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HOUSE OF REPRESENTATIVES

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10:00 A.M.

PRESENTATION ON
PRESCRIBING ISSUES AND WORKERS' COMPENSATION

BEFORE:
HONORABLE JIM COX, MAJORITY CHAIRMAN
HONORABLE CRIS DUSH
HONORABLE RICH IRVIN
HONORABLE DAWN KEEFER
HONORABLE KATE KLUNK
HONORABLE RYAN MACKENZIE
HONORABLE PAUL SCHEMEL
HONORABLE PATRICK HARKINS, DEMOCRATIC CHAIRMAN
HONORABLE LEANNE KRUEGER
HONORABLE GERALD MULLERY
HONORABLE ED NEILSON

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Pennsylvania House Of Representatives
Commonwealth of Pennsylvania

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TESTIFIERS

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SUBMITTED WRITTEN TESTIMONY

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(See submitted written testimony and handouts online.)

P R O C E E D I N G S

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MAJORITY CHAIRMAN: Good morning. I want to thank you all for coming, and I'd like to start with the Pledge of Allegiance if I could.

(The Pledge of Allegiance was recited.)

MAJORITY CHAIRMAN: I'd like to welcome everyone to this hearing of the House Labor and Industry Committee and, at this point I'd like to make sure everyone knows that the meeting is being recorded, and so I'd ask that all the members and those in the audience if you could silence your cell phones and any electronic devices. And at this point, we're going to jump in really quickly, but I want to just lay a little bit of groundwork and give the Minority Chairman an opportunity to say a few comments if he'd like as well.

We called this hearing today to discuss some problems, kind of ongoing problems that we've seen over the last few years. Last year the General Assembly actually passed legislation in an attempt to address the issue, and it would have required the Department of Labor and Industry to implement an evidence-based drug formulary for workers' compensation, but the Governor chose to veto that

legislation. Shortly after that, the Governor did announce some executive actions, and they were directed at the Department of Health and the Department of Labor and Industry. They were intended to address the overprescribing of opioids and compound medications, so today we have the secretaries of both of those agencies here to provide us with an update to see how those executive actions are panning out. Are they doing what we had hoped? And we'll see where we can go if there's any gaps that are there that we need to address with legislation. That's what we're hoping to hear from today.

Chairman Harkins, do you have any comments or questions at this point?

CHAIRMAN HARKINS: Thank you, Mr. Chairman. I look forward to the testimony today. I know this is an ongoing issue. There's a lot of concern in my area as well as the entire Commonwealth with this. I think there's got to be common ground that we can reach with everyone on it at some point, and I hope that we can get there soon. Thank you.

MAJORITY CHAIRMAN: All right. I'll introduce each of the panelists as we go. Today, we're going to start with Secretary Oleksiak with the Labor and Industry Department. If you want to just start right off.

SECRETARY OLEKSIAK: I'll be happy to, Chairman.

Good morning Chairman Cox, Chairman Harkins, Committee members, and Committee staff. I appreciate the opportunity to appear before you today to testify about the steps that have been taken under Governor Wolf's important executive action aimed at reducing the overprescription of opioids to injured workers. I'm Gerry Oleksiak, the Secretary of Labor and Industry, and with me is Scott Weiant, our Deputy Secretary for Compensation and Insurance.

The Governor's comprehensive executive action announced in April 2018 included a number of initiatives designed to limit the overprescription of opioids while still ensuring that injured workers in Pennsylvania receive all the care necessary and appropriate for their injuries. In response to this charge, my department has partnered with the Department of Health to institute some important steps that keep injured workers safe and ensure appropriate treatment.

First, the Governor committed to creating prescription guidelines for opioids in workers' compensation. Under the leadership of Dr. Levine, the Department of Health developed and published those guidelines in June of 2018. I'm extremely happy to report that since the implementation of those prescribing guidelines, and since the Governor's executive actions were announced, we have begun to see results. We've noted

significant reductions in opioid prescriptions throughout the workers' compensation system, especially in terms of prescriptions under the State Workers Insurance Fund (SWIF) which is the largest provider of workers' compensation insurance in the Commonwealth.

Beyond those guidelines, my department has successfully partnered with the Department of Health to create a process to use a prescription drug monitoring program to monitor workers' compensation prescriptions that are submitted for medical fee review and utilization review. Working together, we are also providing training for all workers' compensation judges on the appropriate use of opioids in the treatment of workers' compensation injuries. Dr. Levine will be presenting that training at our conference in June.

Additionally, the Bureau of Workers' Compensation in our department has partnered with Drug Free Workplace PA to provide substance abuse and opioid-related training as part of the Pennsylvania Training for Health and Safety Initiative. That's PATHS. Many of you may know this training as part of the Workplace Safety Committee Program which provides an incentive of a 5 percent insurance premium discount for employers who participate in the program. In the past year, 57 separate trainings have been held, and nearly 1,500 individuals have been trained in

recognizing the signs of opioid addiction.

Labor and Industry has also partnered with Health, the Department of Human Services, and the Department of Drug and Alcohol Programs to receive a $5 million federal grant to address opioid use in work force development. The grant will provide some of the state's hardest hit areas with support needed to develop a multi-pronged approach to treatment, training and re-employment of those affected by the opioid crisis. This interagency cooperation is indicative of the approach the administration has taken to address the crisis. We continuously coordinate with these and other agencies taking on the opioid crisis through the Opioid Command Center at PEMA. Weekly meetings are held. Weekly phone calls are held at the command center, and that is in addition to the program communications through the normal course of our business.

Additional measures taken by the Bureau of Workers' Compensation to carry out the Governor's directives include close scrutiny of utilization reviews, specifically for cases undergoing medical fee review or utilization review that include opioid use. Our nurses review records for signs of overprescribing. The Bureau has worked closely with the Department of State which licenses health care professionals so that we can then

report those providers who appear to be overprescribing to the Department of State and the Department of Health. The State Workers Insurance Fund, which is the largest writer of workers' compensation insurance in the Commonwealth, has also taken steps to closely monitor opioid prescriptions. Some good news ... Since the prescribing guidelines were published in June of 2018, less than a year ago, SWIF has seen a 23.5 percent decrease in the number of claimants receiving opioid prescriptions.

We are also taking steps, as the Governor directed, to address the cost of topical compound opioid prescriptions. Labor and Industry has conducted several stakeholder outreach meetings with health care providers, insurance carriers, and self-insured employers, workers' compensation attorneys, and other interested parties to solicit their input regarding possible measures to properly and effectively reduce the cost of these prescriptions as well as other non-opioid compound drug prescriptions. This input is being reviewed by the policy office, and we anticipate recommendations some time this legislative session. At Labor and Industry we have taken, and will continue to take, significant steps and we are making real progress in the fight to reduce the dependence on opioids in the workers' compensation system. We take these steps with the important realization that injured workers deserve

prompt access to appropriate and meaningful treatment to address their injuries and with an appreciation of and respect for the doctor-patient relationship. Our focus has been and remains on systemic issues that will allow us to identify and address overuse but not to eliminate appropriate treatment for those who need it. With that, I'll defer the rest of our time to Secretary Levine and then Deputy Secretary Weiant and I will be happy to take any questions you may have. Thank you.

MAJORITY CHAIRMAN: Thank you. At this time, we will hear from Dr. Rachel Levine.

SECRETARY LEVINE: Good morning. Thank you for inviting me here today. I'm very pleased to be with my colleagues from the Department of Labor and Industry, so thank you Chairman Cox, Chairman Harkins, and all the other members of the Committee.

I'm very pleased to have the opportunity to speak about the Commonwealth's prescribing guidelines for workers' compensation. In 2017, there were more than 174,000 workers' compensation claims made in Pennsylvania. A recent study had found that in the past Pennsylvania had ranked third highest in the nation in the percentage of injured workers who had become long-term opioid users. In addition, workers who received longer-term prescriptions of opioids for work-related lower back injuries had actually a

longer duration of temporary disability.

