Business and Labor Committee November 27, 2018

Rough Draft

(Recorder malfunction—testimony lost)

BRIAN ALLEN: [00:00:03] How challenging it is for you to manage as a state if it is, you know, or how unchallenging it is, I guess, and what you can expect in different ways you go about doing it. We as a-- we are a pharmacy benefit manager for workers' comp claims, we don't do any pharmacy benefit management work outside of workers' comp, so our expertise is fully in the workers' comp space. I can tell you that we have been involved in the development of most the formularies around the country, providing advice and counsel to policymakers. And we think that-- each state has found a way to kind of meet their own particular need and I think each state has found a way to be successful in developing that formulary. Let me just give you a little bit of background. So I've been involved in workers' comp issues and policy around the country for about almost 16 years now. I have been actively involved in development of drug formularies, and thank you. I kind of felt like, you know, it goes-- it felt like it was back on my law enforcement days. I used to use the spotlight and rubber hose and phone book, it was kind of feeling like that up behind there. But so I appreciate you taking that off my eyes. So the-- anyway, I extensively worked with Texas when they developed theirs. I've worked with Arkansas, with Tennessee, with California. I've been working with Kentucky and Montana. I've worked some with Indiana, and I've been working some with New York. So there are-- and all of those states have taken a little bit different approach to how they've addressed their formulary. And you can do a formulary in a number of different ways. And what I try to tell policymakers is when you're considering a formulary, you need to keep in mind that the care of the injured worker is--should be of primary concern, is what-- we want to make sure they're getting the very best care available to them. And we want to make sure that we're getting-- they're given the kind of care that's going to help them recover more quickly. And we want them, obviously, to recover to the fullest extent possible. I tell people that that's sometimes that's the

difference between workers' comp and group health, and most people have a lot of experience with group health. We don't have much experience with work comp, but you know in working-- in group health kind of the outcome is we want the patient to quit complaining about whatever it is that is bothering them. But in workers' comp, we really want to try to get them up to the fullest recovery and productivity possible. And that varies depending on the type of injury and the patient. So the pharmacy care is integral in making sure that we get the right pharmacy care to make sure that that happens. And some pharmacy care can actually inhibit recovery. And a good formulary will help you help guide the physician to find those medications that would be best suited for the particular injury that they're treating and stay away from those that might actually inhibit that recovery. So there are a lot of different ways to go about doing a formulary. Texas has a very open, a very broad formulary. The Texas formulary includes all FDA approved medications, except there are some nonpreferred drugs on a-- on a list, they're called "N drugs." And those drugs, while you still have access to them, they require some-- some preauthorization process to get approval to prescribe those. And I try to-- I think the best analogy that I've come up with for what a formulary-- how-- how a formulary really works is-- I was mentioned earlier I was in Dallas over the weekend visiting grandkids for Thanksgiving and I had to drive 635 from one end in Dallas to the other and it's-- there's an expressway. And a formula, if you prescribe a drug that's on the formulary, it's like the expressway, you go through, you don't have all the conflicts and traffic and all the things you have to deal with, you just breeze from one end to the other with that process and it goes fairly smoothly and we've seen that work really well in the states that have adopted a formulary. If you decide to go off the formulary, then it's a little bit more like driving in the regular lanes of traffic, you're going to encounter a little bit more bumps in the road that you have to deal with, but the-- the drugs that are approved on a formulary, I mean, you have to understand that the formularies that we see out there are the formulas that we've used in our business processes for the last number of years are-- they are peer reviewed, they're evidenced based. They have been, you know, tried and tested by a number of medical professionals have had input on these. These aren't things that, you know, and it's really all

about the kind of care that's being delivered and it has less to do with about cost of the medications. Although cost is a consideration if you have a brand name drug that does the same thing as a generic and the-- the generic is just as efficacious as the brand name drug in most cases that's going to be the drug that ends up on the formulary probably not the brand because it does the same thing but it's less expensive. But that's the only time cost becomes a consideration, if you have to equally therapeutically equivalent drugs, then, you know, ultimately costs will be the deciding factor. But if there is no other therapy equivalent option, then that's the drug that's going to end up on the list. And we have found that to be very helpful to us in our business in making sure that we're delivering appropriate care to injured workers. But the other ways that you can do a formulary, and some states have done this, where they have a preferred list of drugs and these are the drugs they want you to prescribe. So it's a finite list. It's not as broad as Texas' list, but-- and most-- we see those typically in monopolistic states, although California did theirs that way it's more of a-- kind of a finite list of here's the medications that are sort of on the preferred list. And as long as you prescribe those preferred drugs, they go right through the system. There's no preauthorization requirement. There is a check to make sure it's suitable for the injury. You know, not every drug that's an approved drug is going to be right for every injury. And interestingly, the other thing that we see frequently is that we see medications coming across as a workers-- being billed to the workers' comp insurer and we do a little-- and it doesn't look right for the injury, it doesn't fit the formulary, and we find that's actually a group health plan that inadvertently got-- the injured worker has a group health claim going at the same time they have a workplace injury going and sometimes they get confused in the pharmacy as to which drug goes where. So we help, you know, the formulary can help sort some of that stuff out as well. And so the-- and then other states have their-- some of the states have adopted commercially available drug formulas. There's a couple out there that are both very good, and those are options where states don't have a lot of medical expertise on staff. They have gone with one of these commercially based formularies. Other states have taken the tack of developing their own. They had the expertise to do that. Arkansas is a good example of that;

Arkansas used a formulary that they had their school of pharmacy had developed for their state employees for their health program and they adapted that and then applied it for their workers' comp program. And that's worked for them. Other states have taken the commercial formularies and adapted them. So they've taken that kind of built the-- they've taken the foundation of the commercially available formulary and then they've made modifications based on what they felt their needs were in that particular state and they had a group of people that worked on that. Primarily they were pharmacists and physicians. And so they'll take those and then build on those. And then the monopolistic states, Washington and Ohio, they developed their own formularies. It's a little bit easier for them to do that because they're, you know, they're the only-- they're the only carrier in the state, so it's kind of easier-- easy to tell your own entity what to do. It's a little bit more challenging when you get out the commercial space and there's a lot of different competitors. But we have found that the-- the-- the state adoption of a formulary has worked well for us. I mean, we-- we-- we-- I will-- I will tell you we went into a mix with kind of a mixed feeling because we are a PBM and we have our own formularies. We have formulas that we've developed over time based on, you know, customer preferences, based on medical evidence, based on all the things that are out there. We use basically the two commercial formularies. We've used those historically to develop our formularies. And, you know, we were kind of worried it was going to supplant us in the marketplace. You know, initially it's kind of that fear of the unknown, but we ended up embracing the one in Texas because we thought it was a good step forward and it was part of a compromise. And we didn't feel like it would be right for us to engage in the compromise legislation in 2005 and then six years later oppose what was a [INAUDIBLE] piece of the compromise. So we decided we were going to go ahead and embrace this and we actually were very happy that we did because it end up being extremely helpful to us in our work product. But it's also been very beneficial to this, the stakeholders of the Texas system. One of the things that Texas did that I thought was really good and it's been very helpful to us is that they-- they collected data before they implemented the formulary on their drug costs and they were able to kind of establish a baseline of where they were

