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HOUSE OF REPRESENTATIVES

LABOR AND INDUSTRY COMMITTEE
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10:30 A.M.

PRESENTATION ON HB 18 (MACKENZIE)
DRUG FORMULARY TO PREVENT
OPIOID ABUSE IN
WORKERS’ COMPENSATION

BEFORE:
HONORABLE ROB W. KAUFFMAN, MAJORITY CHAIRMAN
HONORABLE STEPHEN BLOOM
HONORABLE SHERYL M. DELOZIER
HONORABLE CRIS DUSH
HONORABLE FRED KELLER
HONORABLE RYAN E. MACKENZIE
HONORABLE DAVID M. MALONEY, SR.
HONORABLE JACK RADER, JR.
HONORABLE JESSE TOPPER
HONORABLE JOHN T. GALLOWAY, DEMOCRATIC CHAIRMAN
HONORABLE MORGAN CEPHAS
HONORABLE MARIA P. DONATUCCI
HONORABLE LEANNE KRUEGER-BRANEKY
HONORABLE DANIEL T. McNEILL
HONORABLE BRANDON P. NEUMAN
HONORABLE PAM SNYDER

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Pennsylvania House of Representatives
Commonwealth of Pennsylvania
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**SUBMITTED WRITTEN TESTIMONY**

**NOTE:** (See submitted written testimony and handouts online.)
MAJORITY CHAIRMAN KAUFFMAN: Good morning.

It is 10:30, and I like to be on time, so we are going to start this meeting and call this meeting to order.

And if you’ll indulge me, I would like if we would begin to rise and give the Pledge to the flag.

(The Pledge of Allegiance was recited.)

MAJORITY CHAIRMAN KAUFFMAN: All right.

I would like to welcome everyone this morning to this meeting of the House Labor and Industry Committee.

Just as a reminder to all in the room, this meeting is being recorded, and I would appreciate if the Members -- and this is a reminder to myself as well -- would silence their cell phones and electronic devices to eliminate as many interruptions as possible.

And to start out, I’m going to ask the secretary if she’ll please call the roll.

(Roll call was taken.)

MAJORITY CHAIRMAN KAUFFMAN: Thank you very much.
Today we will be discussing Representative Mackenzie’s legislation, House Bill 18. This would require a drug formulary for workers’ compensation.

We have a number of witnesses here today to discuss the legislation. And the Committee has received some written testimony, and those who have submitted written testimony in lieu of being here today are the PA Chiropractors’ Association, the PA Orthopaedic Society, Optum Workers’ Compensation Pharmacy Benefit Manager, and the Pennsylvania Chamber of Business and Industry.

I appreciate you all being here today. I do like to keep things moving. We have given all of those who will be testifying some guidelines, and I will attempt to move you along if you are not meeting those guidelines, because we have another hearing this afternoon.

So as we move forward, I’m going to recognize my Executive Director, John Scarpato, of the Committee to provide a brief synopsis of the bill. And then at some point during this -- the prime sponsor is not here currently, but he is en route and has just been held up a bit. So I’m going to open that up for John to give a synopsis.

EXECUTIVE DIRECTOR SCARPATO: House Bill 18 is Representative Mackenzie’s bill. The bill will require the Department of Labor and Industry to adopt a nationally
recognized, evidence-based prescription drug formulary after taking comments from the public.

The current formulary would be available on the Department’s website for reference by the medical community and the general public, and prescription drugs not consistent with or recommended by the formulary would not be considered reasonable and necessary for the purposes of utilization review.

The bill also provides that the Department will approve only those utilization review organizations that have obtained certification as a utilization review entity from the Department of Health under the Insurance Company Law.

The bill also requires that the peer review process and peer review organizations will comply with the requirements for utilization review under the law.

MAJORITY CHAIRMAN KAUFFMAN: Thank you, John.

And I noticed that Representative Donatucci has entered the room and joined the Committee.

Now I would like to ask our first panel to come forward. Joining us now we have Michael Vovakes, Deputy Secretary for Compensation and Insurance at the Department of Labor and Industry here in Pennsylvania; Dr. Jeffrey Jacobs, a Fellow with the American College of Occupational and Environmental Medicine; and Sam Marshall,
who we all know is President of the Pennsylvania Insurance Federation.

As we begin this morning, I would ask all of our witnesses to please summarize their testimony in about 5-minute statements. Again, I have noted we have a limited time today, and we want to make sure we get to everyone on the agenda.

Glendon, who is on our staff here, he will signal you when you have reached approximately 30 seconds remaining in your remarks to attempt to keep everyone on schedule. I’m not trying to be the principal in the room; I’m just trying to make sure we keep on task here.

So you can -- if Glendon is waving a “30” at you, you’ll get the picture, I think, pretty quickly.

And any questions from the panel as we start out?

And I note that Representative Dush has entered the room, as well as Representative Delozier.

And we are going to get through as many questions as possible with each panel. I’m going to keep on our timeline. And if at some point we don’t get to all questions, we will be taking questions in written form and referring them to whoever they are directed to. We don’t want there to be unanswered questions left, but we do want to keep on a timeframe here.
So it’s time to move on, and thank you to all of the panelists who have joined us today. We look forward to working with you. And I’m going to start -- actually, I’ll start with Sam this morning.

MR. MARSHALL: Okay. Thank you.

Sam Marshall with the Insurance Federation.

You have our testimony. I’ll be brief.

The opioid problem needs no introduction, you know, either in Pennsylvania or nationally. What is encouraging is that this Committee recognizes that in Pennsylvania, we face a unique workers’ compensation aspect in the opioid problem.

I have attached to my testimony pages from the Workers Comp Research Institute study from last July, July of 2016, and we provided the Committee with full studies. And what they show is that, first of all, opioid prescriptions are higher in workers’ comp than they are generally, and, you know, health insurance generally, that’s almost to be expected. That’s the nature of those injuries.

But in Pennsylvania, Pennsylvania is the outlier of the outliers, and in Pennsylvania, the prescriptions of opioid in workers’ comp are significantly higher than most other States. I think New York and Louisiana are also up there. They have enacted reforms to try to address it, and
reforms actually similar to this.

So what you have is a problem where workers’ comp is unique on the opioid, and generally, Pennsylvania is an outlier of the outlier. The question is, what do you do to solve it?

Representative Mackenzie’s bill, House Bill 18, the topic for today, we believe does that, and it does it in a very fair way. It says, here, let’s have nationally recognized, evidence-based guidelines to, you know, guide the provider community and to guide people who are reviewing the provider community in, you know, their drug formularies.

Then, you know, the second thing it does is that it says, let’s make sure that those who perform that review, and in workers’ comp it’s a separate system. It’s done by utilization review organizations that are approved by the Bureau and assigned by the Bureau. So it’s not insurance companies picking their own favored UROs. It’s all done through an administrative process. What the bill says is, let’s make sure that those are the gold standard, and that means that they’re URAC certified, the Utilization Review Accrediting Commission. You’ll hear from them later on today.

So what that does is it addresses the two weaknesses you have in the workers’ comp system that lead
right now to excessive opioid prescriptions. It establishes a meaningful drug formulary, and it establishes high-quality utilization review organizations.

One of the things we get asked about is, well, you know, is this going to mean better treatment for injured workers or worse treatment, particularly when compared with their regular health insurance counterparts? You know, how does the health system generally deal with it? The answer to that is that it will bring the treatment to injured workers up to the level -- where right now, they're not at the level -- that the State requires of health insurance generally.

Health insurers all use treatment guidelines. That's how they do it. Health insurers, by law, have to use URAC-certified UROs. The Health Department, if you -- I mean, frankly, I represent health insurers as well. If you didn't do it, the Health Department would shut you down, and correctly. I mean, we don't challenge that. I would note, tragically, this isn't a newly identified problem, and it's not a newly identified solution. You know, Representative Mackenzie has spoken about this vigorously and openly for just about a year. And he has had, you know, he's introduced it to this Committee. He has introduced it to the Senate and House, you know, the Democrat and Republican Policy Committees,
and he has had an open-door policy to welcome all
perspectives, you know. So this is a proposal that has had
considerable exposure already that has -- you know, it’s a
problem it has and a solution it has.

We support it. You know, we worked with
treatment guidelines in other States. We’re familiar with
URAC-certified UROs here in Pennsylvania as well as in
other States. We are confident that it will address that
unique opioid workers’ compensation connection that
requires a specific and unique solution to the workers’
comp system.

I would close by just saying, this is not a new
problem; this is not a new solution. If you disagree with
it, fine, but I would ask, you know, people who will follow
and others, if you disagree with it, what do you have to
offer?

I know it’s very easy -- and, you know, sometimes
I’m sure people could say, you know what, Sam; you’ve done
that yourself. It’s very easy just to castigate somebody
else’s solution to a problem that we all admit. But I
would ask anybody who’s going to criticize this as a
solution to offer something yourself, to come up with an
idea that you have that will address the problem.

We think this will. We think it will improve the
care given to injured workers. We think it is long
overdue, and we hope you move forward on it.

Thank you.

MAJORITY CHAIRMAN KAUFFMAN: Thank you, Sam.

And moving on, Dr. Jacobs.

DR. JACOBS: Thank you, Principal Kauffman and Vice Principal Galloway.