As has been mentioned, in May of 2018, under the direction of the Governor, the Safe and Effective Prescribing Task Force, which is a collaboration of the Department of Health and the Department of Drug and Alcohol Programs, developed guidelines to support providers as they seek to define the most careful and judicious way to prescribe opioids for the treatment of acute and chronic pain following work-related injuries. The decision to prescribe opioids for work-related injuries places providers in a rather unique situation where issues such as duty status and safe pain relief in the occupational setting become factors for consideration in developing a roadmap for the worker's recovery. The prescribing provider plays a key role in protecting injured workers from unsafe treatments. These guidelines are targeted to any provider who may encounter and treat a patient with a work-related injury. While it may be appropriate to treat pain with opioids such as acute pain arising from a traumatic injury, or acute post-operative pain, we do recommend strongly in the prescribing guidelines that opioid prescriptions be at the lowest dose and the shortest duration possible and in conjunction with alternative treatment options. The guidelines were specifically designed to promote delivery of safe, quality health care

to injured workers, ensure patient pain relief and functional improvement, to be used in conjunction with our other treatment guidelines, not in lieu of other recommended treatment, to prevent and reduce the number of complications which can be caused by prescription medicines including the possibility of the disease of addiction, and recommend that opioid prescribing practices promote functional restoration. The workers' compensation prescribing guidelines are not intended, as all the other guidelines; they are intended to supplement, not replace, clinical judgment. The workers' compensation prescribing guidelines are added to the ten other that we have developed for health care practitioners. We have pediatric guidelines. We have geriatric guidelines. We have dental guidelines. We have pharmacist guidelines. We have orthopedic guidelines. We have OB-GYN guidelines. We have emergency department guidelines, et cetera. And they are all synergistic, and they are all consistent with the 2016 CDC guidelines. We are constantly reviewing and updating these guidelines. They are living documents, so every two to three years we review them with experts in the field and potentially revise them. And we again update these as medical research and evidence moves science forward.

I just want to take a minute -- it's a little outside the written testimony -- to put this in context

with the Governor's response to the opioid crisis. So, by far the biggest public health crisis that we face in Pennsylvania and in the nation is the opioid crisis. And so the Governor has issued a disaster declaration of which I'm sure you are aware. Those are 90 days in length, and we are in the fifth iteration of this disaster declaration. That brings together 17 different agencies to the Pennsylvania Emergency Management Association together every week to deal with the opioid crisis from our unique perspectives, and L&I is a valuable member of that team. So, we have the Health and Human Services hub; we have PEMA; we have Public Safety and Law Enforcement, and then we have L&I, Education, DMVA, et cetera, all at the table to look at the opioid crisis.

There are three pillars to our response. The first is prevention. The second is rescue with the medication naloxone, and the third is treatment. And so we have to do all of those at the same time to address the opioid crisis. So the workers' compensation guidelines are in that first category, prevention. We do have school-based prevention efforts with the Department of Education. We have community-based prevention efforts, and then we have efforts which I like to call opioid stewardship, opioid stewardship. And the idea is that we want to teach the medical community, including physicians who treat

injured workers, how to use opioids more carefully and judiciously. Opioids are necessary medicines and as pointed out, if you had an acute injury and you are in the emergency department in severe pain, then you need an opioid. If you had a major operation this morning down the street, you need an opioid; and if you have chronic pain, examples we use are cancer pain and end-of-life pain, you need an opioid. We do not want patients to suffer. But we do need to use opioids very carefully and judiciously for acute and chronic pain. And the prescribing guidelines that are mentioned are one of the linchpins of our efforts. Others are the prescription drug monitoring program that the Secretary mentioned which is another critical aspect of our opioid stewardship efforts and there are more. I know the Secretary had talked about success in the workers' compensation prescribing realm. In general, our data from the Prescription Drug Monitoring Program indicates that in the last two and one-half years, since the PDMP was active, we have decreased opioid prescriptions over 21~~twenty-one~~ percent. So we are making progress, but we still have more work to do on all of these three fronts.

So thank you for the opportunity to speak about these initiatives and I'm also happy to answer any questions.

MAJORITY CHAIRMAN: Thank you. My initial

reaction to the guidelines was, okay let's see how they work. It sounds like we're hearing that they are having a positive impact. The one thing we continue to hear about though, is what I'll call price gouging. Do the guidelines do anything, do they have any attempt to focus on some of the prescribing, or I should say the prescription price gouging and things like that? Are there things in there that attempt to at least bring that to the attention of the prescribers?

SECRETARY LEVINE: I'll let Secretary Oleksiak speak more about that. These were prescribing guidelines to educate physicians about opioid stewardship, so they do not deal with cost. Secretary.

SECRETARY OLEKSIAK: Sure. We are conscious of costs. We have part of our utilization and medical cost review that was part of the Governor's executive action relates to that. We are looking closely at the cost of compound creams and related opioid creams. We are making progress. The Governor was clear in his executive order that we needed to reduce costs. We have, as I mentioned, our utilization review nurses who are looking at that. He's tasked us to develop regulations that are related to the topical opioid compound prescriptions; and we have, as part of our outreach to stakeholders, which we just concluded in December -- this was a topic of that outreach

that I mentioned -- to insurance companies, other attorneys, claim and advocacy groups, different folks that we reached out to. What I'd really like to do is ask Scott to talk a little bit more about the cost savings that we have seen, if that would be . . .

DEPUTY SECRETARY WEIANT: Sure. Chairman Cox, Chairman Harkins, distinguished members and staff. Thank you for the privilege to answer some questions this morning. Concerning the limiting of overly expensive opioid topics, one of the Governor's executive actions, one of the line items, I do need to point out that although the executive action was to limit the overly expensive opioid treatments, when we started looking at the issue, we looked at the issue from a holistic perspective of not just the opioid compounds but compounds in general in the workers' compensation system in Pennsylvania. And that's the way we were approaching the whole mannerism of it.

As Secretary Oleksiak had stated, we had four stakeholder calls conducted through October through November 2018. And we did identify a number of issues during those stakeholder calls. Some of those issues were known to us. Some of those issues were not known to us. Things like co-packs that were coming into play in Pennsylvania where you have pharmacies adding together different medications and calling it a co-pack and

dispensing them out for the convenience of individuals, and those co-packs were being priced enormously high. We also seen during those discussions and review of the whole incident that we had things as simple as vitamin packs that were being packaged together and being provided to claimants and those vitamin packs were being charged at really, really high rates as well. So, it was not just the opioids within the system or medications within the system that we were used to seeing, but there were some other loopholes in the system, so we're looking at this whole process from a holistic perspective.

But I do have some good news in relation to some of the compounds. When we ran some of the numbers -- and we were fortunate to have the Pennsylvania Compensation Rating Bureau provide us with some numbers this week -- we took a look at the compound drugs that were written, the scripts that were written, and we went back to the first quarter of 2016, and during the first quarter of 2016, the number of scripts that were written for compound drugs were 7,897 scripts. And during that period, for those 7,897 scripts in that first quarter in 2016, the amount paid for those scripts was about $6.4 million. Now fast-forward over the years, you can see every quarter that that number has substantially gone down. If you compare that number with the second quarter number of 2018, the number of

scripts that were written were 924 for compound meds, and the cost associated with those scripts for compound meds was $562,207. There was a decrease between that time period from that quarter to this quarter, just those quarters, there was a decrease of about $5.8 million. That's quite impactful. It's a quite impactful decrease.

During the 2014-2015 period, it was pretty much a phenomenon across the United States where compounds were hitting the scene, and since that time, about 2015, you have seen a drastic decline in the utilization of compounds and the costs associated with them in general, from a holistic perspective, has gone down. I think the WCRI is going to testify after us today, and they'd be leveraged to provide some additional information on that, but those are the numbers that we're seeing across Pennsylvania from all carriers.

MAJORITY CHAIRMAN: Could you provide a little more information, if you have it, on the ... You described it as co-packing. And my understanding is that's taking -- it could be something as simple as ibuprofen and Icy Hot, putting them in a package together and providing that to a consumer, to the patient, but as you described, it's typically at a fairly exorbitant increase in cost just for the packaging. Can you give us an example of what you're hearing on that front and what you're doing to combat that?

DEPUTY SECRETARY WEIANT: Absolutely Chairman. So, one of the things that popped up again was the co-pack issue. What's happening is the seller is packaging together multiple medications and items that are used together by a patient at home, and since the seller is creating the kit, they obtain a national drug code, an NDC code that's unique to the co-pack, and thus they avoid the billing at the ingredient level, having the NDC code. Here's one example that we have seen. We've seen a pack, it's called Napropack Cool, and that's a box containing Naproxen tablets and a tube of menthol gel. And that's packed at an NDC cost they have listed at $4,070. Based on the ingredient level, NDCs listed, and the kit manufacturer, the Pennsylvania workers' compensation cost would be about $198. But also based on the lowest AWP ingredient cost, that cost would be about $28.60. And we have other examples of those as well. That's one of the things that popped up. Prior to our stakeholder calls and prior to the Governor's executive actions, that never hit our radar. We never were approached by any of the carriers. We never had it brought to our attention by the State Workers Insurance Fund, so those types of things that were brought up on those outreach effort calls and also the examples that we're seeing with the compounds with vitamin packs. I have an example here where they put together

CoQ10 -- I take one of those every day; you buy them at the store -- they put together COQ10, they put together some Vitamin D and a couple of other vitamins, folic acid, and they put it all together and they take one capsule by mouth every day, and the cost for that vitamin pill, for the 30-day supply, was $2,550.

And these are things that if they are going to the CDC and they are retrieving their numbers, and they are actually listed as the individual manufacturer that are developing that co-pack, right now, if those ingredients listed within that co-pack are on a drug formulary, one of the two national drug formularies that were to be considered on Senate Bill 936, would not stop those issues. So, those are the type of things -- we're trying to look at a broad-based picture solution to the problems that we have out there.