at and they had some good historical data. And then they implemented the drug formulary and then they didn't change anything else related to their pharmacy rules or regulations for a number of years so they could collect some good longitudinal data on the impact of the formulary. So there wasn't any noise out there because of fee schedule change or some other policy changes that might have impacted how pharmacy was being delivered. And Texas, and so their formulary started in September of 2011. In July of 2016, they released a report that had studied now the results the formulary over a period of years and the results were good. I mean they saw the nonpreferred drug prescribing of those went down anywhere from 70 to 80 percent. They also saw prescribing of all medications go down a little bit, and we saw that in our own book of business. And what we saw is that with the introduction of the formulary and the guidelines to prescribers on which drugs are right for which injuries, it actually helped kind of minimize some of the, what we used to call defensive prescribing where they would prescribe a drug in case you needed it so you didn't have to come back in the office and get it later. We felt like the formularies kind of helped the prescribers in Texas kind of zero in on medications that were really right for that injury and just kind of stayed within that prescribing set. They were on the preferred list. We were able to get those. And it's worked out really well there. We do in most of the states there is a process for retrospective review so if there is a preferred drug that's prescribed, it gets delivered to the patient, it gets through the process. But on the back end they'll take a look at it and say OK this drug came through; was it really right for this injury. In some-- in some cases, not very often, but now and again we will find one that wasn't really correct and then we'll have to go back and say OK we let this go this time but we can't let it go through again because it's not really right for the injury. Then we'll work with the claims adjuster, with the physician and give-- making sure the appropriate medications get prescribed. There is a process for approving a drug that's not on the formulary, and that has worked well in most states. And I go back to Texas a lot because it's the one I have the most experience with and it's been around the longest and in the-- in the-- in the nonmonopolistic state model. And so what-- what Texas did they-- they put in process. So if you wanted to prescribe a drug that was

off the formulary, there was a preauthorization process. And it basically you had to just justify, you know, if you're deviating from what is, you know, medically, you know, evidence based, peer reviewed sort of guidelines and you're going to deviate from those, why are you doing that and give us your medical justification for why that's happening. And Texas, we were concerned about that process. We were a little bit concerned that it might be a lot of disputes up front as the formulary got introduced. And so Texas, at the behest of us and a number of stakeholders, put in place what they called an emergency interlocutory order so that if a doctor and the claims administrator couldn't agree on a medication, there was this kind of rapid review done by the medical director in Texas. And we actually staffed up a phone system-- a phone line-- a phone line with a whole bunch of people thinking we were going to get a lot of disputes, and the phone never rang. Strangely enough, the doctors really took a look at the formulary. Texas did a pretty good education campaign with the doctors and they looked at the formula and they said, look, most of the drugs that we need to prescribe are on this list. If we need to deviate from it, we're happy to do the preauthorization, and it seemed to work. It's from--- from our perspective, we haven't heard a lot of noise from physicians in Texas or any of the other formulary states on the drugs getting prescribed. And I think partly because there's been, you know, if there's a good educational effort up front, it seems to help and that-- in that-- in the overall adoption of the formulary. And I think the other thing is that having a plan in place. So the formulary,-- anyway, so in Texas anyway, we had this interlocutory, and I should probably finish this thought up, Texas had in the first year of their formulary operation, and Texas had a pretty good size system, they had less than 25 actual disputes go to that far. I mean, they all got resolved before then, which is good. And you know, there was some good communication and we've talked to some of our payer partners and they've actually been-- they felt like the communication between the claims adjuster and the insurance carrier or the claims administrator, medical staff and the doctors has been productive because they've been able to understand some of the things they didn't understand just from the medical records. And they felt like they have been able to reach agreement on most of the medications that need to be prescribed. I

think the other thing it's important that that that that states consider when they're doing this adoption of a drug formulary is what do you do with people who are already out there on a lot of these drugs? And that's a big concern, and some-- a couple of-- I think maybe one state took the approach of they're only applying the formulary to new claims going forward. So there's sort of a bifurcated process system in place in that state. The other states have created a transition period so the drug formulary becomes effective on a given date for new claims and then there's a delayed effective date for claims that are already on the books. And what that delayed effective date timeframe is designed to do is to give the insurance carrier or the claims administrator an opportunity to work with a physician to figure out is there an opportunity with this particular patient who's taking a nonpreferred drug that's a nonformulary drug, is there an opportunity to transition them to a drug that's on the formulary that might work better for them or at least be more appropriate for them, or do we need to keep them where they are. And then if we are, then we're going to put in this sort of ongoing preauthorization process for a given period of time and then reevaluate it again after a period of six months or a year, whatever. That's worked pretty well. It does require some communication. If you do it right, and we have no, I mean, there were cases where doctors and insurance companies didn't get together and patients ended up showing up at the pharmacy with the nonformulary drug and then it was a little bit of a hassle for the-- for the injured worker. But for the most part, when they followed this process of getting together and actually working together, I mean, it's shocking to hear these people work together, working together actually to figure out what's the best appropriate line of care for this injured worker, how can we make that work. And then we can put in place on our end these preauthorizations upfront so that when that drug hits we know it's already a part of an approved treatment plan and it just goes through as if it were a formulary drug. So it just goes through very smoothly. So there are ways to handle those transitions, and you can learn a lot from what some of the other states have done. And we think, you know, typically, Texas had a two-year transition period, which was pretty long. But they were the first one to do it, so I think they were erring on the side of caution. It seems like a year for us seems to be the

most workable because it gives you enough of a sense of urgency that people don't procrastinate to the very end, but it also gives you enough time to adequately deal with the planning and the transitioning. And so we think that's really helpful. The other states that have done formularies that have now, you know, a little bit more seasoned. We don't have a lot of data on Oklahoma so I can't really speak to what the results have been. We do have a fair amount of data on Tennessee. And Tennessee's not been in play that long but they-- they did a Texas style and it looks very promising. It looks like they're getting a lot of similar results to Texas. They didn't have quite the same educational effort up front, so they had a couple of hiccups up front with helping doctors understand how the formulary was going to work for them because they didn't get out to every single doctors that was a prescriber in the work comp system. But they did a pretty good outreach. But they-- but that's been smoothed out and I think things are going well there. California is still pretty new and they used a different model than the other states and their model seems to be working pretty well for them. There's some preliminary data out there and they've seen a real reduction in nonformulary drugs being prescribed. And the other thing that that some of the states have done, some states have had some challenges with different kinds of prescribing methods that are out there. Some states have struggled with some of these compounded medications that are these creams that have been developed and the formulary can be helpful in making sure that if you're going to get that it's really right. And some of them, we see sometimes some of those come across our desks are two or three thousand dollars a month for a-- for a 30-day supply of a cream and we look at the ingredient costs that it would take to actually build it ourselves and it's like $20. It's not that-- there's a big difference in the actual costs of ingredients versus what this compounded medication looks like. And it's typically coming as sort of a first line, kind of a bulk development process and those-- some states had problems with that and they've been able to help curtail that. We're not against compounding medications, it's just they have to be appropriate and I think that's-- the that's the ultimate goal is making sure that it's an appropriate care model. There are ways that if you have-- if you have a particular area that you're concerned about, you know, in some states very concerned about opioids