I’m Dr. Jeff Jacobs. I am board certified in occupational medicine. I have been practicing occupational medicine for over 20 years. I am primarily clinical, but I also have had roles in utilization review, and I am a strong proponent, advocate, for evidence-based medical guidelines. That’s how I practice.

I wanted to just briefly -- if I can do it in 5 minutes; we’ll see -- give a few takeaway points about my perspective on the opioids in the workers’ comp system.

Number one, opioids have a role in the treatment of pain, but they’re not the first-line medication in most situations, and I base that on three reasons.

One, the available studies don’t support the belief that opioids are better at pain relief than nonsteroidal anti-inflammatory medications. They also have a higher risk profile. I have in my written testimony more details on that, of the increased overdose rates of admission to hospitals as well as deaths, and so that doesn’t really need a whole lot of explanation.
Prescription opioids are also, in my opinion, a gateway drug to heroin. There are details of that in my testimony.

And for me, I think the hardest part is the quality-of-life issues. The adverse effects of opioids include constipation, sexual dysfunction, sedation, insomnia, and depression. And in my role as a utilization review provider, I see so many people taking medications for their medications, and it’s sad. It’s sad, the poor quality of life that people with chronic pain have.

And then finally, there are disability issues, and studies have shown that prescription opioids delay recovery, increase the chance of becoming chronically disabled, and patients who are on opioids are more costly to treat.

My second point is, no one ever became a chronic-pain patient without going through an acute and subacute treatment phase first. And I take that as a charge to myself, because I am a primary-care doctor. Even though I specialize in occupational medicine, I’m the one who sees patients in the first 90 days in Pennsylvania. That also includes other primary-care providers, surgeons, and emergency room providers.

And having practiced here in Pennsylvania, I basically divide the 90-day window into three phases.
The first phase is conservative management, and that typically doesn’t include opioids. If people aren’t getting better in 2 to 4 weeks, then I’m going to think, did I make an error in my diagnosis? Do they need some type of specialist referral or imaging? But opioids don’t have a place in it.

I looked up my record in the PDMP, and I saw that in the last year, I had only prescribed eight prescriptions for opioids. And it’s not like I’m seeing different patients than other people; it’s just that the majority of people don’t need it and don’t do as well as people who just take nonsteroidals. So I look at it, why screw it up with an opioid?

And I was part of the generation in the nineties that was trained that you do give opioids quite liberally, until I was challenged by a hospital administrator that I was writing too many opioids. And in fact, I actually wasn’t. I was about the average; one in five patients get opioids for an acute injury. But I have been able to change my prescribing habits, and I think that’s one thing that using evidence-based medicine and having a formulary would do. It sounds somewhat devious that you’re forcing change in providers, and I will move on.

And just to talk about it: The intent of formularies is to reduce overprescribing, to maximize
healing and improve return-to-work outcomes, and contain drug costs, and if we want to improve outcomes, we have to change prescriber behavior. I think getting better quicker, having less adverse outcomes with less side effects, less lost work time and better productivity, less costs and improved patient satisfaction, are reasonable goals that I don’t know anybody would disagree with.

And then finally, I think we should be advocating for non-pharmacologic strategies in the treatment of acute and chronic musculoskeletal pain, and they include physical therapy, cognitive behavioral therapy, and acupuncture.

So in summary, the last statement is, all stakeholders have a share of the blame for the opioid epidemic and must be a part of the solution.

Thank you.

MAJORITY CHAIRMAN KAUFFMAN: Thank you, Dr. Jacobs.

I want to note that Representative Cephas, Representative Maloney, Representative Neuman, and the prime sponsor, Representative Mackenzie, have joined the Committee this morning.

And we’re going to move on to the Secretary for your testimony.

DEPUTY SECRETARY VOVAKES: Good morning, Chairman Kauffman, Chairman Galloway, Committee, Committee staff.
I appreciate the opportunity to be here today to testify before the House Labor and Industry Committee regarding Representative Mackenzie’s proposed legislation.

My name is Michael Vovakes. I’m the Deputy Secretary for Compensation and Insurance at the Pennsylvania Department of Labor and Industry.

As in the rest of the country, the opioid crisis is a serious issue in Pennsylvania. Governor Wolf’s Administration is committed to doing everything we can to help people who are already in the throes of addiction and to prevent people from becoming addicted in the first place.

It’s not a stretch to recognize why this is an issue in the workers’ compensation arena. Workers become injured. Sometimes they are prescribed medications that can lead to addiction. We want to make sure that these medications are being prescribed in an appropriate way to help workers instead of harm them and to mitigate any chances that people develop an addiction.

Governor Wolf has put forth a number of initiatives to address this crisis, and we in Workers’ Compensation are certainly eager to support the effort in whatever way we can.

Representative Mackenzie has proposed the adoption of a nationally recognized prescription drug
formulary for the treatment of all injuries covered by the Workers’ Compensation Act. The Department supports this proposal’s basic objectives to ensure that injured workers receive prescription drugs that are appropriate for their injuries, which in turn could also reduce the costs associated with workers’ compensation claims.

In conjunction with various Administration initiatives concerning opioid addiction in Pennsylvania, it is the Department’s desire to implement legislation that will assist with the reduction of opioid abuse in the workers’ compensation system.

You have my written testimony. We have some items that we think -- that we would like you to accept as input to create a better bill out of this process. There are two that I want to just take a moment to highlight.

The first and most notable concern with the proposed legislation is the potential argument regarding adequate standards or guidance to the Department in selecting a formulary.

There is a case that is currently in the Pennsylvania Supreme Court affectionately known as the Protz case, and that case revolves around an unconstitutional delegation of legislative authority regarding the adoption and application of certain guidelines and the evaluation of impairments.
So if we could further, or if you could further articulate the basic policy considerations that you want to effectuate through this legislation so that we can avoid a similar situation, we think that would be very helpful.

Also, Sam talked about utilization review, as did the good doctor. Utilization review is a dispute resolution process that is used if there is a question about the reasonableness and necessity of a treatment, and this is a process that can be invoked by an employer, an insurer, or an injured worker.

The provisions in the bill regarding utilization review point to the Insurance Company Law of 1921. We just want to acknowledge a couple of things: one, that there are alternatives to certification, including URAC, primarily URAC. I think they are the nationally recognized accrediting body. And also that you consider a phase-in of whatever you do so that we don’t have a hard stop with only a few utilization review folks or companies prepared and in compliance with the standards.

So, you know, those are the two that I wanted to call out. I’m happy to discuss this, Mr. Chairman.

MAJORITY CHAIRMAN KAUFFMAN: Thank you, gentlemen.

We’re going to move on to questions for the panel, so if you have a question, make sure you get John’s
attention here.

And I’m going to start with questions this morning with Chairman Galloway.

MINORITY CHAIRMAN GALLOWAY: Thank you, Mr. Chairman, and thank you all for being here today.

Good morning. I know we have got a lot of people to talk to. We’ll make it quick.

Good to see you. Good to see you again on this issue.

I appreciate your points about opioids, first of all, about alternatives, and I’d like to stick there for a second.

First, is this bill just about opioids? Does this affect just opioids or all medication?

MR. MARSHALL: All medications.

MINORITY CHAIRMAN GALLOWAY: You mean this bill just doesn’t apply to opioids, it applies to all medications?

MR. MARSHALL: It’s the drug formulary. It’s nationally recognized---

MINORITY CHAIRMAN GALLOWAY: Then why are we just talking about opioids? Why don’t we just have a bill that concerns opioids?

MR. MARSHALL: If you want---

MINORITY CHAIRMAN GALLOWAY: Why aren’t we going
with a formula for all medication? You mean, like
inhalers, everything prescribed by a doctor is falling
under this, yet that’s all we’re talking about is opioids?

MR. MARSHALL: And I think you’ll hear from some
of the nationally recognized, evidence-based, you know,
people.

I’m not sure that -- I mean, frankly, I would
think you would want it for all drugs. I mean, if it’s
good for opioids---

MINORITY CHAIRMAN GALLOWAY: That’s fine, but you
didn’t mention anything about that in your opening. Nobody
talked about, it’s one point after another talking about
the opioid problem.

And we have taken significant steps in the last
couple of years in a bipartisan manner, the Prescription
Monitoring Program and others, which are the alternatives
that you brought up, yet that’s all you talked about in
this whole bill, was opioids. Yet you never mentioned once
that it’s not just opioids; it’s every single drug, every
single prescription prescribed by a doctor. Why wasn’t
that mentioned?

MR. MARSHALL: Actually, Representative Galloway,
I actually did point to that, and I say here, it says, for
all, you know, reasonableness of all prescriptions. You
know, it certainly includes opioids, and opioids highlights
the need for it.

    I think that you would actually have -- and there was reference made to the Protz decision. I think you would actually have -- you know, I’m not sure why you would say that we want drug formularies for one type of prescription and not all others, and I would ask you---

    MINORITY CHAIRMAN GALLOWAY: Well, because that’s where the problem is. You identified the problem. The problem is with opioids. The problem is not with asthma inhalers, right?

    MR. MARSHALL: And, Mr. Chairman, if you want to limit it, if you want to limit the drug formularies to just opioids, then fine.