MAJORITY CHAIRMAN: You answered the first part of my question which was some examples, and we heard some similar stories. How are you looking to combat that? How are you looking to prevent that from happening?

DEPUTY SECRETARY WEIANT: I apologize.

MAJORITY CHAIRMAN: No problem.

DEPUTY SECRETARY WEIANT: I did hear the second part of the question. So what we're doing now is -- and I think the Secretary touched a little bit on that -- so we

had the outreach stakeholder calls. We have communicated back and forth internally with our policy people down in the front office. We have the workers' compensation nurses involved. We have the chief of the health care services folks involved. And we're trying to determine through also our legal folks whether or not there are statutory requirements that need to fix these things or if we can possibly promulgate some regulations and get those out there as fast as possible to try to solve some of these issues. That's where we're at right now in the process.

MAJORITY CHAIRMAN: Okay. Thank you.

DEPUTY SECRETARY WEIANT: Sure.

MAJORITY CHAIRMAN: Did you have something to add or just adjusting?

SECRETARY LEVINE: No, I'm just adjusting.

MAJORITY CHAIRMAN: We have a question -- Chairman Harkins has mentioned that he does not have a question at this time, so I'll move on to Representative Mullery.

REPRESENTATIVE MULLERY: Thank you, Mr. Chairman and thank you, Secretaries, for your testimony today. Last session when we were debating and ultimately voting on SB936, one of my biggest concerns with that legislation was that it seemed to me that it focused on how much money it would save insurance carriers. It actually had a section

in the Bill that talked about the PCRB within 18 months conducting an audit to determine exactly how much savings were obtained, but there was no mandate or any mention anywhere in the bill to conduct a survey or to ascertain in any way how implementation of the formulary would have affected the quality of care received by injured workers in Pennsylvania. Now while I completely appreciate your mission here of attempting to address the opioid epidemic in the Commonwealth, are either of you in either of your departments doing anything to address the issue of quality of care received by injured workers in Pennsylvania? Is there anything in your formula or in your procedure whereby you do any type of analysis to say, are these injured folks getting the treatment that they need? Because I could cite multiple studies, whether they're from Harvard or Stanford, that show you in some instances the best treatment that could be provided to someone is an opioid prescription?

SECRETARY OLEKSIAK: Well, thank you for the question, and as you alluded to, the administration felt there were some significant problems with Senate Bill 936, one that you just heard Deputy Secretary Weiant refer to, that the issues of the overcost were not addressed. We felt that it did intrude on the doctor-patient relationship, and it could potentially get in the way of care. There weren't the opportunities to seek exceptions

to the formulary that was prescribed. The formularies weren't complete. It went beyond opioid care. So there were serious issues. That's related to 936, but I think I can speak for all of us at L&I, patient care, successful patient care, avoiding injuries - safety in the first place, is one of the primary focuses of our workers' comp deputy -- and I can ask Scott to speak in more detail -- but we are constantly working with our staff to improve safety. We have the safety committees, the PATHS training, and we're looking at the utilization review to make sure that -- we don't want to say no opioids as Secretary Levine pointed out. It's, in many cases, the appropriate level of care. We want to make sure that the doctor-patient relationship, which is ultimately what's going to help somebody recover from their workers' comp related injuries, is protected. I don't know, Scott, if you want to add anything?

DEPUTY SECRETARY WEIANT: Yes, being respectful of time, I just want to add one thing. I don't think at any part of this process -- and I know you all are very cognizant of that as well -- is that we never need to lose sight that at the end of this process and procedure, there's folks and real people that are walking in the shoes, that these decisions impact. No worker -- I have a background of safety in the workplace and workers'

compensation, and I've seen a lot of things over the years. I've had friends that lost their lives on the job personally, and I've seen, working in manufacturing for twenty-some years prior to joining the State, I've seen people to go out and I could tell you his name right now -- Terry, just an example off the top of my head, went out and did the snowblowing at a manufacturing firm and tried to unclog the chute and lost his fingers. The whole point is that no worker leaves their house in the morning and says to their loved ones, Hey, I'm never going to see you again, or Hey, I'm going to have a tragic injury that's going to change the rest of my life. The reality of the fact is, and Secretary Levine testified earlier, in Pennsylvania, we have 170,000 people or so hurt on the job every year. And nobody leaves their loved ones in the morning feeling they are going to get hurt on the job, and they don't have the intention to get hurt on the job. So all of the knowledge and the facts that go into these decisions, it's always considered at the end, the end result of how it affects these workers.

I can add this. We just recently released our annual Workers' Compensation Accessibility Study, and that accessibility study had some very positive results, and I was curious to see this. In my mind, there was a correlation, I thought -- and certainly the Doctor would be

able to correct me if I'm wrong here -- but there's a correlation between if you start taking away opioids in the process of the treatment of some of these injured workers. When our accessibility study goes out, I was expecting a sort of decline in the satisfaction of treatment that was being provided to injured workers. We didn't see that at all. In fact, we've seen that from a five-year period, the statistics and the satisfaction from the treatment being received by the injured workers was at its highest stage in five years. So that was a positive that I was happy to see.

REPRESENTATIVE MULLERY: Quick question for Secretary Levine. Since you testified mostly about the guidelines, can you tell me how those guidelines are being published and disseminated to the folks that would really need to see them, whether they are health care providers, insurance carriers, employers, workers' compensation judges, practitioners?

SECRETARY LEVINE: So, first I wanted to get back to your first question. You are entirely correct. We want to make sure that patients are taken care of appropriately. So, to that end, we have two new initiatives. One is we're developing patient guidelines -- so, instructions for patients in terms of working with physicians, both in terms of acute and chronic pain. And the second is we're

developing a new patient advocacy program within the office of the Prescription Drug Monitoring Program so that patients who feel that they have been inappropriately treated, for instance in terms of pain -- they might be on chronic opioids and their doctor has abandoned them, which is unethical, that they can actually call that line and we'll be able to refer them and get them the care they need. Both of those are in development.

In terms of the guidelines, how they are developed is under the prescribing task force. This task force has been in existence for probably about five years now. It started even before our administration, and it involves content experts and other stakeholders from throughout the state. And then we will decide what guidelines we want to tackle. Again, we have 11 guidelines now; the Governor had had the executive order for workers' compensation guidelines. Then we pulled together a committee of 15-20 different content experts. We have staff members who work on that. We often are led by Dr. Michael Ashburn who is the director of the pain clinic at Penn, who helps us lead those efforts. And then we have a thousand phone calls, and we work together to develop a consensus document. That document is voted upon by both the internal committee and then by the prescribing task force and adopted. It's then placed on our website, and we

try to promulgate that through the medical community. They're all also taken to the Board of Medicine and the Board of Osteopathic Medicine for their consideration and their adoption or acceptance as a voluntary standard of care. So that's how we work that.

MAJORITY CHAIRMAN: Ok. Representative Mullery, if you have additional questions after the others have gone. . . we're going to try to work our way through a number of members and then if you still have questions, I'll come back to you. Is that okay?

REPRESENTATIVE MULLERY: Thank you, Mr. Chairman.

MAJORITY CHAIRMAN: At this time, Representative Klunk has a question.

REPRESENTATIVE KLUNK: Thank you, Mr. Chairman, and thank you, Secretaries, for joining us today. My question goes to the utilization review, the nurses who are reviewing these cases. What type of training are they receiving? And then, who is reviewing those reviewers and regulating them to make sure that they are, in fact, doing their job and really upholding the training and the requirements that you guys have set forth for them. Because if they are doing their job, then they are identifying those doctors and patients who are either appropriately receiving the correct prescription or not, the correct treatment. I guess my concern is -- and would

love information -- if they do find a doctor that is improperly prescribing for a particular patient, what happens then with the communication between that reviewer, the Department of State, and then the review of that individual doctor's license? And how has that process worked? Have we found doctors that have been improperly prescribing? Are we going after them to get those doctors off of practicing because clearly they are not helping these victims, if you will, of a system that's not working for them? And then, on the victim/patient side, if you will, that patient who has been improperly given these prescriptions -- I know the Secretary talked about it a little bit with what you're doing on that patient side -- what are we doing then when we are identifying those doctors who have been improperly prescribing and those patients who have been improperly getting opioids? Because we've seen that reduction of 23 percent, which is fantastic, but I have to think that there are patients out there who are ... some of those patients in that reduction are addicted to opioids. How are we identifying them to make sure that they're getting the proper treatment to get off opioids, and then they're not going down that path of becoming addicted to heroin, becoming an overdose victim? So there are a lot of questions there, but training of the reviewers, the nurses, who regulates them? What are we

doing when we find a bad doctor and the license process, and then how are we helping those patients who are essentially the victims of this horrible doctor who didn't properly prescribe?