so they're really focused a lot on their drug formularies. For example, Arizona initially adopted an opiate only formulary and then a couple of years later, in fact just this year, expanded that to all drugs. So you know, there are particulars areas of concern, you can focus on what your formulary and that can all be done with the commercial models or something that you develop yourself or some hybrid of those two things. So there's those opportunities out there as well. But, so our experience with formularies has been very positive. We've heard from some in the medical community that they like the formulary, especially when they have a patient who wants a drug that the doctor doesn't feel real good about giving them, but they're very persistent. They can point to the formulary and say well this really is not on the formulary. It's kind of out of my hands. I mean you have to talk to the state about it; the state said, these are the drugs I can prescribe. So in some cases it gives the doctor an out if they have a really persistent patient that wants a drug that the doctor may not really feel that good about giving them, but sometimes they just, you know, rather than-- sometimes the squeaky wheel simply give it a little grease it goes away. But, and so, there's-- we've heard from some professionals about that. I know that our own inside clinical staff has evaluated these drug formularies and they feel very confident in their ability to do what we were doing before as a PBM. And we just, you know, we basically in the states that have a drug formulary, we take our drug formulas and kind of set them aside and use the one that the state has and we--you know, and it's been very effective for us and we've-- we've been happily, I guess, surprised about how well that's worked for us, because we did have that concern going in that somehow replace us in our business model. But it's actually turned out to be a very positive thing for us in the marketplace and we're a big supporter of the use of a drug formulary. And we've-- we use them in all the states now anyway, they're just not state mandated so we're just using them sort of informally as we help, you know, manage the care for the customers that we serve, for the injured workers that they serve. And we-- the other thing that I'm hearing and there hasn't been a study done on this yet but I'm hearing anecdotally from both Texas and Tennessee and, oh and California, I guess has mentioned this as well, but they are seeing a reduction in overall medical costs and indemnity costs after the

implementation of the formulary. It's a little bit hard to isolate it because a lot of policy changes happen all the time in those states. So it's hard to say was the formulary directly related to it, but they're seeing a reduction in medical costs and indemnity costs. They think part of the result of the drug formulary, so we're hoping somebody we'll actually get a study done. We can-- we could do it, but the problem is we can't isolate all the policy factors in our data, but the states have a little bit better handle and fixed on that. They can get the stuff that we can't get from payers that have the data. But the reality of it is we think there's a there's a real positive impact to formularies. We understand that it's a little bit different than doctors are used to now and we know they have to adapt their practices a little bit to manage it. We think if the doctors stay close to the formulary and understand it that they prescribe drugs that are on the formulary, it's-- it's actually much easier for them, they're going to get a lot less noise and a lot less phone calls from the pharmacy. The pharmacies like it, at least our pharmacies that we work with seem to like it because they get less-- they have to do less homework on, you know, a denied script that comes in because if it's on the formulary it's going to go through without any challenge so they seem to like it. But it is a little different, I'm not going to say that it's all a breeze initially. I mean it's a breeze once you get used to it and you understand it, I prescribe on this list it's going to go through. It's a breeze if you understand if I need to make a deviation, I just have to document it and make a case for it and present it to the insurance carrier. And we find that most of the time, if there's good medical justification, there's not any problem with the insurance company you know approving it, we get notices from insurance companies all the time in our book of business that we have approved this this this nonformulary drug for this patient for this period of time and we set that up in our system and it just breezes through. So there's lots of ways to handle it. There's a lot of good technology out there that makes this go really quite smoothly. And from our perspective, we think it's-- it's a big win. It will help you with your opioid problem. It will help you with a lot of what we consider unnecessary prescribing of medications and really help zero in, I think, on what we believe is the best care for the injured worker and help them get back to the life they had before they were injured

to the extent that they can.

ALBRECHT: [00:22:44] Very good. Did you time yourself before you started this?

BRIAN ALLEN: [00:22:47] No, but I'm done. Look, I try to be brief. I mean I'm not-- I am a recovering politician, I can go on and on.

ALBRECHT: [00:22:53] Oh, you did very well.

BRIAN ALLEN: [00:22:56] I am going to not do that to spare you the misery.

ALBRECHT: [00:23:00] OK. Mr. Allen, do we have here yellow? Did you get it? No. Do you have-- did you get your sign-in sheet filled out?

BRIAN ALLEN: [00:23:05] No, I didn't, but I'll get one and get it done for you.

ALBRECHT: [00:23:06] We got to have that so she can enter everything here, if you don't mind. But before so what-- is it OK if we take some questions before you do that? Okay. Senators, do you have any questions for Mr. Allen? If you don't, I do, but go ahead and start if you like. Would you like to go?

CRAWFORD: [00:23:24] No, go ahead.

ALBRECHT: [00:23:25] I can wait. I'm supposed to wait until you get through. Senator Lowe, do you have anything right now?

LOWE: [00:23:32] Oh, sure I got a lots.

ALBRECHT: [00:23:32] OK, good.

LOWE: [00:23:33] You guys aren't going to do anything.

ALBRECHT: [00:23:34] No, I'm going to go, but I'm trying to be gracious and let you go first.

LOWE: [00:23:42] OK. Mr. Allen, you said you've been on the forefront of many of these formulating-- formularies that have come across.

BRIAN ALLEN: [00:23:47] Yes.

LOWE: [00:23:50] Have you found one that works better than most? I know you talked a lot about Texas, and Tennessee struggled. I take it communication is key in all of this. Which one do you prefer I guess?

BRIAN ALLEN: [00:24:11] Well, in a week, we work with both of the commercially available ones that are out there, and we also work with states that have developed their own. So we're kind of agnostic on like which one we prefer. I think what we find what works best is as you develop the policy and as you make the choice, engage your stakeholders. One of the things that we, you know, I spend a lot of time when Tennessee was working on theirs flying back and forth from Salt Lake to Nashville, you know, helping them with the rulemaking and helping them understand the policy implications around some of the decisions they were making and they engaged a lot of stakeholder discussion, as did Texas. I mean, Texas the law that enabled Texas to pass a drug formulary passed in 2005. They didn't actually adopt their drug formulary till 2011. And the reason is that because

they had--they did a major overhaul of their work comp system. They went from a work comp commission that was sort of a separate entity to a work comp division that was a division of the Department of Insurance and they had a lot of things they had to do, but they also had a lot of changes they needed to make before a drug formulary would actually be really effective for them just because of the way their system was. They were kind of unique in that. Most states have a much faster up tick on it. But the reality of it is, I don't know that there's one that's any better than the other. I think the thing that's really important is that there's a lot of stakeholder engagement; a stakeholder buy in at the end of the decision and that there's an education effort made to the prescriber so they understand what the formulary does and doesn't do, what they need to do if they need to deviate from the formulary, and really try to create a sort of, you know, good model of communication between the payer and the doctor so that they can make sure that they're actually getting the best care possible to the injured worker. And I think the other thing is just making sure that you don't make it too complicated. Some states, you know, I've been in your chair and I've been on a-- on a regulatory authority body as well and it's real easy to get complicated fast if you don't, you know, if you don't pay attention to what you're doing. I think the thing is to try to keep it as simple as you can. This is not rocket science. There's a lot of evidence based stuff out there already done that you don't have to recreate. And I think make it as simple for your stakeholders to use as possible. And always do so make your decisions with an eye towards making sure that injured workers are getting the very best care possible. And that, you know, that-- and the formularies, I think, are really designed to do that. We have found them to be very, very effective in delivering what we believe is appropriate care and helping guide doctor to that end. And we've developed some really very strong relationship with physicians over the years because the formulary because of their efforts on it and our efforts at helping to educate them on how it works. So I think really it's, you know, I think the more restricted the formulary is the more difficult it becomes for physicians to work within it. I think the broader that you can make it and still keep it sensible is best. So I think that approach works. But, you know, but you can learn something from all the states that have done

it. California took a very unique approach, but it's worked extremely well for them and they've had a really good early success with it. And there were, I will tell you, there was a ton of pushback. I was initially brought in on the California discussion to broker a compromise for a legislator who had a group of stakeholders that just could not agree. And we, after a couple of meetings, we were able to get to a point of agreement on a couple of what I felt were critical points and then that then laid the groundwork for the formulary that's-- that's come out of California and-- and-- but it took a lot of time and effort and working with stakeholders. And I think that's the key thing is, you know, I mean, I don't think your regulatory authority does this. I'm pretty sure they don't. Your workers' compensation court, they don't make decisions in a vacuum. I mean all this is-- all the-- all the policy changes I've seen them do over the years they've involved a lot of input from stakeholders. If they continue to follow that model, if-- if the Legislature decides to implement the drug formulary, they'll have success with it, because that's really a stakeholder engagement. Many people to be heard and having their opinions matter and incorporating the good ideas into your process. And that will make it work.