    MINORITY CHAIRMAN GALLOWAY: I think the scope would make a lot more sense.

    MR. MARSHALL: I actually, I actually -- and you guys have the votes, not anybody at this table. But I would recommend that the Committee not go that route. I think you want uniformity among all prescriptions.

    If somehow you, and you’re going to have the chance to look at the---

    MINORITY CHAIRMAN GALLOWAY: But then there has to be a reason. There has got to be some reason for making the change.

    MR. MARSHALL: And I think that you’re---
MINORITY CHAIRMAN GALLOWAY: You are making the case that there needs to be a change in the opioid, for opioids, for an opioid problem. You know, some would argue that we have made changes that are just coming into law now. But you would have to make a case that there would need to be a formula for every prescription.

MR. MARSHALL: And you know, Mr. Chairman, first of all, on the changes that have already been made, they really don’t address the workers’ compensation system. You know, that’s a unique problem.

MINORITY CHAIRMAN GALLOWAY: But is there a problem other than opioids?

MR. MARSHALL: If you could, if you could -- you know what? No. Opioids are what drive the problem. I think treatment guidelines would be better overall, and I would ask the Committee to consider that.

MINORITY CHAIRMAN GALLOWAY: And I appreciate that.

MR. MARSHALL: But if you could, Mr. Chairman, I do think, and I would urge it on all the people on the Committee, I think that if you have drug formularies for one type of prescription but not for all types of prescriptions, I don’t think that makes a lot of sense. I think you want consistency across the board in how injured workers are treated.
It shouldn’t be, gee, you know what, if you fall into this, you get one type of treatment; if you fall into that, you get another type of treatment. I think you want there to be a consistency throughout.

MINORITY CHAIRMAN GALLOWAY: Okay.

MR. MARSHALL: So if you’re going to have different drugs, you know, because opioids are one form of drug, but other forms of drugs also address it. You would want to have the same standards, the same guidelines applying to all the drugs.

MINORITY CHAIRMAN GALLOWAY: I appreciate your answer. And in an effort to move this along, just one last quick question.

Do we know, and I’m going to stick on cost here for a couple different speakers, all right? Costs, what this is going to cost. I know that you probably can’t answer that or wouldn’t answer it. What I want to know is how this affects the insurance agency. Is this something that’s going to save you money?

MR. MARSHALL: We hope, but frankly, it’s not an insurance cost driver---

MINORITY CHAIRMAN GALLOWAY: Is it going to save you money?

MR. MARSHALL: We hope.

MINORITY CHAIRMAN GALLOWAY: You don’t know, Sam?
Come on.

MR. MARSHALL: You know what? If it don’t---

MINORITY CHAIRMAN GALLOWAY: If it does, are you going to return that money to the policyholders?

MR. MARSHALL: Yes. And we went through this, we have gone through this any number of times in this Committee and in other committees, Mr. Chairman.

As you know, our rates are regulated by the State. If there is any cost savings, and we went through this just recently a couple of years ago with the physician dispensing bill, and those costs are required to be reflected in the Pennsylvania Compensation Rating Bureau’s loss cost filing with the State.

This is not -- and, you know, you also overlook the fact when you talk about insurance costs that the bulk of the workers’ comp market is self-insured, so obviously any cost savings they generate.

What we don’t -- you know, I can tell you, we hope it reduces the opioid problem. I can’t guarantee that. I can point to records in other States---

MINORITY CHAIRMAN GALLOWAY: And there is some automatic rollback that passes on the savings to the policyholders.

MR. MARSHALL: You know what? I guess if you wanted to have the same type of language that you have with
physician dispensing, that the Pennsylvania Compensation Rating Bureau does a study for any savings that are realized and---

MINORITY CHAIRMAN GALLOWAY: Is that in this bill, that any savings that is generated to the insurance company automatically goes back to the policyholders?

MR. MARSHALL: You know what? No, I don’t believe it is, but you know what? We’d be happy, we’d be happy to have that amendment if that’s, you know -- and we have known each other a long time, Mr. Chairman, so, I mean, I hope we can speak with the candor of people with a mutual respect.

MINORITY CHAIRMAN GALLOWAY: We can.

MR. MARSHALL: We are not championing this bill, supporting this bill, because it’s going to save the insurance industry a lot of money, that somehow wouldn’t be passed on to our policyholders in any event. We’re championing this bill, we’re supporting this bill, because we have seen empirical data that shows opioid abuse is a unique problem in workers’ compensation.

Now, you know, we’re a pass-through. We make our money one way or the other.

MINORITY CHAIRMAN GALLOWAY: Do we have that data?

MR. MARSHALL: Yes.
MINORITY CHAIRMAN GALLOWAY: Did you pass that on to us somewhere?

MR. MARSHALL: Yes, I did. I attached it as an exhibit to my testimony, and we have submitted the full WCRI reports. And I know some of it---

MINORITY CHAIRMAN GALLOWAY: Is the data related to physicians that are overprescribing? Is that what you’re saying?

MR. MARSHALL: Yeah. What it shows is that Pennsylvania is at the very high end of opioid prescriptions in workers’ compensation.

MINORITY CHAIRMAN GALLOWAY: I understand that. And I’m all for---

MAJORITY CHAIRMAN KAUFFMAN: I think we need to move on so other Members have a chance to ask some questions.

MINORITY CHAIRMAN GALLOWAY: Thank you. Thank you, Mr. Chairman.

MAJORITY CHAIRMAN KAUFFMAN: Because you’re Chairman, I offered a great amount of latitude to you.

MINORITY CHAIRMAN GALLOWAY: I appreciate it.

MAJORITY CHAIRMAN KAUFFMAN: Representative Topper is next on the list.

REPRESENTATIVE TOPPER: I assume I won’t have the same amount of latitude.
Dr. Jacobs, a question.

It doesn’t sound like you fear these standards. It sounds like you practice medicines with standards every day. Is that fair?

DR. JACOBS: Yes. But I have to say I was a very unwilling participant in the beginning. But what I found is that, following evidence-based guidelines, I had better results, better outcomes, and that I can’t argue with, and I don’t know that anybody can.

REPRESENTATIVE TOPPER: That’s great.

In your conclusion, and I’ll draw your attention in your written testimony. It’s point 4, and I think it was the next to the last point you made as well. It says there are other tools available to primary-care providers. You mentioned acupuncture. You mentioned physical therapy. Do you believe that just by simply establishing these guidelines, that somehow you wouldn’t be able to offer those kinds of alternate treatments or do you think it would encourage those alternate treatments?

DR. JACOBS: I think those alternate treatments need to be part of the guidelines. I don’t think you can just tell somebody who has been on chronic pain meds for 20 years that they can’t take them because of a formulary, that it’s not good. You have to give somebody an alternative.
I have plenty of colleagues and friends that are pain management physicians, that are thoughtful, conscientious, and are trying to manage people that they inherited, not their fault, and they’re being told by insurance companies -- sorry.

No, no; I mean, but it’s a problem that it’s not being paid for. So I think any guideline needs to have more than just opioids for this problem. I’m in agreement with Sam on that.

REPRESENTATIVE TOPPER: Thank you very much.

MAJORITY CHAIRMAN KAUFFMAN: Thank you.

Next we’ll go to Representative Neuman.

REPRESENTATIVE NEUMAN: Thank you, Mr. Chairman, and thank you for your testimony today.

First, in terms of lines of alternative treatment, within this piece of legislation, does it require the workers’ compensation to fully pay for alternative treatments?

MR. MARSHALL: That’s in the existing law. This is an amendment to that law. So that in the existing law, when you look at the definition of, I mean, what it covers, or who are the licensed health-care providers, so we do obviously cover physical therapy. I mean, that’s a large portion. And I believe we cover acupuncture, you know.

I mean, so there are any -- if you look at all
the providers that are covered under the Workers’ Comp Act, 
and therefore their services are covered under the Workers’ 
Comp Act, that is all the alternative therapies that we’re 
talking about today.

REPRESENTATIVE NEUMAN: Thank you.

And I think that we’re all in agreement here on 
the opioid epidemic. And the problem I have with Sam’s 
earlier comments is, if you want to talk about opioids, we 
can talk about opioids, but I don’t think everyone should 
be treated as a guideline.

Not every injury is the same, and not every 
doctor wants to prescribe the same drugs to help solve a 
problem -- outside of opioids. I’m not talking about 
opioids right now. But outside of opioids, I don’t know if 
we should treat every single injury and every single person 
the same.

My question for Sam: Right now, I assume you 
personally, as your own professional, you see addiction as 
a disease?

MR. MARSHALL: Yes.

REPRESENTATIVE NEUMAN: Under workers’ 
compensation right now, can you get workers’ compensation 
for addiction?

MR. MARSHALL: No. You know, that would 
actually, particularly if you became addicted during the
course of your treatment, that would then fall under your health insurance coverage.

REPRESENTATIVE NEUMAN: So would you be open to having workers that were addicted in some way be covered under workers’ compensation?

MR. MARSHALL: Sure, it would make sense to do it under workers’ compensation. I mean, that’s where you get -- I mean, that’s where, and, you know, I’m happy to talk to you about it further, but that’s where the health insurance comes in.