SECRETARY LEVINE: So, I'm going to take the second part of your question and refer to my colleagues for the utilization review part. That's through their department.

So the Prescription Drug Monitoring Program is the mechanism by which the administration and the state is able to monitor a physician's prescriptions and take, if necessary, action. As part of the legislation for the Prescription Drug Monitoring Program, the Department of State and the Attorney General's Office has access to the PDMP. Our office has worked with them to develop a very complex algorithm to determine which doctors are significantly overprescribing depending upon their specialty et cetera. So if you're the director of the pain clinic at a major hospital, you're going to have more prescriptions than if you are a family physician in this area. And so the Department of State has access to that data and will take appropriate action to potential physicians and other prescribers, nurse practitioners, physicians' assistants, et cetera, that are overprescribing. And then the Attorney General has their

own algorithms in terms of who might be criminally overprescribing, running a pill mill.

The Department of State has a whole office dedicated to this, so what they will do is reach out to the physicians. They will do an investigation. Many physicians who are overprescribing, or other health care professionals, are in over their heads. They need more education, and there are educational programs that they can be referred to. Actually, Dr. Ashburn runs one, where they can learn about opioid stewardship and how to do this better. And then there are a few bad apples, as you were saying, and the Department of State will take action on their license; and the Attorney General's Office will prosecute them. We are working through our command center. Of course, the Department of State is at the command center, and the Attorney General's Office is at the command center; and so we have worked out a relationship that if they are going to arrest somebody, the AG is going to arrest a physician or a practice and close them down, they will actually work with the command center -- we're still perfecting this -- I guess right after they do that, so that we can actually then intervene with all of those patients to try to make referrals to physicians and practices and clinics in that area so that they are not abandoned. That's a very important issue because if a

patient is abandoned and they are on chronic opioids, they are much more likely to go to the street and to get heroin and then adulterated with fentanyl. We actually are working on a relationship with the CDC. They are developing a rapid-action force, that if we have a major provider, it might be a thousand or a couple thousand patients, the CDC will send a -- I say SWAT Team; they don't like the term -- but essentially an action task force to the state. This hasn't happened yet. This is a new program that they are developing to help us make those referrals. So, a very important point that we've been working on.

SECRETARY OLEKSIAK: I'll ask Scott to talk about the training, but the overall answer to your questions is, the Department of Labor and Industry is responsible for the training and evaluation of those employees that provide that utilization review. It's something, obviously, we take very, very seriously given the nature of the epidemic we're working with. But I'm going to ask Scott to talk in more detail about what's involved with that.

DEPUTY SECRETARY WEIANT: Sure. The utilization review organizations within the workers' compensation system in Pennsylvania, who can become a utilization review organization, and the qualifications of the individuals on staff there, medical providers on staff, all those things

are very detail-oriented within the Workers' Compensation Act. So that's all pushed out by the Act.

Now I can tell you this. At the Bureau Workers' Compensation we hold monthly, our division chief in health care services Patricia Clemens holds monthly calls with all the URO organizations. And the type of things they do is push out training. They have conversations on these type of topics and things like that. That's all out there. It's something that we take pride in. The other part of the equation is that one of the things that the disaster declaration allowed is for the workers' compensation bureau to have access to the PDMP. We never had access to that prior to the disaster declaration being put in place. What that did was allowed us to collaborate with the Department of Health and the Department of State to put together guidelines, criteria to train our nurses within the Bureau of Workers' Compensation to say, okay when you have a utilization review that comes into the Bureau -- now we're only seeing a small number of all the claim universe in Pennsylvania -- but when they come into the Bureau, now our nurses and our nurse staff have the tools and the capability to open an investigation, to look into those details and to identify claimants that are within the system that might be having opioids overprescribed to them.

What we do then is we report those and we move

along and follow up on those. I can tell you -- I do have some stats here for you -- that as of the 26th of February, this year, we actually requested 72 reports from the PDMP, so we looked at 72 situations. Twenty-one of those reports were having to do with having to access data in a few different ways. We didn't have the DEA number legible on prescriptions and things like that, when we came in from a URO process that we needed to do further research on the prescriptions. We had three patient history requests that were made in order to identify how the prescriber was showing up in the PDMP and the prescriber information, and it was really inconclusive, so we had to go into the PDMP to look at some of those things. We had one patient history request that was made out of a concern for multiple prescribers and to verify the prescriber was actually reviewing and checking the PDMP prior to prescribing the opioids in the system. And we also had . . . One of the additional benefits that we have discovered through the access to the PDMP was we had 11 providers that we thought were related to overprescribing, and what this did was it identified six pharmacies that were actually not accurately reporting workers' compensation claims based on the documentation submitted for fee review. What I mean by that is that when a pharmacist writes a prescription and it's for workers' compensation, a workers' compensation

claim, there is a specific code that they have to put in their system at their end, and what that does, that enables us to actually true reports in Pennsylvania on how many opioids are being prescribed and things like that. So we've been working with the Department of Health to try to ensure that these pharmacies that are being identified that are reporting inaccurately -- they might put a general code in instead of workers' comp and things like that. That's important to us to be able to run statistics, so it's been very, very helpful for us. It really has. It has paid some dividends.

MAJORITY CHAIRMAN: Thank you. Our next question comes from Representative Krueger.

REPRESENTATIVE KRUEGER: Thank you, Mr. Chairman, and thank you everyone for joining us here today. I want to follow up on my colleague's line of question around overprescribing. We've all heard the stories of folks who went in for an injury and instead of being given a certain number of pills, were given many more pills than they would necessarily need without follow up from the doctor, and I know there's been a number of pieces of legislation that passed the legislature with bipartisan support that the Governor signed into law. I was also glad to see his executive action last year. So I know, Secretary Oleksiak, you said that the overall prescriptions of opioids have

gone down since the guidelines were published in June of last year. Do we have any data about whether overprescribing has gone down as well?

SECRETARY OLEKSIAK: I'm going to look to Dr. Levine. If you have that?

SECRETARY LEVINE: So, you are correct. There are a number of different acts that were passed a number of years ago so that in pediatric patients no more than seven days of an opioid can be prescribed. And if someone is at the emergency department, no more than seven days can be prescribed. Those type of things are also tracked -- I mean all of the prescriptions are tracked in the Prescription Drug Monitoring Program. But we would support the legislation that was discussed, I know, in the Senate and the House last year about limiting all prescriptions to seven days. There are some exceptions to that -- patients with cancer, et cetera. So there are exceptions with the other acts as well. So we would support that. There is nothing . . . Our guidelines recommend not doing that, not prescribing more than seven days for acute pain and using again the lowest dose for the shortest period of time, but there's no enforcement of that unless there's a pattern of overprescribing that again the State or the AG's Office might find in the PDMP. But we do all hear stories about 30 days for wisdom teeth or things like that. And so all

of our guidelines, all of our opioid stewardship efforts -- I haven't mentioned all of them but there are other efforts. We work with medical schools. We go into medical practices and do what's called academic detailing. There are a whole number of different efforts that we're working on, but I know I can't enforce them, so we would be in favor of that type of legislation.

REPRESENTATIVE KRUEGER: Thank you. My understanding is that that bill passed the Senate and then was not taken up for a vote in the House. Mr. Chairman, I know it wasn't referred to our committee, but maybe its one that we can advocate for. Thank you.

MAJORITY CHAIRMAN: Next we have a question from Representative MacKenzie.

REPRESENTATIVE MACKENZIE: Thank you, Mr. Chair and thank you to both of the Secretaries for joining us today. It's a very important topic, the overprescribing of opioids, and we've been seeking to address it in the workers' comp space for a number of years. Obviously there was legislation which was passed and vetoed by the Governor. So I am glad to see that some action is being taken by the administration on this topic.

Just initially, you feel that the voluntary guidelines which have been implemented are generally being effective in helping in the overprescribing of opioids. Is

that correct?

SECRETARY LEVINE: Again, we have 11 guidelines, and we're writing new ones all the time and, again, we review them every two to three years and potentially revise them. I think that the guidelines, in addition to the other opioid stewardship efforts -- so, for example, with legislation we have core competencies for every graduating medical student about opioids and chronic pain, et cetera. We have the academic detailing that we've discussed. The PDMP; all of those efforts, I think, are being successful. We have virtually eliminated doctor shopping in Pennsylvania with the PDMP which was one of the primary goals; and we have decreased opioid prescribing more than 21 percent, but we have more work to do. At the same time we have to be careful that patients aren't stranded because if a patient is strand . . . You can't have somebody who's been, for instance, on chronic opioids and then stop them because that patient is dependent, potentially addicted, but certainly physiologically dependent to the opioids. If you stop it, they are going to go into withdrawal symptoms and then they will go to the black market; and they might be seeking a pill, but that pill has been made out of fentanyl, which can be deadly. So, it is a balancing act. It would be important not to put the guideline -- I think that you can certainly inscribe the guideline process in

legislation -- it would be important not to put a specific guideline from a specific date in legislation because, again, we revise them every two to three years and it would be challenging to come to the legislature to review all 11 guidelines every two years. And again, we're going to have 12 . . . Next guidelines are going to be sickle cell guidelines, post-op surgical guidelines. There will end up being 15-20 guidelines. To take those to you all every two years would be challenging for us and yourself. But I think that the process, in terms of the task force, could be inscribed in legislation. I think that we're making a lot of progress and we still have more work to do.