LOWE: [00:28:33] Ok. Thank you.

BRIAN ALLEN: [00:28:34] That was kind of a really political answer to a nonpolitical question.

LOWE: [00:28:38] Yeah.

BRIAN ALLEN: [00:28:39] We work with everybody so.

LOWE: [00:28:40] You don't have an answer.

BRIAN ALLEN: [00:28:41] Yeah.

LOWE: [00:28:42] Which is the best? Can you give me an idea? You touched on this. Can you give me an idea how the formulary might help the doctor or the hospital when a patient is requesting more medicine maybe than what he should have or she should have?

BRIAN ALLEN: [00:29:04] Yeah, and we've actually seen this too with some of the prescribing limit laws that have been passing around the country. The doctors-- I've talked to a number of doctors about opioids. I have a long history on opioids. I had a sister, 10 years ago, who died from a drug-- opiate overdose-- oxycodone overdose.

ALBRECHT: [00:29:21] Sorry to hear that.

BRIAN ALLEN: [00:29:22] And so I was kind of on the campaign trail then about the opioids because she-- when I saw what she was getting prescribed, I was dumbfounded. And I thought, wow, this is just like over prescribing. But I also know my sister and I'm sure my sister's personality was one that when she went to the doctor, I'm sure she just berated the doctor until she-- he gave her what she wanted because that's just the way she was. She was like that as a little kid and she didn't change much when she got to be an adult. But I've talked to a number of physicians who have said we really actually appreciate the tool because it gives us an opportunity to tell our patient, you know, I can't give you this because the state's telling me I can't; it's not because I don't want to, it's not because I want you to suffer or whatever. And the reality of it is, a lot of patients, especially people who are-- who are dependent or addicted to opioids, they have a real fear of losing their medications. And I've-- I've worked so I've spent 17 years on a nonprofit board that dealt with homeless addicts and a lot of them were opioid addicts, a lot of street heroin-- heroin and other kinds of drugs. But some of them were prescription drugs as well. And the-- if you were to tell them that you were going to take away their drugs, it would be akin to me putting a plastic bag over your

head and telling you I might take away your oxygen. It would be that same level of fear. It's-- it's not a rational fear from our standpoint, as we sit in these chairs, and we're not struggling with that addiction or dependence, but to them it seems very, very rational. So there's a lot of fear and they get very, very frightened and then the doctors have to deal with that. I mean it's-- they're on the frontline of that trying to deal with these patients who have these fears. And even though a doctor may know that getting them off of it probably the best thing that can happen to them, it's very, very difficult to get them into the state of mind where they're willing to give it a try. So we've seen the opioid-- the drug formularies and, you know, these limits on opioids actually help move patients in that direction. And we've talked to a couple of patients now who have gone through the process who are much better off. They feel better, their life style is better. Their productivity is higher because they've been able to wean themselves off the drugs. But it is not an easy or simple process and it's a frightening process. That's why we think the drug formulary is really a tool. I always liken the opiate addiction problem unto a lake. We've got all these people who are addicted to opioids in this country, they're in this big lake. We've got to get our head around this lake, but we can't drain the lake, we can't fix the lake until we dam the river feeding the lake. And the drug formula really is all about how do we not prescribe the first opioid? How do we not get them on the very first-- oh how do we keep them from ever getting on the path to addiction. I mean you'll never get addicted to an opiate if you never take one. Right? And so it's that kind of a model. So we use the drug formularies, this opportunity to kind of more of a preventative measure. And then we come back and try to deal with-- now how do we go about dealing with the people who are in the lake. And the drug formulary can help with that over time. But really I think the primary focus, as we view it, is it's an opportunity to keep people from getting in the lake in the first place. How do we prevent them from getting to that position? And the drug formulary, in our estimation, has done a very good job of that. We've seen it in our own data. We've seen it in the state prepared data where states have kept track of that and we think it has a real impact. But it's-- it's a challenge. I'm not going to lie to you. It's a challenging, challenging effort and it is hard for doctors who are on the front lines to say

no to a patient. But when they have to, at least they now have the backing of the state saying you don't have to do that. And our mentality in this country is changing about how we evaluate patient care and how we evaluate patient satisfaction when it comes to pain. There's some notion that maybe our evaluation of making pain such a critical component has actually led to the crisis that we're in right now because we're more focused on pain and patient satisfaction, maybe less on some of the things we should have been. So that mentality is changing. I think doctors are embracing the idea that maybe they need to prescribe less opioids. I don't think this is earth-shattering news to them. But the formulary certainly is a tool and a guideline for them to point to so I can follow this. I'm staying within what I believe the state wants me to do. And it gives them a way to explain to their patients why they're doing what they're doing without making it the doctor's fault.

ALBRECHT: [00:33:44] Any other questions? Senator Lowe?

LOWE: [00:33:46] Not right now.

ALBRECHT: [00:33:46] Very good. Senator Crawford, did you?

CRAWFORD: [00:33:47] Not at this time.

ALBRECHT: [00:33:49] OK, I have one. First, thank you for joining us, Senator Chambers, we've missed you. We've just gone through our first speaker and we have two more to follow. But I do have a couple questions.

BRIAN ALLEN: [00:34:01] OK.

ALBRECHT: [00:34:02] OK, so if we were to consider implementing something like this, just talk

to me about the list of players that would be a part of developing this formulary. Who would you bring to the table?

BRIAN ALLEN: [00:34:16] Well, I would bring, well, I mean, first of all medical professionals. I mean your doctors and pharmacists need to be there. They're the ones who, you know, are dealing with this. They're on the front line. I think having a work comp PBM representation is important because they're the ones who ultimately manage all the technology that manages the formulary. Insurance companies and employers have to be a big part of that because they ultimately pay the freight. If you have a strong group of, you know, worker representative applicant attorneys, I think it's important for them to be in the room because they represent the injured workers and should hopefully have the injured workers' best interests at heart. And I think that those are probably the most critical ones. If you have labor advocates, if they're-- I don't know how strong they are in your state, we've had them at the table in most of the states that we've been in and they've been very helpful. But I think those are the critical individuals. And if you're considering one of the commercial formularies or any-- if I-- probably having the people from the commercial formularies, ODG and ACOM in the room, they were very critical too because, I mean, I understand the policy behind a formulary. They understand the formulary. There's a big difference between those two things.

ALBRECHT: [00:35:35] So your company itself wouldn't be able to do both sides. You would just-- if it were you what would--

BRIAN ALLEN: [00:35:41] Well, the PBMs could. I mean we'd certainly be able to-- to be helpful. But I think it's important to have them there because they can speak more authoritarian-- authoritatively to this medical evidence and science that went behind the actual development of their formularies.

ALBRECHT: [00:35:56] OK. So what kind of cost factor is in what these states that join any one of you folks to try to put this together and help us develop the drug formulary?

BRIAN ALLEN: [00:36:12] Well, you know, I fly all around the country at my company's expense. We don't charge a state for my expertise. That's something that we just feel is important to be engaged in the process and to-- to provide the best input that we can. So we-- we-- we manage the-- we just absorb that cost. That's part of our-- what we believe is our civic duty, I guess. I think-- I don't know that any of stakeholders that I've been involved with around the country that have traveled in have charged the states anything to-- as a consulting fee. I don't know that there's been significant ongoing costs when they've actually adopted and developed a formulary though under the-- most of the-- I think the fees have been either the state has paid the fee globally for everybody involved if they were going to use a formulary they just--

ALBRECHT: [00:36:59] But like if I want to educate a pharmacy or-- you talked about education campaign, who-- who does that?