Your workers’ comp coverage and the treatment of the medical care for it covers your work injury. If the doctor overprescribed and therefore you became addicted, or by the same token, if the doctor, you know, cut off the wrong arm, that would become, you know, more of either a medical malpractice case where coverage is under the health insurance policy.

REPRESENTATIVE NEUMAN: So you’re saying if a doctor overprescribes, that could be a medical malpractice case?

MR. MARSHALL: Sure.

REPRESENTATIVE NEUMAN: I’ve never seen one of them in medical malpractice.

MR. MARSHALL: You know, and I suspect that people will start.
REPRESENTATIVE NEUMAN: So we’re saying that the workers’ compensation system is causing addiction, is causing all these opioid problems, but then we’re not going to allow the same system that is causing these problems to solve these problems with long-term recovery?

MR. MARSHALL: That’s because, for the patient that gets poor care. I mean, that’s what we’re talking about.

REPRESENTATIVE NEUMAN: Under the current workers’ compensation system.

MR. MARSHALL: Under the current workers’ compensation system.

The medical costs of that poor care generally, I think, would fall under his health insurance policy.

REPRESENTATIVE NEUMAN: So you’re saying that if a doctor overprescribes a patient opioids, that that would be covered---

MR. MARSHALL: And the patient then goes into an addiction program.

REPRESENTATIVE NEUMAN: That the doctor would be liable for that?

MR. MARSHALL: No, no. I mean, actually, if you have a situation where the injured worker gets addicted to opioids and then -- so subsequent to, you know, he hurts his back but then he gets addicted to opioids.
REPRESENTATIVE NEUMAN:  Okay.

MR. MARSHALL:  When he goes and gets treatment for that opioid addiction, I believe, and I’ll confirm on this, but I believe that that is then covered under his health insurance policy.

REPRESENTATIVE NEUMAN: But should it, because most recovery plans aren’t generally the treatment needed for individuals to get into long-term recovery. So should workers’ compensation that you are claiming is causing this big problem pick up after only 12 days of treatment, maybe 3 days of detox, that their health insurance is not picking up?

MAJORITY CHAIRMAN KAUFFMAN: We’re getting a little bit far of the subject matter at hand and we have other Members who are waiting in line to ask, hopefully, questions that can add to the actual -- if you want to have a sidebar conversation with Sam, I’m sure he would love to do that, but I’m not sure that this is the topic right now at this moment.

REPRESENTATIVE NEUMAN: I appreciate that, Mr. Chairman. The discussions have only been on opioids generally, and I think if we’re going to only talk about opioids and addiction problems, I think that we need to discuss other things.

I will discuss those on a sidebar and private
matter, but I do appreciate the opportunity, Mr. Chairman.

MAJORITY CHAIRMAN KAUFFMAN: Thank you.

Representative Maloney.

REPRESENTATIVE MALONEY: Thank you, Mr. Chairman.

I will try to keep this short.

On the alternative treatments, something that has been somewhat of a, I’ll say a rub, probably, when you have the medicine industry often, I’ll say conflicting with what somebody’s actual pain is and why they have that pain.

In this alternative treatment, would there be any reference to and maybe even the suggestion to chiropractic?

DR. JACOBS: I don’t see why not.

I mean, I think in the guidelines that I have used, that’s available. I’m thinking, particularly in California, I know that they have set limits for physical medicine. So it’s not only chiropractic but also physical therapy. I believe it’s 24 over the lifetime of a case.

REPRESENTATIVE MALONEY: Yeah.

DR. JACOBS: But they are---

REPRESENTATIVE MALONEY: It has been my experience in the past, and I have a family member right now who suffers tremendously from muscle spasms and/or nerve pinching and irritation, and really, the only true treatment that helps that individual is chiropractic.
And when you look at the bone structure and the
things that we have, work related, and many guys like
myself who came from some of that, and also athletics, we
know that a treatment may not even remotely have to do with
any kind of medicinal type of pain management if we can get
to the problem. That’s the only reason I was trying to, in
this evaluation of alternative-type treatments for people,
especially when they’re hurt on the job, okay? That’s why
I wanted to bring it up for just a little bit of
discussion.

I see it many times as something that could
really help us, and maybe economically, and physically for
those individuals. And I don’t really hear -- we had,
actually, hearings in the last session over, we had
chiropractic individuals in here that spoke very highly of
how they can treat people. They alternatively don’t have
to give them any kind of heavy medicine, or an opioid, for
that matter, since it’s being brought up.

So I just wanted to put that out there, if that
would be part of this alternative-type discussion.

MAJORITY CHAIRMAN KAUFFMAN: Okay. Thank you.
We’re going to move on.

We have one last question. Representative
Krueger-Braneky.

REPRESENTATIVE KRUEGER-BRANEKY: Thank you,
Mr. Chairman, and thank you, all of you, for your testimony this morning.

My question is for the Department around implementation. So in looking at the bill, we’re talking about a 30, a public comment period of no less than 30 and no more than 90 days, and then the Department would be required to select a nationally recognized prescription formulary within 30 days after the close of the public comment period.

Now, we know the Department has been under lots of strain lately for other issues not related to workers’ comp. Is this a realistic timeline?

DEPUTY SECRETARY VOVAKES: I believe it is.

To my knowledge, there are only two, maybe more, but two primary nationally recognized formularies. It might get more complex if there are others that I’m not familiar with. But if we have some good public comment, I suspect that we could, we could commit to the timeline captured in the bill.

REPRESENTATIVE KRUEGER-BRANEKY: And does the Department have enough capacity with existing staff to implement this fully?

DEPUTY SECRETARY VOVAKES: We do. And depending on how the whole bill bakes out, we may have more capacity to do work.
REPRESENTATIVE KRUEGER-BRANEKY: Can you clarify that, please?

DEPUTY SECRETARY VOVAKES: If the URAC certification stays in the bill, that may alleviate some of the requirements, some of the work requirements we have internally to certify utilization review folks, which, you know, we could use folks to do some other things as well.

REPRESENTATIVE KRUEGER-BRANEKY: All right.

Thank you, Deputy Secretary.

DEPUTY SECRETARY VOVAKES: Certainly.

MAJORITY CHAIRMAN KAUFFMAN: Thank you very much to the panel, and in the interests of time, we’re going to move on. There may be some follow-up questions coming from Members, so I anticipate the panelists will be happy to answer those questions, as we, I believe, have mentioned that to you before.

Next, the Committee will hear testimony from Joseph Huttemann, representing the Pennsylvania Association for Justice. With Mr. Huttemann, to assist in answering questions, is Mr. Thomas Baumann, I believe.

And Mr. Huttemann, if you would like to take the microphone, and you have 5 minutes to address the Committee and then we’ll go with questions.

MR. HUTTEMANN: Good morning, Chairmen Kauffman and Galloway and Members of the Committee. Thank you for
allowing me to present testimony today in regards to
House Bill 18.

My name is Joseph Huttemann, and I’m an attorney
for 25 years, practicing workers’ compensation law.

My first 5 years I worked as a defense attorney
for the insurance side of things. I moved on to represent
injured workers for the last 20 years.

Before going to law school, I was a construction
worker and a schoolteacher. I worked day in and day out
with the workers of this State, your constituents. I’m
here on behalf of the Pennsylvania Association for Justice,
my organization that protects the rights of the citizens of
this State.

In being a workers’ compensation lawyer
representing individuals for the last 20 years, I field the
calls every day of injured workers, catastrophically, when
their medications are denied, when treatment is denied. I
deal with the reality of a work injury, not just the
dollars and cents.

This law that’s being proposed, and I have
listened to all the discussions here this morning about the
opioid crisis, and I think we all can agree that that is a
substantial issue. And in the last year, there have been
several laws that have been brought forth by this group,
which I hope will have a strong effect on that crisis. As
of right now, we don’t know the effect of that. We can hope that that does move forward and take care of issues.

The law as drafted, as pointed out by Representative Galloway, addresses all medications, everything -- lung injuries, heart injuries, everything. It’s broad, and does it really address the opioid issue?

It sets forth a formula, a guideline from a nationally recognized organization. I don’t know which one. But that guideline will set forth the brand, dosage, the duration of medications to be prescribed. That doesn’t necessarily address the issue of opioid addiction.

Opioids may be the only prescription available for treatment of certain injuries. Putting a guideline on what doctors can prescribe and treat, or choose to treat their patients with, drives a wedge in that sacred doctor/patient relationship.

I was listening to Tom Price testify last week in his confirmation hearings to be Health and Human Services Secretary. Dr. Price, as we know, he’s a physician. He was appointed by the Trump Administration. And the gist of his testimony about abolishing Obamacare or the Affordable Care Act was that doctors and patients make the best decisions about medical care. Not guidelines, not regulations, but the doctor and patient make that best decision.
And I think that there is wisdom in that, because every injury is different. Every injury does require the doctor to have the ability to reach into his toolbox and pick the right tool, not have some national organization dictate what tools are to be used.

As we all know, the workers’ compensation system was enacted over 100 years ago as a grand bargain. Employees gave up their right to sue their employers for personal injuries in exchange for being given two basic benefits: wage losses and medical care. This reduces the value of that grand bargain, and that grand bargain has continually been attacked.

