribed, dispended and the bill comes in, the employer can decide not to pay for it as not medically necessary. Another potential solution is Pre-Authorization – all compounds must be pre-authorized by the payer; the standard is compliance with evidence-based clinical guidelines (state by state basis); approval only if prescriber documents patient fails treatment with oral medications, is allergic to oral medication ingredients and/or cannot swallow. Another potential solution is Employer Direction where the employer can direct patients to network pharmacies and are not required to reimburse non-network pharmacies.

Rep. Santiago asked if an approved formulary would help. Mr. Paduda stated that a formulary is like having speed limits – you need enforcement of it. And the challenge with a formulary is that it needs to be specific to compounds broadly defined and not just the ingredients used in compounds. He concluded by stating that it has worked, to some degree, in Texas. If you adopt a formulary that specifically requires pre-authorization with informed consent, that it is a good path to take.

Rep. Quinn closed by urging Committee member to contact her and/or NCOIL staff to discuss how the issues of physician dispensing and drug compounding should be further handled.

ADJOURNMENT

There being no further business, the Committee adjourned at 5:45 P.M.