BRIAN ALLEN: [00:37:08] Well, it's been handled differently. In Texas has-- they had a staff-- staff members that went out and did it.

ALBRECHT: [00:37:16] Staff from--

BRIAN ALLEN: [00:37:18] From the Division of Workers' Compensation, so state agency staff.

ALBRECHT: [00:37:23] OK.

BRIAN ALLEN: [00:37:23] In Tennessee kind of did a hybrid. They had their medical director and then some other, I would guess, sort of volunteers that went with him to talk to folks. It could be done-- the other states that we've worked with have held-- they've held what they called stakeholder meetings and we presented at those at no costs. We fronted the costs for that. So I think most of the people out there that work in this space are more than happy to come talk for free because I think it's important-- it's important for us that you get it right because it makes our life easier. And I think it's important just because our mission and goal as a company is to provide quality care and to make sure that quality care is accessible for injured workers no matter where they are. And so we think that's part of our mission is to make sure that, you know, as we help with policy that we help policymakers try to understand market implications to decisions that they make. We don't necessarily want to tell you how to do your decision because that's not really our role, but our role is to help you understand if you make this decision here are the implications-- implications out in the marketplace which I think you need to understand because that can impact a lot of people if you make a bad decision.

ALBRECHT: [00:38:41] Right.

BRIAN ALLEN: [00:38:42] And so-- so we come and we provide our expertise at no cost. So I mean I don't-- I, I can't speak for all the other stakeholders out there, but I have found that most people who work in this work comp space really have the desire to make sure things get done right. And I think most of them are passionate enough about it that they will, they will lend their expertise at no cost to help make sure that happens.

ALBRECHT: [00:39:03] OK. And when you talk about it's evidence based and, you know, there's a cost savings to the insurance companies, obviously. Would the Workers' Comp Court or the-- would they be able to give you a lot of information just on our state based on, I mean, did you work

with them throughout the different states in formularies?

BRIAN ALLEN: [00:39:25] Yeah, so every state's level of data is a little bit different. Some states have a really good bit of data and other states it's less so, just because they don't-- that's never been part of their mission as an agency to collect that information. We have data and we can access data on most of the states through NCCI or through, you know, other data sharing entities that are out there in the work comp space. So there is data out there for every state. Some of it's better than others depending on the state. Usually states like, I live in Utah, you know, smaller states, there's not, you know, there's not as much because they're small and people don't pay that much attention to them. But there's still enough data out there that you can make good qualified decisions. And really it's all about how do you- -how do you wrap a formulary into your existing structure and make that work. Do you have the tools in place to handle a dispute process or do you have to come up with another process for doing that? And there's lots of ways to manage that, those different processes. And some states actually outsource their disputes on some things to independent medical reviewers. So there's-- there's many, many options. Do I think your court has the expertise to manage a drug formulary? Yeah, I think-- I think they do, partly because the-- if the commercial vendors already manage it for you. I mean basically you just contract with them and they handle it for you and they have all the medical expertise and all the people involved. Now the one thing you can do is you can invite periodically stakeholders to come and evaluate, you know, where things are at and make sure, on an ongoing basis, you keep that communication open so that if there is a hiccup that develops for whatever reason, we haven't seen one in the state yet, but I'm sure there will be one at some point in time, but if a hiccup develops and you have a group of people that can come talk to you about it and give you input, give you feedback and possibly offer up a solution to help you fix whatever little hiccup is. But I think for the most part, I think any state in the union is equipped to handle and manage a drug formulary because the science and the evidence has already been developed around them and it's ongoing. I mean it's not a static thing where you adopt a

formulary and it stays the same, it doesn't. These doctors and pharmacists and others who are clinical evaluators of drug formularies are constantly looking at new drugs or they're on the market. They're constantly looking at existing drugs, and we learn new things about drugs all the time. I mean, I mean the opioids is a classic example of that. I mean for the longest time they were promoted as a nonaddictive drug. And I don't think anybody would ever believe that today. But, you know, 20 years ago, that was the story.

ALBRECHT: [00:42:17] You know, this might be a question for an attorney that might come up, rather than just yourself, but if you do get injured on the job, and these are some examples that I've heard in the last couple of years, you get injured on the job and the doctor puts you on these prescription drugs and possibly the narcotic or the opioid for the pain, but then you might need surgery. But they just keep prolonging the misery. You know how do you-- how do you get them to do something different so that you could get the employee back to work faster and with the proper care? I mean, where does that come in where the drug formula-- formularies says you can't prescribe too many of these or whatever the best drug suited would be instead of the opioid what is it going to be? How long, I mean, is there data out there how long people can be on certain drugs--

BRIAN ALLEN: [00:43:17] Oh, yeah. There's all kinds of data--

ALBRECHT: [00:43:22] --depending on the injury-- and don't you know, basically, for a knee or an elbow, or a wrist or a shoulder?

BRIAN ALLEN: [00:43:23] There is a lot of data on there, on averages, but you have to understand that every case is a little bit different.

ALBRECHT: [00:43:28] Is different.

BRIAN ALLEN: [00:43:29] And I don't know that-- I don't, I mean the doctors that I know and the doctors that I work with earnestly endeavor to get it right.

ALBRECHT: [00:43:37] Sure.

BRIAN ALLEN: [00:43:39] And earnestly strive to get their patients well. I think they're very, very committed to that. The problem that most-- any professional has in their job is that they know what they know. Right? And there's a lot of stuff out there that they don't know because they can't know everything. What a drug formulary does, what treatment guidelines do, any of those things, it provides an evidence-based set of information that a doctor can look to and say, OK, I've got this guy that's got a knee injury and I'm not a knee specialist, but I'm going to-- this is my-- this is my patient, I'm going to treat him, here's-- what I need to do and how can I best treat this patient. So it's, you know, you're doing it in an area of-- a lot of specialization and you have doctors, especially in your more rural areas, you're treating patients, they may or may not have the depth of experience that someone in one of your urban areas might have. So the guidelines help, I think, help them and I think the drug formulary helps them understand what are the right medications for this patient. And I think the ultimate end is we want to get them well. And so, yeah, there is a lot of data out there on what-- how long you should be on certain drugs. We know for a fact now based on a lot of studies that if an injured worker is on an opioid for longer than seven days, and the longer it goes the greater the likelihood is they'll never return to work. And it increases pretty rapidly. And so we know that based on a lot of studies. That doesn't mean that we're going to cut everybody off of opioids at seven days because some people have pain that goes on longer than that. You know, I'm-- I'm a-- I will tell you, I have had-- I had-- I've had two surgeries this year, not by choice, and one was a medical condition that developed that I was completely dumbfounded and shocked by that required some pretty invasive surgery. I didn't use any pain medication. I didn't even take aspirin.

And the other one was I-- in the process of preparing for that other surgery and then rehabbing from it, I was doing a lot of walking and I slipped and tore my-- some cartilage in my knee and I had to get that repaired. And again, I didn't use any pain medication. I don't know if I'm rare, but-- I hope I'm not, but maybe I am. But I think sometimes there's a sense that we need more than what we really do need because we're used to getting it.

ALBRECHT: [00:46:04] Right.