I want to read something to you that I found last night when I was thinking about my testimony today. Here is a State where there are guidelines on prescriptions and guidelines on medical care in general. The New York Times, November 30, 2016, quote, the title of the article, “‘Victimizing Me All Over Again’: San Bernardino Victims Fight for Treatment”:

“‘A year after a terrorist’s bullets ripped through her, after so many operations and infections she has lost count, Valerie Kallis-Weber has a paralyzed left hand, painful bone and bullet fragments in her pelvis, psychological trauma and tissue damage, including a fist-size gouge in her thigh where a bullet tore away the
Ms. Kallis-Weber, a survivor of the shooting in San Bernardino, Calif., that left 14 people dead and 22 seriously injured, still faces a long, hard road to reach something like recovery. She needs more operations, she relies on a home health aide, and her doctors want her to get physical” therapy “and occupational therapy to relearn” how “to use her arms and legs.

“I can’t type, I can’t put a bra on, I can’t cut a steak...I can’t do laundry, I can’t wrap a present.... I need help with everything.’ ” That’s her quote.

“But the visits from the” home “health aide have been reduced, and she has been told they will end soon. Approval of her antidepressant medication was withdrawn. Her occupational therapy was cut off, and her physical therapy” was “stopped, restarted and stopped again.

“Her conflicts over treatment are not with her health insurance plan; the shooting on Dec. 2, 2015, was a workplace attack, not covered by...” her “insurance. Instead, her treatment comes under the workers’ compensation system, which in California...” restricts its coverage through guidelines.

“Ms. Kallis-Weber and other victims of the attack, all San Bernardino County employees, have spent
months fighting the county and private" insurance
companies that help administer the system, as treatments
that their doctors approved have been delayed or denied."

Let’s not make Pennsylvania California.

MAJORITY CHAIRMAN KAUFFMAN: Thank you.
And now we’re going to open it up to questions,
and I guess I’m going to start.

Is your intent today to say no, or do you have
suggestions on how we can improve this bill? Because, you
know, I want this to be focused on people and workers, and
I believe Pennsylvania is in the top three in opioid abuse
within the workers’ comp system.

I mean, we are out -- I think our testifiers will
get to it in the next panel, some of the abuses that we’re
seeing. And so I guess I’m of the thought of, just saying
no, I think that was a mantra back in the Nancy Reagan
years, but this bill, I don’t think just saying no is the
answer to this bill.

We’re looking for constructive improvements
and constructive criticism rather than saying, no, we
don’t want any of this. Do you have improvements for the

MR. HUTTEMANN: Well, I think that we have to see
what the outcome of the legislation passed last year was --
the Prescription Drug Monitoring Program; the physician
dispensing rules. All those are just being implemented, and to say we’re going to bring this ax in, this sledgehammer to take on a fly, and it’s not a fly but it is a specific problem.

I don’t believe that this act actually addresses the issues, because what it does do is it takes people who are most severely injured and puts them in a position where they may have to go out onto the street to get drugs. I’ve seen it. I’ve seen when a utilization review cuts off my client’s care, and while it’s litigated out, they have gone to the street, all right? So I don’t know that this act actually helps, and it may hurt the crisis by pushing people in a different direction.

I know this question was, if not this, then what? And as I thought about that question, if this, then what? And when I think of “if this, then what,” and I see people being pushed into a direction of using self-medication or having to go to spinal cord stimulators and pain pumps at extreme costs, I think the question is, is this law in any way helpful?

MAJORITY CHAIRMAN KAUFFMAN: All right. I think that was a no. I’ll just say no. I think so, anyway.

Next we will go to Representative Mackenzie.

REPRESENTATIVE MACKENZIE: Thank you, Mr. Chairman.
First off, I would like to apologize for running late this morning, but I do want to thank you for holding the hearing.

So Mr. Huttemann, I guess I want to just follow up on the Chairman’s question. So you have described that there are problems in the current system. Have you ever offered any proposals or solutions to those problems that you described?

MR. HUTTEMANN: I haven’t proposed any legislation.

REPRESENTATIVE MACKENZIE: Okay.

At the last hearing that we held last session, I had an open-door policy and offered everybody in attendance to contact us and offer suggestions. Did you take me up on that?

MR. HUTTEMANN: I did not. I was not here.

REPRESENTATIVE MACKENZIE: Thank you, Mr. Chairman. That concludes my comments.

MAJORITY CHAIRMAN KAUFFMAN: All right.

Moving on, Representative Neuman.

REPRESENTATIVE NEUMAN: Thank you, Mr. Chairman, and thank you for your testimony today.

In your experience dealing with your clients, the same injury, different client, do you see that the same treatment worked for those two different clients?
MR. HUTTEMANN: No. I think every client is specifically individual.

It is a case-by-case basis, and that is why these regulations, these cookbook formulas for treatment, are not good.

REPRESENTATIVE NEUMAN: And when it comes to the opioids, would you be open to at least just discussing that portion, because that seems to be what they are tying a national formulary onto, an epidemic. It seems disingenuous to do that. Would you be willing to parse that out to talk about opioids and see if there is a pathway for reform in the workers’ compensation, just dealing with opioids?

MR. HUTTEMANN: I think so. I think that a good discussion can occur in that direction.

I do recognize that the addiction issue is severe. You know, it’s something that needs to be addressed. I think that addressing it in this manner is not effective.

I do want to go back and correct some questions that Mr. Marshall had from you, or to you, about whether addiction is covered under the workers’ compensation system.

When a client does become addicted, they are covered under the Workers’ Comp Act, and if they end up
passing away as a result of addiction, it is covered under the Workers’ Comp Act. So those costs aren’t pushed on to the public; those are retained within the workers’ comp system.

I just wanted to correct the record on that.

REPRESENTATIVE NEUMAN: Okay. I do appreciate that.

And now that you’re at this hearing, I would encourage you that if you do want to talk to the maker of the bill, I know that he is willing to talk to you. So I would appreciate that.

MR. HUTTEMANN: Yeah. I would absolutely look forward to doing that.

MAJORITY CHAIRMAN KAUFFMAN: Representative Chairman Galloway, I’ll go to you next.

MINORITY CHAIRMAN GALLOWAY: Thank you, Mr. Chairman. Real quick.

To address the point made by the Chairman, the Majority Chairman, about, if not this, what; just say no. I want to address a couple of things: how to make this bill better.

This bill appears to be a shell. There is no “it” to it, right? There’s no policy; there are no regs. We don’t know the formula. We don’t know the company. We don’t know the costs. Speak to improving the bill as it
relates to taking a blank piece of paper and actually putting something down onto it.

MR. HUTTEMANN: Well, the only way that the bill could be palatable, in my opinion, is if it was restricted down to the narcotic medications. But I do believe it may be better to address the issue directly with the physicians who are prescribing these medications and having rules upon them, not under a workers’ compensation formulary.

MINORITY CHAIRMAN GALLOWAY: We know what the doctors -- have the doctors weighed in on this issue? Do we know what---

MR. HUTTEMANN: They did provide a statement, the orthopaedic group provided a statement, and they did discuss how they’re going to be working on self-regulating themselves and reducing and monitoring much better.

MINORITY CHAIRMAN GALLOWAY: Are they for or against this bill? Do we know?

MR. HUTTEMANN: It indicated in its current form that they are against it.

MINORITY CHAIRMAN GALLOWAY: All right. Thank you.

MAJORITY CHAIRMAN KAUFFMAN: Thank you, Chairman Galloway.

And last, I’m going to go to Representative Dush. And there are others who have asked to be on the list, so
if you have questions, we will get those to Mr. Huttemann and we will get those answers to you.

So Representative Dush, you are last.

REPRESENTATIVE DUSH: Thank you, Chairman.

First, one of the things about the grand bargain here, the workers do have the option to sue when they’re not getting their treatment. You wouldn’t be in business if they couldn’t.

Secondly---

MR. HUTTEMANN: They have the option to sue to get workers’ comp. They do not have the option to sue for pain and suffering as any other party would have against a third party who was injured. So no, they don’t have the right to sue.

REPRESENTATIVE DUSH: To my question, in the number of States where this is actually currently going on where they do have the formularies, what are the issues that are causing all the things that you foresee as being a detriment with this bill?

MR. HUTTEMANN: Well, it creates a situation where there’s an automatic denial of medical care while it goes through utilization review. No one pays for it at that point.

I’ve had clients take out loans on their home in order to get payment under the current utilization review
setup in Pennsylvania. The way that these formularies are set up, nothing gets paid at all if it falls outside the formulary.

Now, I could tell you that in Florida, there has been such an attack on the workers' compensation benefits that a Supreme Court Justice in the last few years indicated that the grand bargain was so corrupted, that the employee had the right to sue the employer for pain and suffering.

REPRESENTATIVE DUSH: Is that directly related to what we’re talking about here?

MR. HUTTEMANN: It’s in terms of some other benefits.

REPRESENTATIVE DUSH: Thank you. So it’s not---

MR. HUTTEMANN: Well, correct.

REPRESENTATIVE DUSH: Thank you.

MAJORITY CHAIRMAN KAUFFMAN: All right. Thank you. We do have to move on.

Thank you very much for being here. We possibly have some follow-up questions, if Members would want to submit those to my office and we will get those answered.