REPRESENTATIVE MACKENZIE: Go ahead.

SECRETARY OLEKSIAK: If I could throw some numbers your way, some of the differences we've seen. We already talked about a 23.5 percent reduction in the number of claimants receiving opioid. Again, this is comparing the last six months of 2018 to the prior year. We found a 29 percent reduction in the number of opioids prescribed, a 33 percent reduction in the cost. For all of 2017, the Pennsylvania Compensation Rating Bureau that sets the rates for insurers, they reported about 80,000 opioids prescribed worth 20.5 million. September of 2018, and there's still time left obviously -- we don't have all the data yet -- they reported about 43,000 opiates. So from 80,000 to

43,000 worth 10.9, so both almost cut in half. So, we have seen some significant, significant improvements since the executive action was put in place.

REPRESENTATIVE MACKENZIE: Agreed. So you guys jumped into my line of questioning there a little bit. So my question is really around the mandatory use of a guideline. Because we are doing it voluntarily, it seems, and we agree, that there is no silver bullet to the opioid crisis. It is going to be a number of different things, actions we're going to take that are going to help this, and guidelines being one of them. So we have implemented them now in Pennsylvania in a voluntary fashion. They seem to be having a positive impact in the overall collection of actions that we're taking. So my question is around mandatory use, and Dr. Levine hit on that. I'm in receipt of two letters. One is from the Senate. Senator Don White contacted the Governor back on August 7, 2018, in response to a letter from Dr. Levine on June 18. She was writing to Mr. Gene Barr, President and CEO of the Chamber, Pennsylvania Chamber of Business and Industry. And Madam Secretary, you say that "unfortunately in the absence of legislation we are unable to mandate use of a guideline." So would you be in support of mandating a use of a guideline?

SECRETARY LEVINE: In theory, yes. The key is in

the details, of course. Again, if you put the task force in legislation, and then you mandate -- what the task force comes up with is mandated as opposed to voluntary, that we would be in support of. However, if you inscribe each individual guideline in legislation, that the workers' compensation guideline from June 2018 is mandatory, then every time I have to . . . In two years when we revise it, and this is true for all the guidelines, then we have to come to the legislation and you're going to have to look at all 20 guidelines every two years. That's not . . . Medical practice changes, and we've changed almost all the guidelines originally that were in 2014, 2015 and 2016. So, how it's worded would be critical.

REPRESENTATIVE MACKENZIE: I agree with you, and my understanding is that the nationally recognized guidelines that are out there are constantly being updated.

SECRETARY LEVINE: That's correct.

REPRESENTATIVE MACKENZIE: So, would you be in support of mandating the use of a guideline that is constantly being updated such as one of those nationally recognized ones?

SECRETARY LEVINE: There are national guidelines, and there are state guidelines. The national guidelines, for instance, the CDC guidelines, are pretty specific for chronic pain by family physicians, by primary care

physicians. We have actually expanded the guidelines to -- that are location specific and specialty specific. So we would want -- the key is in the details about how it's worded and how it's implemented through the legislature.

REPRESENTATIVE MACKENZIE: And, I'll close, Mr. Chairman, but I do just want to say that I think the idea that we were both subscribing to is that guidelines are a good practice, and so if they are voluntary and some people are utilizing them to reduce the overprescribing, it would seem logical to me that we would want all doctors to follow similar guidelines, and we would get to that end by mandating their usage here in Pennsylvania. Thank you.

MAJORITY CHAIRMAN: Our next question comes from Representative Keefer.

REPRESENTATIVE KEEFER: Thank you, Mr. Chairman, and thank you everybody for participating on the panel. Representative MacKenzie addressed -- part of my question was regarding the mandatory guidelines and what kind of data you have as far as compliance and adherence to those guidelines. I know they are evolving, so each case by case is probably more sensitive but, in general, the teeth to those guidelines. We know all the guidelines we want, but if they're not being adhered to, there's no enforcement component to that, so working on something that would give a little bit more teeth to it, that we could collect that

kind of data would be helpful. Is this something . . . Have you helped doing that?

SECRETARY LEVINE: The Department of Health -- we do not have a way of enforcing the guidelines. Of course, the Department of Health doesn't license medical practitioners. It is the Department of State that is the enforcement arm, so they would need to be brought into the conversation about how that would be done. I think it depends on the details of how the law is written and its scope.

REPRESENTATIVE KEEFER: Again, thank you for that, for your insight on that, and I just think, collectively working together to give it more teeth. The other question I have for the panel is so we had in our legislation last year -- because we had many complaints about the consistency and the differences that the UROs were using was all over the place and part of that legislation had the accreditation, requiring the accreditation of the UROs. Is that something that you guys could get behind, having these UROs accredited to have some kind of standard that's there?

SECRETARY OLEKSIAK: I'm conferring with my colleague here, and I think he can answer that.

DEPUTY SECRETARY WEIANT: Sure. I'm very familiar with the legislation, and I believe within the

legislation it asks for the Bureau of Workers' Compensation or the Department to contribute -- I think it was $1.5 million -- towards the certification of the UROs toward URAC certification. There's a number of concerns we had from a budgetary perspective, but also concerns that we have from supplementing individuals -- organizations within the workers' compensation system, to obtain their URAC certification. One of the concerns we had was how many new URAC organizations are going to pop up and now because it's all being funded through the Department, and how's that going to impact the entire system and the quality of the system. So I think again, the details surrounding that whole issue is really what would push the issue forward or hold the issue up in our eyes at the Department. But there's no question that the URAC certification is a certification that's recognized throughout the country as a standard for utilization review organizations, and it would not be a deterrent for the process in Pennsylvania.

REPRESENTATIVE KEEFER: Other states do use it, and they do not subsidize it, so it's an accreditation you have to come to the table with.

DEPUTY SECRETARY WEIANT: Yep.

REPRESENTATIVE KEEFER: Thank you.

DEPUTY SECRETARY WEIANT: You're welcome.

MAJORITY CHAIRMAN: Our next question is from

Representative Dush.

REPRESENTATIVE DUSH: Thank you, Chairman. Thank you, panel. Since the legislature started focusing on this, I think it's really significant that we've seen that 23.5 percent decrease in opioids on SWIF claims. Twenty-one percent reduction in opioid prescriptions, and then when we really started focusing in on these compounds, a 90 percent reduction in one quarter in those payouts. One of the concerns that was just raised -- and we're talking about voluntary versus mandatory -- my concern is once the -- if we don't do something legislatively to fix this and to make it mandatory and criminalize -- when you've got a Napropack, Naproxen and some cooling gel, $4,070 for a $28.60 product. Basically a multi-vitamin mix with COQ10, a 30-day supply is $2,500. If we take that focus that the legislature has on this and say it's going to stay -- it will be voluntary -- and then all of a sudden it'll be cool for a little while and then all of a sudden it will revert right back to what it was. Secretary Oleksiak and Scott, you both alluded to recommendations that you are planning on making. What are the teeth that you are looking at and I'd also like to see some of the reports, Scott, that you received lately. I'd like to get us copies of those as well.

DEPUTY SECRETARY WEIANT: Certainly.

REPRESENTATIVE DUSH: But, what are you looking at to give teeth so that we can get the Attorney General's Office and other law enforcement focusing in on these people who have, not just a client relationship as an attorney or medical practitioner, but also in whenever they start prescribing, they are prescribing their own particular formularies.

SECRETARY OLEKSIAK: We have taken the input that we have gotten from the stakeholders that we have reached out to. The Governor's policy office is looking at that. That's where the recommendations will come from, as Scott alluded to, whether it's recommendations for legislation, recommendations for regulation. We are ready to enforce whatever we are told to enforce as a regulatory agency. Again, keeping in mind that we want to make sure that the appropriate -- that people who are injured on the job get the appropriate medical care they need, that may involve those creams or opioids. So we'll do what we're told -- I guess is what I'm saying -- and the teeth will come from whatever regulations or legislation are proposed. And we'll review them when they are in the process of being created. We'll talk about what we think the impact would be on the agency, whether staffing, dollars, if we think it will be effective. But that's a process that we'll be happy to be a part of, but where it ultimately lands is not

up to us as an agency.

REPRESENTATIVE DUSH: I understand that, and I know it's been mentioned before. There's not a single person up here on either side of the aisle, or even out here in the audience that I'm aware of, that wants to see patient care reduced. So I'd like that not to be part of the discussion because what we have to do is focus on what the real problem is and start looking toward solutions. Thank you.