BRIAN ALLEN: [00:46:04] And I think the drug formulary helps kind of set the expectations better. And I think part of it, and I'll tell you quite honestly, I went into both the surgery with the expectation I was not going to take any pain medication. You know my-- with my sister's addiction issues and some other sibling addiction issues that we have in the family, I'm just thinking if I start taking that stuff I would probably be like off to the races I'll never get back. You know, I mean, we obviously, there's something in our genetic code as a family that, you know, we probably should name a wing at a Betty Ford Clinic after the family. I don't know. I mean, I just know we've had a lot of addiction issues. So, I didn't want to put myself in a position where I was going to be one of those problems and so I just avoided it at all cost. And that-- but that was a personal choice. But it was also an expectation I set. And I think the drug formulary does help set expectations in a way that maybe helps kind of promote an outcome a little bit and I think that's also helpful. But yeah, there's a lot of data out there on a lot of drugs on what works and what doesn't work and what drug shouldn't be co-prescribed. I mean some drugs with opioids you get the bends on opiate together and that's can be a very lethal combination. So formulary helps guide doctors on that and I think that's important. Doctors are very, very good at what they do. Most of them that I know will readily admit they're not experts in pharmaceutical stuff. I mean, they learn what they learn at conferences and from pharmaceutical representatives and what have you, but they're not experts at it. And so I think a guideline is it's not like it's a terrible thing. And again, I tell people all time, it's not a gate

across a road, it is not a gate you can never get past, it's a speed bump. But basically if-- if you, if you want to take the expressway and ride on a formulary drug, take it. If you want to do a nonformulary drug, then there's a little speed bump you have to get over to get there and that is justified medically why is this really necessary. And it may be in that process of discovery that you realize it's not that that that there's a better option out there or the drug that's on the formulary is the better option. And that's OK, as long as you come to a conclusion that's the best option, I don't know that that's a bad thing that we got there by using the formulary to get there. I think that formulary is a very valuable tool in that respect.

ALBRECHT: [00:48:15] Very good, thank you. Any other questions? Seeing none, we'll take the next one. Thank you very much.

BRIAN ALLEN: [00:48:22] All right, thank you very much, appreciate it.

ALBRECHT: [00:48:22] That yellow sheet to Beverly real quick here that would be great.

BRIAN ALLEN: [00:48:25] Where do I find--is it out here in the hall?

ALBRECHT: [00:48:26] It would be right outside on a chair in the hall.

BRIAN ALLEN: [00:48:27] I'll get it, I'll get it. You don't need to get it for me. I can do that.

ALBRECHT: [00:48:34] OK. We're going to take a little-- OK, she's got -- Lucy. OK, our next speaker is going to be Lucy Shannon. And we've got yours for her, all right. OK, Lucy, go ahead and get started. Ms. Shannon.

LUCY SHANNON: [00:49:35] Thank you. Good afternoon. I'm Lucy Shannon, I'm from ReedGroup. And I am the director of editorial research and development. And in that role, I'm responsible for the content that we have developed and published through MDGuidelines. And that includes the ACOEM clinical practice guidelines. I am not a government affairs individual. I do work on the content so that's the area of expertise that I'll speak about today. And I did put together a deck just to keep me on track today and hopefully answer some of the questions that Amara was kind enough to supply to me ahead of time. The first question is really what is a formulary? I have had the opportunity to work with Ken Eichler for a number of years. And the first quote here is what he says all the time, it's about the right treatment at the right time. So formulary is a tool that is for assuring the selections of medications that are demonstrated to be safe, effective, and affordable, while maintaining or improving quality patient care. This is a definition that we came up as a-- as a group when authoring a paper through the IAIABC. That is the International Association of Industrial Accident Boards and Commissions. And this paper was published in 2016. Ken and I actually both contributed to this paper. And I'd be happy--either one of us can share it with you, but it talks about what is a formulary lessons learned from the various jurisdictions that have adopted a formulary. So the steps that they took to undergo this process, the speed bumps that they encountered, things that they would do different if they had to do it again. And is a-- is a great overall introduction to this-- this type of consideration that you're looking at today. I rephrased a question that Amara provided. And I took it as why is a formulary important? The formulary is really intended to help all of the stakeholders so that when we look at the inappropriate use of prescription medications negatively affecting a patient's health and return to work, that can have lasting consequences for the rest of their lives. So this is really about hope, helping that individual that's been injured or ill in the workplace. The formulary also helps to bring attention to and potentially change the prescribing patterns for drugs with the highest abuse potential and that includes the opioids, benzodiazepines, the neuroleptics, skeletal muscle relaxants, and investigational medications. So here we're supporting the providers, the prescribers that are-- that

are writing these medications and making sure that we're really bringing attention where it needs and belongs. A formulary is based on evidence based guidelines. So here we're bringing evidence to the forefront on safety and efficacy, what are the best medications to treat specific conditions. There are new studies that come out every day. No provider is able to keep up with every single study that's coming out. And guidelines, we really do that for them. So we're looking at all of the studies that are coming out, all of the medical literature to see what are the best treatments, what are the best diagnostic interventions to diagnose you. But then on the other end, what are those best treatments? Senator Albrecht asked a question about, you know, what else do we do besides providing a medication? And there are lots of other treatments that are available. So guidelines help to provide those ideas, if you will, for what else do we do and when do we do those-- those other treatments? One is medication appropriate. So I am going to talk a little bit about the ACOM formulary and the work that we do in order to-- to create this. So it is an evidence being-- evidence based formulary for the workers comp treatment arena and our formulary relies on the strength of the ACOM Occupational Medicine Practice Guidelines. So these guidelines have a very rigorous and transparent methodology. Those things are important because we are creating clinical practice guidelines that are going to be used on patients and the outcomes are really important. Having a transparent methodology means that somebody else that comes behind us could come up with the same recommendations that we are coming up with. So that's also really important. You want the people that come behind that are also developing guidelines to benefit from the work that we're doing. The panels that we put together in order to come up with these recommendations are multidisciplinary. So we have MDs, PhDs, we have nurses, lots and lots of folks serve on the table. For every guideline that we develop, that panel looks different. So the makeup-- the experts that we bring to the table are going to change depending on the body part or the topic that we're looking at. And then our guidelines go out for a really extensive external review process. So we're going to our peers, we're sending these guidelines out to a wide variety of medical societies that have an interest in reviewing the guidelines and providing us input to the guidelines. So we do this before the

deadline is ever published and we respond to every comment that we get in this guideline process and they help us to create better guidelines. They bring issues that-- that maybe we didn't address. They may have additional evidence that they would like us to look at. So all of that sparks that type of discussion and we address those before the guideline would ever be published. And at the end, this guidance is to help the injured worker, it's to support the physicians, the claims professionals, legal and regulatory communities, and all of the other stakeholders that are in the process. So that's a little bit about the guidelines. And the guidelines are the framework from which the formulary is developed. So the guidelines talk about medications, right, because that's-- that's a treatment that we would have. But the formulary extrapolates all of that. So it makes sure that it brings that information to life in an easy to use format. That's just talking about the drugs and not all the other content that we have available. So when we went to create a formulary, and we actually developed our formulary in November of 2015, so it's not very old. It is again based on the ACOEM Clinical Practice Guidelines which have been around for a very long time. But like I said, we wanted to pull this information out and really bring it to life. In order to do that, we thought that we needed to have additional resources. So we brought a team of clinical pharmacologist that have been led by Dr. Robert Goldberg at HealtheSystems, which is also a PBM. So we have a team of clinical pharmacologist that are actually going through and reading the guidelines. So they read word for word everything that we write. Some of our guidelines are really long. We have a chronic pain guideline that's over 1,400, pages. So they've read all of this information and they help bring all of the-- the pharmacy recommendations. They're providing greater specificity to that type of information. So for example, we may say that NSAIDs are recommended for carpal tunnel syndrome. And the HealtheSystems and this clinical pharmacologist go through and help us to pull out what are the, you know, based on safety, efficacy, cost, what are those-- the best NSAIDs that we could recommend. So they're helping us to provide that-- that greater specificity and really bring another set of eyes on the recommendations that are in the guidelines. In some cases, the guidelines are very specific. So it might call out a drug. It may say that Gabapentin is recommended for a