MR. HUTTEMANN: Thank you.

MAJORITY CHAIRMAN KAUFFMAN: And the next panel we have here today: Carlos Luna, the Director of
Government Affairs for the Reed Group; Kenneth Eichler, Vice President at Work Loss Data Institute; and Aaron Turner-Phifer, Director of Government Relations of URAC.

And I appreciate you very much being here today. All three of these gentlemen came from out of town, and two of them came from great distances to be here, Florida and Colorado. So I thank you very much for being a part of this today.

And I am going to open it up, first to you to start out. These gentlemen, I’m going to bunch them together and I’ll let them present together, but we’ll start with you, Aaron.

MR. TURNER-PHIFER: Sure. Thank you, Mr. Chairman.

My name is Aaron Turner-Phifer, Director of Government Relations at URAC. I’m based out of DC.

I just want to do a couple of things real quick so we can have time for questions. Just give a little bit of background about who we are, what we do.

As a disclaimer, as a not-for-profit independent organization, we don’t take policy or political positions. So my role here is to provide background and market expertise about what we have seen across the country with respect to utilization review.
I would also note that we are the country’s largest accredits of pharmacy services, so PBMs, specialty pharmacies, mail-order pharmacies. So I’m happy to field any questions about formularies as well.

But specifically about utilization review. I want to just highlight that from our perspective as an organization focused on setting quality standards and using best practices. We’re focused on ensuring that organizations have a process to drive reliable outcomes for injured workers, and that means protecting workers from medically unnecessary care that may in fact do harm in the end.

So one of the issues that has been brought to my attention here in Pennsylvania is that the utilization review process as it stands now, there’s a high degree of variability, potentially a high degree of variability in the process. So one of the ways you can control for quality for the injured worker is to drive a process that is structured around best practices that ensures the injured workers are getting fair and equitable treatment based off of evidence, but not to say that every worker is treated the exact same way.

So guidelines are in fact guidelines. They are not meant to be protocols. There is a process in place to ensure that exceptions are made for those injured workers
that don’t fit the guideline.

Our role in Pennsylvania: We currently accredit 65 organizations that have actual brick-and-mortar locations here in Pennsylvania. Specifically, eight of those hold utilization review accreditation. The list of those organizations is included in my testimony.

I’ll highlight, the last gentleman mentioned some of the issues that are happening in California. I think that was a great example.

California, last year, actually passed legislation to reduce variability in their utilization review process, and one of the things that they did was require accreditation. So we’re in the process now of working with the State of California to ensure that there is some quality controls around the utilization review process based off of what other States are doing as well.

Finally, I just want to highlight, what can accreditation do for the opioid issue?

The thing that struck me is, in this conversation that I have had over the last year, is States are starting to engage in this more and more. This isn’t an issue that’s unique to workers’ compensation. It may be a highlighted issue in workers’ comp, but it’s an issue that the medical community broadly is facing.

The solution to the opioid issue isn’t going to
be solved in workers' compensation; it's going to take the entire system. So we often talk about injured workers as if that's some different thing than an actual patient. When a worker gets injured, they are a patient and they see their physician.

The response from the system has to be one that is holistic, that's focused on improving the care that a patient receives, regardless of who's paying for it. That's what the accreditation is meant to do. Regardless of what market that business is operating in, it's focused on quality care for the patient.

So what the accreditation does for the opioid issue is it creates a structure around the process and allows you to identify issues and target your activities around resolving that problem. So accreditation alone isn't going to solve the issue, but it is a framework by which you can base decisionmaking to engage in the problem.

And I just wanted to highlight something that the Secretary said. We would, if you should so choose to move legislation that includes an accreditation requirement, we would encourage a phase-in period. It typically takes about 10 to 12 months for an organization to go through the process. Especially if organizations haven't gone through the process before, it could take a little bit longer. So we would encourage a phase-in period with that.
So with that, I will pass it on.

MR. LUNA: Good morning, Honorable House Labor and Industry Committee Chairs and Members.

My name is Carlos Luna. I am the Director of Government Affairs for Reed Group, owners of the ACOEM-based Drug Formulary and Practice Guidelines researched and developed independently by the American College of Occupational and Environmental Medicine.

I also serve on the Research and Standards Committee, Disability Management and Return to Work Committee, and Medical Issues Committee for the International Association of Industrial Accident Boards and Commissions, also known as the IAIABC, and the Claims Administration Committee and Medical and Rehabilitation Committee for the Southern Association of Workers’ Compensation Administrators, or SAWCA.

I’m here today to share, from my perspective, how drug formularies can be used to improve the quality of medical care provided to injured workers to restore function post-injury or illness and avoid dangerous health effects, like prescription drug addiction due to inappropriately prescribed drugs.

I would like to focus my comments this morning on the following: what is a drug formulary; and secondly, who benefits most from a drug formulary.
The formulary concept, as has been said today, is not a new concept. The earliest version that I could track down was possibly from the 1700s. The purpose of the early versions of a formulary was to define a standard for the compounding and dispensing of medications in U.S. military hospitals, and by the late 1950s, early '60s, formularies had been adopted by nearly every hospital in the country.

The concept of a formulary has since evolved well beyond the simple drug list of its origins. In fact, today’s options include formularies that consider the patient’s medical condition, whether their condition is in the acute or chronic phase, and provides visibility to the strength of scientific evidence. This modern application allows prescribers to take into consideration each patient’s unique medical needs.

Modern formulary versions also have clear links to the scientific evidence, helping all stakeholders, providers, payers, employers, and employees have access to view the science that supports the drug’s recommendation, or lack thereof. These modern traits ensure that the right pharmacological therapy is provided to the right people at the right time.

Health benefits to injured workers are achieved by a formulary’s separation of drugs into two categories using scientifically and evidence-based information:
formulary drugs and non-formulary drugs.

Formulary drugs are preselected, are preferred, and their delivery can be simplified and expedited to injured workers. The primary goal of these drugs in work comp is to keep injured workers safe from the negative effects of drugs that are not medically necessary, are overly prescribed, or are not proven to be effective.

Non-formulary drugs, on the other hand, are not part of this expedited, streamlined approach and will require preauthorization. Please note, this does not mean that non-formulary options are definitively unavailable to injured workers. It does mean, however, that based on the preponderance of evidence and expert medical consensus, these options may not be the most effective, medically necessary, or serious risks and adverse effects outweigh the benefits to the patients, thus requiring prospective utilization review prior to dispensing.

Some jurisdictions, like California, create “special fill” policies, making certain that certain non-formulary drugs are available to patients for short periods of time while the prospective utilization review is completed.

The exceptions process from the formulary that is implemented along with the formulary cannot and should not be overly cumbersome. Patients should not be denied
medically necessary treatment.

Based on the information that I have provided respective to what a drug formulary is and what it is intended to do, you may now be able to reach a conclusion on what a formulary is not:

A formulary is not a license to say no to patients.

A formulary is not a cost-containment tool.

A formulary is not a blunt instrument.

A formulary is a tool to help guide medical decisions on best, most effective pharmacological care for the functional restoration of injured workers.

Now, who benefits most from a drug formulary?

A properly implemented and regulation-supported drug formulary provides multifaceted benefits to various system stakeholders in work comp. The health benefits to the injured worker, by far, are the most important.

In California, where according to the California Workers’ Compensation Institute report, “A Review of Preferred and Non-Preferred Drugs,” which was published in August of last year, 27 percent of all California work comp prescriptions were opioid analgesics. All of the opioids are listed as non-formulary or nonpreferred drugs, while the exception of limited “special fill” prescriptions that are subject to prospective utilization review exists.
Also addressed as nonpreferred drugs are bulk chemicals, which are raw ingredients for compound drugs. They represent only 3 percent of prescriptions and 11 percent of payments. They are considered non-formulary, making them subject to prospective utilization review.

The report also identified that the top 20 common brand-name drugs within the study sample represented the majority of all prescriptions of the State’s formulary’s preferred drugs.

As far as California goes and certainly for Pennsylvania, the formulary would provide a framework that requires meticulous consideration, through prospective review, of drugs that have been proven to have more risks associated with them, are considered experimental or non-FDA approved, like compound drugs, and expedites the delivery of drugs that are proven to be safe, effective, and restore function to the injured worker.

I hope that I have provided some insight to you this morning that will allow you to give thoughtful consideration to passing legislation around a drug formulary. As echoed today multiple times, it’s not about the numbers, it’s not about the costs; it’s about the lives that are being impacted, not only by opioid prescription drugs but also by other potentially dangerous drugs available to workers’ compensation patients.
Thank you.

MR. EICHLER: Representative Kauffman, Representative Galloway, Members of the Committee, thank you for having me today.

My name is Ken Eichler. That’s E-I-C-H-L-E-R. I am Vice President with ODG/Work Loss Data. We are a division of the Hearst Health Network. We publish the formulary and guidelines that have been adopted in most of the States across the country that have adopted formularies.

In preparing for testimony, I had a conversation on Monday with an esteemed colleague of mine, a gentleman named Bill Zachry. Bill ran the workers’ compensation and risk management programs for Safeway and Albertsons, one of the largest grocers in the country here.