MAJORITY CHAIRMAN: And coming back around for our second round of questions, we have Representative Mullery.

REPRESENTATIVE MULLERY: Thank you, Mr. Chairman. Not really a question. I just think we would be remiss as a committee if we didn't congratulate both of you and the administration on receipt of the $5 million grant to combat the opioid problem that we have here in the Commonwealth. And I need to give a brief shout out -- in my district I have Luzerne County Community College, and they are establishing a first-of-its-kind program where they will be granting human service degrees to those who will be treating our constituents who are suffering this opioid epidemic and these new students will receive certificates in recovery specialties. The administration has been out. They fully support it. If either of you or anybody on your

staffs would like to have more information about it, please feel free to reach out to me because I'm making a pitch for some of that $5 million. Alright, thank you very much for your testimony today.

SECRETARY OLEKSIAK: If I could just add, it wasn't just our agencies. DHS, DDAP, there were several agencies involved in this as well. Thank you.

MAJORITY CHAIRMAN: Our next question is from Representative Keefer.

REPRESENTATIVE KEEFER: Thank you. I just want one more question. A lot of my -- going through all of this, I look at it and say, are we reinventing the wheel here? What are we doing in other areas and as far as the patient-doctor care -- not infringing on that relationship -- and formularies go. I mean, we have formularies in the private sector -- with all of my health insurance plans -- we all have formularies that are there so what is the difference with workmens' comp and private sector as far as the formularies go?

SECRETARY OLEKSIAK: I think we addressed that somewhat in the specific legislation that was introduced. There were several concerns that we had, and I know the Governor had, that impacted the doctor-patient relationship but didn't contain a patient-centered exception process. It had some impact on the grand bargain that's part of the

workers' compensation system where workers' compensation folks can be -- people receiving workers' compensation receive it and give up the right to sue for their injuries. There were only two established drug formularies. It didn't just cover the opioids. It went way beyond that, so there was a lot of concern as we said before in the details of that particular piece of legislation. That was why, I know we opposed it; and I believe the Governor vetoed it.

REPRESENTATIVE KEEFER: So if we had something that mirrored what is done in the private sector with the understanding of the -- I know there's that component in there regarding accepting the claim and suing so you have that in there to maybe be a little bit more cautious -- but was that the general approach, is mirroring what's in general policies? No?

SECRETARY OLEKSIAK: I'm not sure what your questions is Representative.

REPRESENTATIVE KEEFER: The applicability to the formularies as far as what is done, what's common practice currently, non-workmens' compensation insurance compared to workmen's compensation.

SECRETARY OLEKSIAK: There are significant differences in the workers' comp world and that was some of the concern we had with that particular piece of legislation. As we've said before, it really is in the

details and how it would impact those things that we talked about that were our concerns with the bill initially.

REPRESENTATIVE KEEFER: Thank you.

SECRETARY OLEKSIAK: Thank you.

MAJORITY CHAIRMAN: Our next question comes from Representative Neilson.

REPRESENTATIVE NEILSON: And it will be a quick one, Chairman. I have to promise that. Scott, you identified a lot of the reductions in the creams and stuff like that. Have you seen any correlation in the co-packs going up? Creams going down. Co-packs going up. Because you identified the co-packs as being your next problem that we have to tackle.

DEPUTY SECRETARY WEIANT: That's a really good question. So it seems like my staff -- they often talk about the game that your children play at the beach when these things pop up and you hit them in the head, and another one pops up and you hit them on the head, and hit them on the head. When we're sitting down and we're having the discussions and trying to solve the compound issue from a holistic perspective, those are the kind of questions that we have and the vision we are trying to put forth to try to solve a problem so we're not constantly having to hit another head with suggested legislation and regulations. And those are exactly the type of issues that

we look at. We are seeing not a drastic rise in the co-packs at this time. We are just wondering in our eyes whether or not that's going to be the next thing that sweeps across. But we are seeing a drastic reduction in the compounds that are being written. And . . .

REPRESENTATIVE NEILSON: That's something that you regulate and you examine. I mean Representative MacKenzie and I have been at the department, and, I mean, that's something clearly that the department looks at constantly to see where usage is, where it's not, and where we can save money for the department. Am I still taking care of the hurt workers? I mean, that was there when I was there, and I'm not going to say I was there decades ago, but it's been a little while.

DEPUTY SECRETARY WEIANT: Yeah.

REPRESENTATIVE NEILSON: MacKenzie followed me up and now you guys are following us up, right? That's how it goes. That's something that we've always looked at as a department, and I think that should be talked about here because it's something that you go through on a monthly schedule and look at every single thing.

DEPUTY SECRETARY WEIANT: Yes, we do, and since we have access to the PDMP, we have a regular process in place within our health care services division to -- flags go up when we see things like this now. Our staff are

trained; they are trained to see unusual dispensing, whether it be in the opioid world or whether it be the compound world. Like I said we identified the vitamin issues now and the co-pack issues, so our staff are trained. They are on top of it.

REPRESENTATIVE NEILSON: Thank you, Scott. Madam Secretary, we keep on hearing mandatory, mandatory, mandatory. Is there a group that's not participating in these guidelines? Because right now it's voluntary. You come up with these guidelines and all. I keep on hearing people, well we should put a mandatory task force, mandatory, mandatory. Is there someone that's not working with you? Like a group, an individual group or someone who's saying, no we're not doing that, because it sounds like a lot of cooperation from a lot of people here.

SECRETARY LEVINE: Really, the process has been very collaborative. So again, under the prescribing task force we'll pick a topic -- for instance, the next one we're working on is sickle cell pain guidelines for acute and chronic pain -- and then we pull together content experts from throughout the state, and we have many phone calls, and we develop over about three months a consensus document that we review. It's reviewed by the Governor's Office and that is formalized. And then we take it to the Board, so we would take that to the Board of Medicine, the

Board of Osteopathic Medicine, et cetera, for their affirmation and acceptance. The issue is that it is establishing a voluntary standard of care and . . . Someone had mentioned I don't have an enforcement mechanism for that guideline. There is no specific group that is not following guidelines, but we do still hear at times of overprescribing and so we want to get to the root of that.

REPRESENTATIVE NEILSON: But that wouldn't be your department as you identified earlier in your testimony here today. That would be the Attorney General's . . .

SECRETARY LEVINE: And the Department of State, that's correct.

REPRESENTATIVE NEILSON: And the Department of State, would collaboratively work on -- nothing that we do legislatively would prevent that or make that -- that happens automatically.

SECRETARY LEVINE: So that happens automatically, it was actually part of the Prescription Drug Monitoring Program legislation -- is that the Department of State would have access and the Attorney General's Office would have access; and we collaborate with them, and they are, of course, the licensing enforcement arm and the legal enforcement arm.

REPRESENTATIVE NEILSON: Well, thank you so much for all your testimony here today and further educating us

all on this issue. Thank you, Mr. Chairman.

MAJORITY CHAIRMAN: And we are winding down on the time, so I'm going to ask that these next two be our last. Representative Dush, a brief question.

REPRESENTATIVE DUSH: Thank you. Secretary Levine, you said that we were third worst in the nation on opioid addicted workers' compensation. I'd like to know where we are now and then also some clarification on your remarks about location-specific guidelines. Why are we doing those?

SECRETARY LEVINE: Sure. The article was published in 2017, and I am not aware of a more recent publication.

DEPUTY SECRETARY WEIANT: I can put a little more context on that. I know the WCRI is going to be testifying right after us, and that was actually their data and their study that came out with those numbers. But very briefly, I look at that -- and I've had the privilege to testify before this group last year, I think on the same topic -- and after I left and I heard the number the third worst in the nation -- and I sit on the WCRI Pennsylvania Advisory Committee, and we talk about these things multiple times a year. When you look at the study that's out there in the longer-term dispensing of opioids and the statistics that are out there, that study was based on a study, I believe,

of only 26 states. It's not the whole nation, so it's 26 states. When I look at that study, it's based on opioids that were within the first three months after the injury had three or more script fills within that first three months, so there were actually two states that were worse than Pennsylvania but then there were also four states that were tie at 9 percent for Pennsylvania. There were six states out of those 26 states that were like even with Pennsylvania or worse, so when you say it's the third worst in the nation, you have to put that in context. Just a little clarification.

SECRETARY LEVINE: To clarify in terms of location, I don't mean in Pittsburgh or in Philadelphia guidelines. I mean a location such as emergency department guidelines, or dental office guidelines, or pharmacist guidelines; so specialty and location meaning a medical area where medical practitioners might practice, like an emergency department.

MAJORITY CHAIRMAN: And our last question comes from Representative MacKenzie.