particular injury. So in that case, you know, it's very straightforward for them to put that into the formulary. But in other cases when we're talking about a class of drugs, then their expertise really helps us. So building on their work, we send the guidelines, the formulary guidelines out to external reviewers. So these are peers in the industry that are taking a look at the formulary and also providing us input. And you can see all of the individuals that are represented here. But ultimately you'll see the name in the bottom right-hand corner of this slide is Dr. Kurt Hegmann. Dr. Hegmann is the editor in chief of the ACOM Practice Guidelines. So, he knows the material inside and out. He's giving that final signoff after HealtheSystems has gone through and helped us pull all the information. He's going through and taking that final look at the work that we're doing. So, this slide pulls together all of the things that I have said thus far. So we start with the guidelines themselves and we look at all of the recommendations that are based on literature and we talk about class of medications and specific medications and those recommendations. And then we have that read through by the clinical pharmacologist that are adding the specificity to those guidelines. They're also looking at pharmacy and medical literature, as well as safety and cost information as well. And then finally, the external review process where we go up for that external peer review, get the input, and then, as I said, that final signoff that we have with Dr. Hegmann. The formulary is reviewed and updated quarterly, but it can be more frequently. So if we've updated a guideline, obviously we need to update our formulary. If we've created a new guideline, so we recently had a guideline on traumatic brain injury, so that would be another case where we update the formulary because it's brand new and we need to cover that material. And then finally, having had these systems in our-- on our-- involved in our process allows us to make sure that if there are any FDA warnings, anything that comes to market that tells us we have a drug that needs to be removed, we could do that right away. So things like that would not wait for a quarterly update. In the formulary, it is specific to the conditions. So our formulary takes a look at what are the conditions that we're treating and making sure that the medications are appropriate for those conditions. Same thing holds true for the phase of care. Is it an acute injury or is it chronic? This is important. When we look at

an acute injury, an opiate might be completely appropriate to treat. When that condition becomes chronic, if that condition becomes chronic, an opioid may not be appropriate. So this formulary breaks it down in a couple of different ways. In the formulary, we assign diagnostic codes so doctors can come in to the formulary with a condition, they can come in with a diagnostic code. They use these codes every day so they're familiar with them. They could also come in with the drug that they want to treat with. So those are all entry points into the formulary where they can look at that information. We provide the class medication and then get specific medications and the generic listing. We provide prescribing comments for the physicians and for the claims professionals. So it's additional information that they may want to be aware of when they're prescribing a particular drug. And then we link all of the information, the formulary, back to the full length guideline. So, I've said a couple of times that the formulary is based on the guidelines. The link takes them to where that original recommendation came from and allows them to read the recommendation in the context in which it was written. That also allows them to get directly back to the evidence. So by going to link into the guidelines, they're able to access all the studies that we looked at to support that particular recommendation. They can see the scores that the study was given, any conflicts of interest, a summary of that study, and then a link out to that study so that they could read the whole thing if they so chose. The formulary also includes a national cost data for a relative comparison. So when all things are equal, if we're looking for, you know, an NSAID, we do include that cost information so that, you know, if that's going to be a consideration, it's there to be considered. A good example of that would be with Celebrex. It's an NSAID, it's a very expensive NSAID, and it's appropriate if the individual that it's being prescribed for has a propensity for ulcers or has ulcers. If they don't, it may not be the best, they may not need that-- that really expensive NSAID. So that's the type of information that the formulary would provide. This slide shows all of the areas that our formulary currently contains. So traumatic brain injury, eye, asthma, we have a number of different musculoskeletal guidelines, so everything from chronic pain, neck, back, shoulder, elbow, hand, wrist and forearm, the hip and groin, knee, ankle, and foot. We

are just finalizing a guideline on post-traumatic stress disorder that will come out so that the guideline will also address that. Then we have a number of other mental health modules that come out after that. So again, the formulary will address those. This slide is intended to show the strengths of the formulary, so I won't go through all of this, but it's basically everything that I've talked about. And again, just the basis on those treatment guidelines as the first step. One of the questions that we were provided was talking about differences between the formularies. So I've already talked about one of them. Our formulary is tied to a specific condition, injuries or illnesses, as well as the phase of care. But then within those guidelines, and this site is hard to see, it is small, but this talks about differences among guidelines. They're not all the same. And this one looks at the CDC, it looks at ACOM, and it looks at ODG at different points in time. So guidelines are changing. And we first published our opioid guideline in 2014. So we came out with our guideline before the CDC ever came out with their guidelines. And they actually used copies of our chronic pain guideline and then prepublication versions of our opioid guideline when looking to create their guideline. So there are similarities between us and the CDC and there are differences there as well. And then same thing with ODG. We definitely have differences. And this is just we picked out a handful of items to look at here and call to the attention of this committee. The next thing we were asked about is--or one of the items that we were asked about was experience, if we had any data on the implementation of a formulary. So these slides actually come from the workers compensation fund in Utah. And they are actually going to-- Dr. Phillips is going to be publishing a paper on this. I think it's going to come out in the December issue of the Journal of Occupational and Environmental Medicine. But this is a little bit about their experience. So they actually teamed up with Mitchell International and developed RightRX which is a first-fill opioid review protocol that was based on the ACOM opioid guideline. And prescriptions were reviewed for appropriate indication, duration of therapy, and the daily dosage. So this is where that maximum equivalent morphine-- I'm sorry, the maximum morphine equivalent becomes important. That was something that they were looking at in this study. So what they saw was that their first-fill opiate prescriptions

were reviewed in the first seven months. So that was 365, and 38 percent of those were partially certified. That means that there was a reduction to the dose or duration of the prescription. Twenty-four percent of the prescriptions that were written were denied, and 37 percent were certified as written. And this next slide shows that it's comparing 2016 to their results the first seven months in 2017 and they had 11 percent reduction of claims with an opiate fill. They had 12 percent reduction in average opioid fills per claimant. And a 30 percent overall reduction in dispensing of an opioid. So these are pretty impressive results for the first seven months of their experience. ACOM formulary adoptions, so I mentioned that our formulary was released in November of 2015. The adoption process can, and Brian can both speak to this, is really long and really involved. So to date, we've been involved with California, New York, and Utah. So California adopted the ACOM treatment guidelines. They've actually had our guidelines in place since 2004 with other guidelines. And then a complete adoption of the current guidelines occurred in 2017. They adopted our formulary and that was effective in January of this year. So we worked very closely with them in taking a look at what we've done with our formulary and then created a version that they-- that's called the MTUS Drug List that they have in play today. New York has also done the same thing, adopted guidelines, all of this is-- is in their public comment period. So they do have a version of our formulary that's out for public comment right now. It's actually the second. They have to go out for two public comment periods. So it's out right now for the second public comment period. And then the work comp fund in Utah has adopted the opioid, specifically the opioid guideline. And that is what I put together in the PowerPoint presentation. I'm happy to answer any other questions that you might have for me.

ALBRECHT: [01:11:09] Thank you, Ms. Shannon. Do we have any questions from the senators? None? Senator Lowe.