In preparing for the testimony, Bill gave me a wonderful piece of advice. Bill has done reform across the country and has been a good mentor to me. He said, Ken, rip up your testimony and be real. He said, give the basic numbers, talk about how this is going to impact business, talk about how it’s going to impact injured workers, and talk about how it’s going to change lives. He said, also be responsive to the Representatives who are at the hearing today. So in doing so, I did abandon the standard presentation and came up with some notes as we were going
and some key points.

As Carlos mentioned, what is a formulary? A formulary is basically a list, and we all have formularies in our lives, whether it’s in group health, and believe it or not, here in Pennsylvania, most of the PBMs and insurance companies do utilize formularies of some sort, but they’re silent formularies.

The adoption of a comprehensive formulary here in Pennsylvania will open the playbook, so to speak. It levels the playing field, and it puts everybody on equal standing, guaranteeing standards for all injured workers. We have got to protect the injured workers, but we’ve got to expedite the delivery and access to those medications.

Why do people focus on opioids? It’s sexy, it gets publicity, and it’s what’s killing people, but the formularies go far beyond that. Representative Galloway and others asked about the access to other medications and what does the formulary do on that: It expedites the delivery.

If you turn to any physician that is a specialist, there has been a cadre of maybe 10 to 15 prescriptions or medications that they generally use in their practice for an orthopod, a neurologist, an ophthalmologist, and the like. An internist is going to use many other medications.
By having a formulary, it’s basically bucketing the drugs into two lists. One is a list that does not require preauthorization, which is the majority of the drugs. It’s a FastPass. It’s an E-ZPass. It gets it through quickly and gets the drugs into the hands of the injured worker.

The drugs that do require preauthorization, the nonpreferred drugs, are a stop and pause. That’s a chance to stop and think about it: think about whether that medication is appropriate and whether there are alternatives.

And the name is blocked, but I’m sorry, the Representative in the back corner had asked about chiropractic care and alternative care. What a formulary further does is encourages the use of alternative treatments other than just turning to chemicals to treat and help the injured worker to get better. We have got to do what’s right by the injured worker.

I’ll toss a couple of facts and figures out to you and some other basic information in response to questions that were raised.

On the issue of the drugs and how does it impact folks, I’ll give you an example. Let me stop for a second and ask you to all ask yourselves a question: Is there anyone in this room that does not have a friend, a family
member, a member of their church, a business associate, or somebody they know who has not been impacted by opioids negatively? I doubt there are very many people that could raise their hands and say they haven’t been touched within just a couple of degrees of separation.

In Texas, which was the leader in using formularies, prior to formulary, there were over 15,000 people on over 100 morphine equivalents a day. That’s a lot of morphine equivalents. Those are the people who get into trouble. Post-formulary, there are less than 500 individuals in the State of Texas workers’ compensation receiving those levels of opioids. It protects those injured workers.

No State that has adopted a formulary -- and there are several that have, either self-developed or gone with a commercial formulary -- has turned back. Every State has had success.

I serve on the committees, as does Carlos. I have chaired the committees with the IA, with SAWCA, with others. I’m an appointed member of the advisory council that’s available to regulators and Legislators. And I’ll tell you, Director Weiant from Labor and Industry has those resources, can speak to the other regulators, has spoken to those other regulators, and can document that these formularies work and expedite the care, expedite the
treatment.

    I’ve got to move quickly here.

    Texas. I’ll give you some quick numbers as far as the results, because that was asked, as far as costs and whatnot.

    NCCI, by the way, the National Council on Compensation Insurance, has done predictions that the adoption of the formulary, depending upon the State, will drop the cost between 10 and 20 percent overall while expediting care.

    In Texas, the numbers -- and this I just got from the former commissioner, who is still involved in Texas -- that the number of prescriptions overall since the formulary has been down 10 percent. And that’s changing doctor-prescribing patterns, because when the docs know what can be easily authorized, they go forward with it. It doesn’t deny care.

    You’ve got the overall risky drugs, the ones requiring preauth, down 76 percent. You’ve got an 11-percent drop on opioids. You got an 81-percent drop on the spend of those risky drugs. The total costs for all medications are down 15 percent, and the nonpreferred drugs are down 85 percent. The more current numbers are currently being tabulated for Texas.

    Overall, it works. It empowers the physician,
and it does nothing but have positive results.

MAJORITY CHAIRMAN KAUFFMAN: Thank you, gentlemen, for your testimony.

And in starting questions, I’m going to start with Representative Delozier.

REPRESENTATIVE DELOZIER: Thank you, Mr. Chairman.

I have two quick questions for Mr. Luna. Thank you all for your testimony.

Mr. Luna, in your testimony you bring up the issue of acute versus chronic, obviously within the diagnosis that we have with our workers. Along that same line, you also bring up the unique medical needs.

So we have had testimony where it was stated that everyone is treated the same and just cut off at certain points. So can you address that point that you made in your testimony about their ability and the doctor’s ability to address the uniqueness of every case, which was mentioned; everybody is a little bit different. So can you address your comments on that.

MR. LUNA: Absolutely.

I certainly don’t want to take away from the gentleman’s testimony before me. I do believe that there might be outliers out there where parties may use a tool, like a formulary, in an inappropriate manner. However, I
think by popularity, and really far and large, I think you’re going to find providers utilizing these tools with wisdom and with common sense.

It’s true that not all prescription drugs are appropriate for all people all of the time, and I would be the first to admit that not every single person or not everybody in this room is the same and has the same medical needs.

I think the concept of formularies has come a long way since the 1700s. I think that had we continued to implement that type of system, you would very well have patients that are cut off, that are, unfortunately, denied care that their physician feels that they need. But in this day and age, if you speak with other State jurisdictions that have enacted formularies, I think you’re going to find that the majority of patients that go beyond the formulary options are actually afforded those medications because their physicians do the due diligence, do the research, to substantiate that their patients’ medical conditions actually require these medications.

A formulary is not a license to say no. It is not a mechanism to interrupt medical care for anyone. It’s a tool to add additional consideration to whether or not this prescription is appropriate for the patient.

It allows patients to point to a resource other
than their own expertise and knowledge. In fact, many doctors that are advocates of evidence-based medicine, particularly formularies, will admit to you that their initial response was somewhat hesitant to utilize it. But once they actually begin to utilize the tool, it provides them a lot more support from a scientific evidence standpoint to be able to support their recommendations to their patients.

MR. EICHLER: If I can weigh in on one comment to that as far as physician participation.

REPRESENTATIVE DELOZIER: Okay.

MR. EICHLER: Physicians will initially flinch, as would anyone with any potential regulations about to be imposed on them. But the facts and the statistics show that Texas and every other State that has developed a formulary has greater physician participation now with decreased transactional processes and delays at the physician’s office than ever before. It makes it easier for them.

REPRESENTATIVE DELOZIER: Okay. And just, if I could, just one other follow-up, Mr. Luna. You mention in your testimony, in California, only 27 percent were opioid prescriptions? Did I read that right, or do I have that---

MR. LUNA: Correct; 27 percent of the overall
worker’s compensation prescriptions.

    REPRESENTATIVE DELOZIER: That just seems low to me, considering we’ve been having a conversation as to the high level of opioid overuse and then, therefore, addiction.

    So the 27 percent. So a majority in California, according to this report then, is not opioid prescriptions; they are the lesser, and I’m not a doctor so I don’t know the official term for them, but they’re not the opioids, so they’re not the ones that people are getting as addicted to. So I guess that kind of conflicts with some of the things that we have been hearing as to how high the opioid prescriptions are.

    MR. LUNA: Twenty-seven percent, to put it into context is, one out of every four pills that is prescribed in the State of California for workers’ compensation is an opioid. I think that that also speaks to the question of, are we just dealing with an opioid problem? The answer is no, we’re not.

    REPRESENTATIVE DELOZIER: There are lots of other ones that are out there as well.

    MR. LUNA: Correct.

    REPRESENTATIVE DELOZIER: Okay.

    MR. LUNA: Today’s opioid problem is tomorrow’s benzo problem.
The problem is not so much with the pill itself; it’s with prescribing habits. States that have enacted formulary tools have actually been successful in changing the mindset around prescription drugs. Providers begin to look at more beyond their own clinical expertise to support their recommendations for prescriptions, understanding the dangers that could potentially lurk.

MR. EICHLER: Also, the formularies that have been adopted in several other States include some short-acting opioids and musculoskeletal agents as drugs that do not require preauth. We have got to make sure that there is never a gap in treatment.

There was a citation made earlier that patients are denied access to medications during utilization review. That’s all in how the regs are written. And the Department here is very competent at writing strong, good regs that will protect the injured worker.

And if those opioids that are on the preauth list that do not require preauth are there, there are those stopgap measures to make sure there is continuity of care and somebody does get access to the medications.

MAJORITY CHAIRMAN KAUFFMAN: Thank you. Thank you very much.

Representative Donatucci.

REPRESENTATIVE DONATUCCI: Thank you,
Mr. Chairman, and thank you for your testimony today.

“The primary goal of a drug formulary in workers’ compensation is to keep injured workers safe from negative effects of drugs that are not medically necessary, are over-prescribed, or are not proven to be effective.”

Shouldn’t that be true of all patients? I mean, it’s almost unconstitutional to treat one group of patients so much different than another.