REPRESENTATIVE MACKENZIE: Thank you again, Mr. Chair. My question is for Secretary Oleksiak. You mentioned one of the Governor's reasons for vetoing Senate Bill 936 was that the guidelines went beyond opioids. So my question would just be if we think that a guideline is

effective in reducing the overprescribing of opioids, obviously there can be detrimental effects of overprescribing other non-opioid medications, what are your thoughts on guidelines for non-opioids in the workers' comp space?

SECRETARY OLEKSIAK: My thoughts are going to be the same that I responded before. I think we need to see -- that was one of several issues that I know the department had with the bill. I listed some of them. Scott mentioned the cost factor that was all absorbed by the workers' comp system, so we would have to look at the details to see specifically what's involved and make a decision based on those details.

REPRESENTATIVE MACKENZIE: Okay. Since I am the final questioner, I'll just close with a more general question for both of you. Secretary Levine, you and I have had the pleasure of working on the Maternal Mortality Review Committee together. I appreciate all your work on that. Secretary Oleksiak, I serve with you on the Work Force Development Board, and we do good work there. Obviously we can have a collaborative relationship between the legislature and the administration, so my question to you is, publicly would both of you commit to continuing to work on legislation to address this issue? I share Secretary Levine's feeling or sentiment that unfortunately

we have not addressed this in legislation. I think we can do a better effort if we do work collaboratively and come up with legislation, so would the two of you be willing to work with me on legislation to continue to address this problem and actually come up with something for this legislative session?

SECRETARY OLEKSIAK: Every opportunity that I have to testify, I say that to whatever the committee is. We are always at the department, ready and willing to talk to any legislator about potential legislation. We do follow the dictates of -- you know I work for the Governor -- so we aren't going to go rogue but we will certainly work with any legislator that has ideas.

SECRETARY LEVINE: The Department of Health is all about collaboration, and we are very pleased to collaborate with you.

REPRESENTATIVE MACKENZIE: Great. I'll have my office follow up with both of you, and we'll schedule a meeting where the three of us can get together and start working on that legislation. Thank you.

REPRESENTATIVE NEILSON: And we'll leave out the word mandate too.

MAJORITY CHAIRMAN: All right. Again, I thank all of you for your time today in testifying, and we appreciate your willingness to come today.

SECRETARY OLEKSIAK: Thank you.

DEPUTY SECRETARY WEIANT: Thank you.

MAJORITY CHAIRMAN: At this point, we're going to ask Dr. John Ruser, President and CEO of the Workers' Compensation Research Institute, to join us up front here.

Dr. Ruser is here to provide an update on some research data about prescribing in Pennsylvania's workers' comp system. For those of you who are not familiar with the Workers' Comp Research Institute, they are a non-profit organization that conducts a variety of research on workers' compensation issues across the country. So they bring to us a great grouping of data and, if you are ready to begin, then we are happy to hear from you.

DR. RUSER: Thank you very much, Chairman Cox. Thank you Chairman Cox, Minority Chairman Harkins, and the members of the House Committee on Labor and Industry for inviting me to talk about our work.

My name is John Ruser, and I'm the President and CEO of the Workers' Comp Research Institute or WCRI. We are a non-profit, public-policy research organization located in Cambridge, Massachusetts. We provide information to all stakeholders in the various state workers' compensation systems. That information is regularly used in public policy debates. Importantly, we

do not take positions on policy, nor do we make policy recommendations. We provide just the facts so that stakeholders can make informed decisions about possible workers' compensation reforms.

Today I'm going to talk about prescriptions in the Pennsylvania workers' comp system. I'm going to focus on two aspects. One is the impact of House Bill 1846, which was designed to limit physician dispensing of drugs. The other is trends in prescriptions and the landscape of prescriptions as of the most recent time period for which we have data, which is the first quarter of 2018.

Let me begin by discussing the regulation of physician dispensing generally and then focus on Pennsylvania. There are two broad approaches that states have implemented to control physician dispensing of drugs. These approaches are price-focused reforms and limiting reforms. Under price-focused reforms, physician dispensers may dispense drugs but only at prices related to average wholesale price of the original National Drug Code, or NDC, of the drug. Limiting reforms limit the type of drugs that physicians can dispense or limit the dispensing to short time periods.

A number of states, including California and Illinois, regulated physician dispensing by means of price reforms. A WCRI study entitled *A Multi-State Perspective*

on Physician Dispensing found that after these reforms, physicians dispensed fewer prescriptions, but physician dispensing was still common. The study also found that the prices paid to physicians for common drugs decreased substantially after the reforms in those states. However, we observed increased physician dispensing of higher priced new strengths and a new formulation in several states driving up physician prices for several common drugs.

In contrast to the reforms in other states, Pennsylvania's HB 1846, which was effective at the end of 2014, combined both price and limiting reforms. Under the bill, reimbursement cannot exceed 110 percent of the average wholesale price of the original manufacturer's National Drug Code used in the repackaging process. That is the price regulation component of the bill.

In addition, the bill stipulated that there would be no reimbursement to a physician for dispensing over-the-counter strength drugs while physician dispensing of DEA Schedule II drugs, such as Vicodin and Percocet, was limited to a short fill, and physician dispensing of all other prescription strength drugs was limited to a 30-day supply. These were the limiting reforms of the Bill.

At the request of the Pennsylvania Workers' Compensation Advisory Council, last year WCRI conducted a study of the impact of HB 1846. We compared the

prescription data for two years before the bill became effective; that is, 2013 and 2014, to the two years afterwards; that is, 2015 and 2016. We looked at prescriptions filled each year that were filled within the first two years after the injury.

What we found was that fewer prescriptions were dispensed by physicians after the bill became effective, and the prices paid to physicians dropped after the reforms went into effect. So, please refer to Figure 1, which is in the copy of my written testimony, and also on the screen. What we see is that one in three prescriptions were physician dispensed pre-reform while only one in ten prescriptions were physician dispensed after the reform. Further, physician dispensing accounted for around 50 percent of prescription drug costs before the reform but only 4 percent afterwards. Finally, not in the slide, prices paid to physicians for common drugs decreased by 15 to 81 percent after the reforms.

Looking beyond just physician dispensing, we found that fewer prescriptions overall were dispensed after the reform, and drug costs per worker decreased among Pennsylvania injured workers receiving medical care.

However, the emergence of some new pharmacies moderated the price reductions from the physician dispensing reforms. These new pharmacies

disproportionately dispensed expensive compound drugs, over-the-counter topical analgesics, and new-strength drugs.

Compound drugs are created by mixing individual ingredients together, generally forming into a topical cream. In focusing specifically on these, we saw that the share of prescription costs accounted for by these drugs quadrupled around the time of the physician dispensing reforms. And you can see that in this slide here. Whereas in 2013, only 8 percent of all prescription payments were for compounding, that share increased to 43 percent in 2015 before dropping back to 31 percent in 2016. The growth in compounding was fueled by the new pharmacies that dispensed compounds more frequently than existing pharmacies. But, importantly, data that I will mention shortly, indicate that compounding is no longer a significant share of prescription costs.

Our report on physician dispensing stopped with 2016 data. It is important to know what has happened in Pennsylvania since that time. The data that I'm going to present to you now are unpublished and preliminary. I'm reporting on them to give you a sense of the most up-to-date picture that I can of prescription drugs in the Pennsylvania workers' comp system and to provide some comparisons with some other states.

We measured prescription payment shares for groups of drugs, therapeutic groups of drugs, for prescriptions filled each quarter within the first three years post injury. We measured the payment shares quarterly from the last quarter of 2014, so just before the passage of the physician dispensing bill, up to the first quarter of 2018, the last quarter for which we have current data.

Over this time period there was a change in which drug group had the highest share of prescription payments. While compounds had a high share of all prescription payments early in the time period, that share has dropped substantially in recent quarters. As of the first quarter of 2018, compounds accounted for 7 percent of all prescription payments. The recent Pennsylvania experience with compounds is not unique. Compounding has dropped in all states where it has accounted for a significant share in past years.

As compounds began to decline, the share of all payments accounted for dermatologicals began to increase. Dermatologicals include both prescription and over-the-counter strength products such as Lidoderm, Lidopro, Terocin, Pennssaid, among others. In the fourth quarter of 2015, when compounds were at their peak, dermatologicals accounted for 10 percent of all drug payments. That share

increased over the next couple of years, and dermatologicals have continued to have the highest payment share of any drug group since 2017. In the most recent quarter for which we have data, dermatologicals were one third of all prescription payments. These dermatologicals are often dispensed by the new pharmacies that previously engaged in dispensing compounds.

Like its experience with compounding, Pennsylvania's experience with dermatologicals is not unique. Dermatologicals account for a growing share of drug payments in a number of states, most notably Delaware. And also note that our peer organization, the California Workers' Comp Institute, recently reported on the growth of dermatologicals in California. In our data, we see that dermatologicals accounted for more than 20 percent of prescription shares in 11 of 27 study states in the first quarter of 2018.