And let me continue and you can answer all the questions at once, is, you know, Purdue Pharma, when they came out with OxyContin, they branded it as being non-addictive, non-dependent. There was a $600 million fine from the government early on, and nobody did anything about it until now. We have people dying every day.

So how do I know that the way Purdue Pharma went about getting databases of who prescribes pain medicine, how they targeted certain doctors, how do I know that other pharmaceuticals aren’t going to do the same thing to get on that list, and they are two of my biggest concerns.

MR. EICHLER: You are spot on, and if I could address that for you.

Why workers’ comp being treated differently? In group health, you get what you pay for. Group health, you buy a policy. You have defined benefits. There are specific drugs that are covered and not covered. If it’s
not on the list, you’re not getting it unless you’re paying out of pocket.

In workers’ comp, that’s not the case. An injured worker is entitled to any treatment or any medication that can be medically substantiated. Hence, in workers’ comp, there’s a carve-out there where you need these extra layers of protection to empower getting the right drugs and to have that pause to review the drugs that are questionable to make sure they are substantiated. We have got uninformed medical consumers in the workers’ comp community, and this becomes a protection for them.

As far as claims being made by Big Pharma, we’re all subject to that. This bill is not meant to control those claims, but it does give, again, that stopgap to get a chance to look at them and protect the injured worker.

MR. LUNA: I’ll add on to that.

Workers’ compensation, keep in mind, is a dollar-one benefit, meaning that benefits are paid beginning with the first dollar spent.

Workers’ compensation is particularly susceptible to these types of abuses because of that reason. There are studies that have been done that actually document providers admitting that they are shifting costs from public programs to workers’ compensation because of that reason.
Touching on your point regarding your concern about the marketing of drugs getting onto lists. I think it speaks to the importance of having a high quality, evidence-based formulary. The evidence-based process by nature will weed out any bias, any studies that aren’t of high quality that are developed by marketing firms that have intentions on skewing perspective.

Evidence-based medicine also requires external review, meaning that nationally recognized associations, like the American Medical Association, potentially the Pennsylvania Orthopaedic Association, could be called upon to review specific recommendations for drugs for formularies. These steps ensure that the drugs that actually make it on to an evidence-based formulary are actually effective, that they actually do what they are intended to do.

Additionally, an added layer of protection for the State -- and many States have done this; particularly in California, they’ve done it well -- is to create what is called a P&T Committee, a Pharmaceutical and Therapy Committee, where they include local providers, pharmacists, and health-care specialists to participate in this committee to ensure that the formulary that is adopted by the State, although being nationally recognized, is actually right for the State of Pennsylvania and its
people.

So there are a couple of layers of protection there to prevent those types of issues from coming up.

MAJORITY CHAIRMAN KAUFFMAN: Thank you.

And lastly, we’re going to go to Representative Krueger-Braneky, please.

REPRESENTATIVE KRUEGER-BRANEKY: Thank you, Mr. Chairman, and thank you, gentlemen, for joining us today.

I’ve got a couple of brief questions, and I appreciate, Mr. Chairman, that you’re keeping us on time today.

So my first question is for Mr. Turner-Phifer. So you represent an accreditation organization, correct?

MR. TURNER-PHIFER: Yes.

REPRESENTATIVE KRUEGER-BRANEKY: What is typically the cost of accreditation?

MR. TURNER-PHIFER: So the cost varies. We’ve got 27 different programs, so the cost is structured based on that program’s market, what the market can bear, and then our overhead over 3 years.

So the accreditation is good for 3 years. An applicant would pay a one-time fee. For utilization management, that fee is just under $37,000.
REPRESENTATIVE KRUEGER-BRANEKY: Okay. So the fee is $37,000 for them to become accredited.

And I see in your testimony you currently accredit 65 organizations in Pennsylvania. Fifteen are under utilization review. So total cost of accreditation would be 37,000 times those 15 providers in Pennsylvania?

MR. TURNER-PHIFER: So an organization would pay -- an organization would pay once. So if you’ve got 20 UROs, it would be 20 times 37,000. A URO pays themselves, if that answers your question.

REPRESENTATIVE KRUEGER-BRANEKY: Okay. So 20 times $37,000.

MR. TURNER-PHIFER: I just don’t know the stats on the number of utilization review organizations in Pennsylvania.

REPRESENTATIVE KRUEGER-BRANEKY: Okay.

And then my second question, so for the other two panelists, my understanding is that you represent the only two formularies who would actually be qualified to be selected by the Department of Labor if this bill was to pass? Is that correct?

MR. EICHLER: It depends how you look at the definition. Generally when you’re looking at the nationally recognized, commercially produced, we’re the two that are at the table.
REPRESENTATIVE KRUEGER-BRANEKY: Okay.

MR. LUNA: I can add to that.

The State of California also considered the State of Washington’s drug formulary as well, so we are not the only two at the table for discussion.

REPRESENTATIVE KRUEGER-BRANEKY: So possibly the only two at the table, possibly not.

MR. EICHLER: Yeah. The reason I say that, it’s nationally recognized. What is the definition?

REPRESENTATIVE KRUEGER-BRANEKY: Sure.

MR. EICHLER: Is it one State? Is it two States?

The State of Washington is monopolistic. Everyone looks at it, because monopolistic, they can do certain things other jurisdictions can’t.

REPRESENTATIVE KRUEGER-BRANEKY: Sure.

MR. EICHLER: So folks look at it. Does that mean it’s nationally recognized? Well, if we all look at it and recognize it as working---

MAJORITY CHAIRMAN KAUFFMAN: Okay. Thank you. We need to move along.

REPRESENTATIVE KRUEGER-BRANEKY: A follow-up question, Mr. Chairman, please.

MAJORITY CHAIRMAN KAUFFMAN: No; no. We’re actually going to move along. You can have a sidebar with him afterwards.
REPRESENTATIVE KRUEGER-BRANEKY: Okay. I’m curious of the cost of what they’re proposing---

MAJORITY CHAIRMAN KAUFFMAN: I’m going to move on--- Excuse me. We’re going to move on to Representative Mackenzie to offer closing remarks.

REPRESENTATIVE MCKENZIE: Thank you, Mr. Chairman.

I appreciate us staying on schedule. I know everyone has busy schedules today.

So I do want to conclude just very quickly in saying that I appreciate the discussion that we have had today. We had a hearing on House Bill 1800 last session. We have received lots of significant and very positive input from the different stakeholders, many of whom are represented here today.

We also heard from others who were opposed, and when we heard that opposition, we looked at how we could make this legislation better and actually effect the impact that we want. And so specifically a turning point in this legislative process was a hearing on, the Policy Committee held a hearing on opioids down in Philadelphia at Temple University, and there was discussion about other treatment guidelines which are already going into effect here in Pennsylvania for other types of medical treatments.
And during that discussion, myself and Representative Gergely, who is not here today, expressed, both expressed a willingness in working on a drug formulary guideline for workers' compensation. He expressed an interest in working on that with me. And since then, I've heard from lots of other Members, bipartisan Members, who think that opioids are a problem here in Pennsylvania.

I heard some who want to diminish that fact, who want to take no action on that fact. And unfortunately, this continues to be a significant problem in Pennsylvania. And in workers' comp specifically, we have the third highest amount of opioids prescribed per injured worker out of 25 States studied by the Workers Comp Research Institute. We have the second highest number of opioid pills per prescription per claim. And morphine equivalents per injured worker averaged 78 percent higher than the median State studied.

If we are going to undertake a drug formulary for opioids to reduce this problem, that should be sufficient to work for other drugs as well. And we know, even though we have good data on opioids, we know that over-prescription and addiction is a problem with all medications.

So thank you again, Mr. Chairman. I want to really express my gratitude for holding this hearing. And
again, I want to stress to everybody that I do have an open-door policy. Ever since House Bill 1800 last session, we have met with many stakeholders, both in support and against, to come up with House Bill 18 to directly impact, and in a positive way, over-prescribing and addiction in workers’ comp.

Chairman Galloway, I want to extend that offer to you as well. You did not take me up on that since last session to discuss this topic, but I want to extend that to you again as well, that I am open and always willing to discuss.

Thank you.

MAJORITY CHAIRMAN KAUFFMAN. Thank you very much.

I appreciate the panelists being here, everyone who participated. And I do want to encourage all Members and stakeholders to reach out to my office or Representative Mackenzie’s office to improve upon legislation. You know, when you -- yes. There is one correction.

I know one of the panelists indicated they thought the Orthopaedic Society was opposed to the legislation, and the Orthopaedic Society informed us they are not opposed to the legislation. They have some constructive criticism and some help to make the legislation better, but they are not opposed to this. And
that’s the kind of conversation we want to have to make this the best legislation possible and, you know, to move forward with the process.

So thank you all very much. And if the panelists are here, if there is further conversation to be had, I don’t think they’re going to rush off to Colorado and Florida and DC. So thank you all very much.

We will reconvene at 1 o’clock for the next informational meeting.

(At 12:01 p.m., the public hearing adjourned.)
I hereby certify that the foregoing proceedings are a true and accurate transcription produced from audio on the said proceedings and that this is a correct transcript of the same.

Debra B. Miller

Transcriptionist

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