Pennsylvania and many states have been taking steps to reduce the dispensing of opioids both in workers' compensation and in the general health system. These steps are reflected in the declining shares of payments for opioids in all 27 states that we studied, including Pennsylvania. In Pennsylvania, opioids accounted for 16 to 17 percent of all prescription payments in the first half of 2015. That share has dropped to 10 to 11 percent in the

first half of 2018.

In sum, HB 1846 substantially reduced physician dispensing, but new pharmacies appeared coincident with the bill that first dispensed compounds and now dispense dermatologicals. In the most recent data available to us, dermatologicals account for the highest share of prescription payments, while the payment for compounds has dropped substantially. The payment shares for opioids has also dropped, reflecting measures to control opioid prescribing.

Thank you to the committee for this opportunity to share our research findings. I look forward to addressing your questions.

MAJORITY CHAIRMAN: Thank you. You packed quite a bit of information in a very short period of time. The question I have is kind of continuing from the prior discussion. I was curious to know if your research included, or will begin to include if it's not already in, the co-packing of the various items. Is that something you are looking into or you are seeing in other states as well?

DR. RUSER: Yes. Deputy Secretary, we had mentioned the co-packing. Again, our data are only through the first quarter of 2018. We looked into the data. We did see instances of co-packs, convenience packs, in

Pennsylvania and as well in other states. They are relatively rare in the data that we have for all the states, however, when we see them, indeed, they are quite expensive.

MAJORITY CHAIRMAN: Chairman Harkins

CHAIRMAN HARKINS: (Microphone feedback noise.) That's why I've been keeping low on asking any questions. Thank you for your great testimony. I guess I just, more or less, wanted to add that I received a call late last year from an injured employee who went to the emergency room on a Friday evening and was prescribed, but the doctor was hesitant on prescribing anything real strong to him. He got caught in a situation where he couldn't get back to the doctor the following week quickly, Monday or Tuesday. But the cost factor, I guess, is one issue as well as overprescribing, the worry from the doc's end, that the Attorney General is going to be on their backs. I just hope we're not going down a slippery slope with that. What I hear from many of the people with the issues, is that it seems as though they are more or less a number, and there's a cost factor involved. If you want to add anything on that, or comment on that?

DR. RUSER: Well, I mentioned the cost numbers that we had seen. They are the easiest things to see in claims data which is the data that we frequently work with,

but there is much more than just the cost. There is, in fact, the patient experience and the outcome of the injured workers and those are much harder to see in claims data that do tend to focus on the services that are delivered and the prices associated with those. I would like to think that costs, however, are correlated with worker outcomes. If you get an injured worker back to work sooner, presumably the costs of the claim are going to be lower.

CHAIRMAN HARKINS: I agree with that, and I appreciate that. I just, again, hope we don't lose sight of the injured worker for the sake of cost. That's it for the day.

REPRESENTATIVE MACKENZIE: All right. Thank you. Next we have Representative Dush. I'm sitting in for Chairman Cox while he's out for a moment.

REPRESENTATIVE DUSH: John, I appreciate your testimony, and you brought some very interesting things that kind of correlate with what Deputy Secretary Weiant had brought up, in terms of the whack-a-mole thing here. Every time we target something that these people who should be taking care of either their attorney clients or physicians as clients, they are taking advantage of their position and this should be something that would fall under RICO as far as I'm concerned. Are there any states out

there that have any kind of enforcement bills that would prevent this kind of stuff, where you go after one part of it and then they shift their target, these new formularies? Are there any states that are doing anything that is effective?

DR. RUSER: Well, states vary in terms of whether they have a mandatory drug formulary or not, and they also vary, as it turns out, on whether or not they address some of these new phenomenon like dermatologicals. And so let me give one example. One of the most significant dermatologicals in Pennsylvania is a diclofenac solution which is -- Voltaren is the brand name. It's a non-steroidal, anti-inflammatory drug, and in Texas the diclofenac is a no drug, so you have to get prior approval before you use it. However, in the California formulary, it's not a no drug. You don't have to get prior approval to use it. So even in different states when you look at their drug formularies, where they have drug formularies, they can differ about this particular drug and others.

REPRESENTATIVE DUSH: Is there any kind of a clearing house as to where the legislation is being effective and specific types of legislation from one state to another.

DR. RUSER: So I guess the answer is that I don't know of a study that has done a comparative study of the

different drug formularies to ascertain which are more effective than others. The drug formularies tend to be fairly new, and so it takes some period of time to put together the data to analyze those impacts.

REPRESENTATIVE DUSH: Thank you.

REPRESENTATIVE MACKENZIE: Next we're going to go to Representative Neilson.

REPRESENTATIVE NEILSON: Thank you, Chairman MacKenzie. I appreciate that. Thank you for your testimony here today. Your stats, are they focusing just really on workers' compensation, or do you have other reports that you may be able to share with the committee for general medicine? Because here in Pennsylvania we have a problem -- and I'm from Philadelphia, so my problem usually shines a little more than everyone else's because of the population -- and we want to make sure that we can do everything possible across the board. Do you have anything to go with that because -- the reason I asked -- general medicine is kind of personal to me because I have a 17-year old who got hurt playing sports. And some of the answers that we've gotten from the specialist we went to was do this, do that, do that and this. And we're trying to seek that out. So a 17-year old, he has a ruptured disk , it's not going to fix unless surgery, so we're trying to avoid surgery and everything else. But he's taking Motrin

like pretty heavy because we won't let him take anything else. It's a scary thought as a parent, so it's something that we're trying to keep a close eye on because it's so easy for these kids to get, and we're losing a generation here. Although we are talking about hurt workers today, we are losing a generation to these opioids, from sports injuries and stuff like that, just getting hurt at home. How about your numbers? Do you have numbers on both?

DR. RUSER: So the short answer is no. We focus solely on workers' compensation insurance. Our data are based on data feeds from the payers, from the third-party administrators, from pharmacy benefits managers, and the like, all in workers' comp.

REPRESENTATIVE NEILSON: Although we see a decline here, we might be seeing an up climb there because they might not be going through the workers' compensation system. I'm a construction worker. I'm in a construction background and what we've seen was -- we actually hired someone to take care of this problem full time, to take care of all the union members there, so they have someone to go turn to because, after workers' comp, that's where they seem to be shifting into the heroin end and all because they know they no longer have access to the stuff. So we're trying to look at it and combat it in a few different directions because even though they're not shown

on here, they are going to be shown on there. That's why I was hoping maybe you could enlighten us a little bit on that, those numbers.

DR. RUSER: The only thing I can observe is that many of the guidelines are outside of workers' comp too, so there's CDC guidelines and many state guidelines are not just specific to workers' compensation. They are focused on opioids more generally, and we see their impact in workers' comp because that's our focus, but hopefully they are being seen outside of the worker's comp system as well.

REPRESENTATIVE NEILSON: Thank you again for taking the time, and testimony today. Thank you, Chairman. Chairman MacKenzie, thank you.

REPRESENTATIVE MACKENZIE: Thank you, Representative Neilson. Next we're going to go to Representative Keefer.

REPRESENTATIVE KEEFER: Thank you, Representative MacKenzie. Thank you for participating on the panel. One Question or two-fold question. First is, how many states do have formularies?

DR. RUSER: Drug formularies? I'm going to have to pass on that question. I'll be happy to get you the answer. I just don't have it right at my fingertips. If I hazard a guess, it's going to be wrong.

REPRESENTATIVE KEEFER: Okay.

DR. RUSER: It's certainly not the majority of states.

REPRESENTATIVE KEEFER: Okay. Have you done any study or have any statistics of what has the impact been in general terms on the patient-doctor relationship, the impact of those formularies on that relationship?

DR. RUSER: No, I don't know anything about that.

REPRESENTATIVE KEEFER: You haven't done any studies on that.

DR. RUSER: No. As I said, a lot of the claims data focus on the delivery of services, on the prices of those services, so it's hard to see things like the patient-doctor relationship. We have other studies that we do where we do interview the injured workers, and we ask them about their experience in the workers' comp system, but it's a more general set of questions about whether or not they are able to get the doctors they want to get, whether or not they get the services that the doctors think they should get. So we have a broad set of questions that we ask in our worker outcome surveys, but they are not specifically focused on opioids.

REPRESENTATIVE KEEFER: Okay. Thank you.

MAJORITY CHAIRMAN: All right. I don't see any other members that have any other questions. Mr. Chairman?

CHAIRMAN HARKINS: My mic's bad.

MAJORITY CHAIRMAN: All right. He broke his microphone so we're not going to let him say anything else. Well, again, I do thank you for taking the time to come here and provide us with the information. Very valuable data. As I said, you packed a lot of information into a very short presentation. But again, thank you for traveling here and sharing the data with us, and we look forward to updates in the future. And with that, this hearing is adjourned.

(Hearing concluded at 11:35 a.m.)

C E R T I F I C A T E

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.

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Transcriptionist

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