LOWE: [01:11:19] Thank you, Chairman. Ms. Shannon, what happens when a workmen' s comp

claim when somebody falls and they may have been-- had an infection which may have caused the fall, so there are multiple things going on. Does the drug formulary or the guidelines take that into consideration, kind of away from the doctor's hands?

LUCY SHANNON: [01:11:45] No. So the guidelines are intended to be a guideline. It's never intended to replace the expertise of the physician or tell them what they can't do. What it does is provide them the evidence for the best treatments that we have medical literature on and, you know, consensus expert opinion when we don't have medical literature to rely on. So it gives them a starting place. If they find that there is a treatment that they want to prescribe for their particular patient that perhaps isn't in the guidelines where maybe it's not recommended in the guidelines. If they have medical necessity for that particular patient to do that particular treatment, then guidelines can-- can be the first point where they can see here's-- here's all the literature that we looked at. We didn't find, you know, good efficacy for this particular treatment, but it shows them if you're going to do this, you know, perhaps this is the criteria that you should pay attention to; these are the studies that we looked at. So it gives them a place to start when they're trying to come up with that, the support for the medical necessity for the particular treatment that they're going to do.

LOWE: [01:13:03] Thank you.

ALBRECHT: [01:13:03] I have a question. When you talk about these quarterly updates, so if-- if this were in statute that we have this formulary, how does-- is that just these changes are out there for the doctors to look at? Or do we have to come back to the table and say we need to upgrade on a yearly basis any changes? Or how does that work?

LUCY SHANNON: [01:13:28] So that's going to depend on the, and Ken will speak to this, I'm sure, but the regulatory language that you put in place--

ALBRECHT: [01:13:36] Um-hum. So it's pretty broad, correct?

LUCY SHANNON: [01:13:37] It could be. If you say that this is where adopting the 2014 version or the 2018, whatever version of this guideline, and that's it, then-- then your formulary doesn't get updated or you have to come back to the table to update that formulary. Right? If you say perhaps we're going to-- we've adopted the most current version and all of the subsequent updates, you know, that's another way to go about this. So I think that the regulatory language is going to-- to really dictate that. I can tell you that in the state of California, as we update our formulary, we provide them all of those updates. They created language in their process that allows them to expedite the changes to their formulary. So, you know, they're-- they're able to very quickly review, adopt, and publish those changes. So we are quarterly, and they've-- obviously they're behind us, but they've adopted all of the changes that we've provided.

ALBRECHT: [01:14:48] Okay. Any other questions? Thank you for your presentation. I know you need to get going and if you do that's perfectly fine. We certainly won't be calling you back up. Thank you.

LUCY SHANNON: [01:14:58] Thank you.

ALBRECHT: [01:15:03] And up next, we'll be moving right along, we have speaker Ken Eichler.

KEN EICHLER: [01:15:11] Thank you, Madam Chairman.

ALBRECHT: [01:15:12] You betcha. Go ahead and take your time to get set up there.

KEN EICHLER: [01:15:46] Great. Senators, attendees, thank you for the privilege of being here today. Ken Eichler, Eikler, tomato, tomato. I'm Vice President of Government Affairs for MCG Health and I specifically work most commonly on ODG, which is one of our-- on ODG which is one of our product lines specific to workers' compensation and the disability lines. Real quickly, just for disclosure, I am not a lobbyist. I am an in-house vice president. MCG Health is the largest provider of guidelines in the country. We currently-- with the nine of the ten largest compares, more than 1,600 hospitals, and we currently, through our sister companies, impact over 200 million covered lives. We currently impact 60 to 70 percent of the total healthcare decisions in this country. MCG Health was formerly known as the Milliman Care Guidelines, which some of you may know it from Milliman Consulting. It spun off as a private company and then was purchased by the Hearst Corporation. The Hearst Corporation, some of you may remember from good ol' William Randolph Hearst, we're still a privately held corporation. We represent--we have approximately $60 billion, with a B, a year in revenue and over 20,000 employees domestically. So we are committed to the-- to the healthcare system. We have sister companies of Zynx, First Databank, Homecare Homebase, MedHOK, and Map of Medicine. FTB, some of you may-- some of you-- all of us actually incur on a regular basis, FTB publishes the drug fact sheets that are inserted with all pharmaceuticals. So we're common to the space and our mission is to guide the most important healthcare decisions by delivering vital information into the hands of everyone who touches a person's health journey. We actually have a video that we did, I'm not going to show it today, which really captures our mantra, and our mantra is patients not payments. Really makes a difference. We actually have real patients that test-- that give testimony for that. So workers' comp formularies and guidelines, and the reason I say both is the formularies are actually, both ACOM and ourselves, and Lucy and I know each other for what, 20-plus years now. President Reed is an old friend of mine. We both worked together for many years and we agree that the workers' comp guide-- formularies are merely an extrapolation from the treatment guidelines. It's not somebody just listing go through the list of drugs. It's going through the guidelines pulling out the actual drug references in the guidelines and

it's supported by the evidence. The CDC came out with some very strong statements. And we all believe that formularies and guidelines should do no harm while improving quality of care and outcomes. Very important to do no harm. What is one of the physician-- what's one of the first lines in the physician's oath? The Hippocratic Oath is do no harm. So we've got to carry that forward. So per the CDC, improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safe, effective treatment while reducing the number of people who misuse, abuse, or overdose from these powerful drugs. Now it gets further in to the fact that performing agencies, providers, medical professional organizations that evidence practices can improve our patient outcomes. One of the reasons I also bring this up is questions came up about where does the guidelines company come into play and where are you involved? We're uniquely positioned and we come in from the earliest stage. We come in at hearings like this. We work with the legislators. Lucy spoke about California. I was involved in California. I rode shotgun for the bill author on the formulary bill and helped them work it through. So we come in at the earliest phases. We work through the legislative process. We attend the hearings; we attend the meetings, we're available to stakeholders, we facilitate outreach. If guidelines or formulary are adopted by the state, and we often recommend that the legislators not pick product, but adopt concept or mandate the agency to pick product. That's very important and it just came up. You asked about who updates and does the state have to review? When you've begun with any vendor in any line whether it's workers' comp or not, you need a certain amount of latitude and longitude to move if you need to. If a company is sold. If a company goes out of business. If a company changes business practices. If something is baked into legislation, good luck trying to change that on a dime. We know it can take anywhere from what, one to five years, to get legislation change. In the meantime, you've straddled an agency with something that may not work at some point when it gets broken versus allowing the agency to make an educated decision as has been demonstrated in every state that has gone down this road, allows them the flexibility by regulation to modify and to change and to be responsive as they need to. If it's a matter of tweaking the regs on how something is done, they can tweak them. If

a vendor was to go belly up, and we know-- we've all seen this happen in other areas, both ReedGroup and myself. ReedGroup is owned by Guardian Life Insurance, so they're an insurance company, and we're owned by the Hearst Corporation, both large mega million or billion dollar corporations and we're fairly stable. But one never knows. So we have to give that flexibility to the agency such that by regular emergency reg they can change as things need to. And all the states have been very successful in the process. We'll get involved with the state, work with the agency in developing the regs, we'll facilitate communication between all stakeholders in the state and outside to learn what's best, what's in place, what's working, what's not working. We'll then work in the development of their protocols and we'll do the training. We'll do extensive outreach. From the three states that I'm working on this year we are in the trenches working with all the stakeholders, you name it and that's stakeholders being addressed. We cobrand training programs. So example, later, it's either this week or the next, Montana, which is due off on an audit, has a cobranded Webinar program such that we provide training on the navigation, but they provide training in the regs. Kentucky is doing similar programs where we want to educate, we want to be out there, and we want to be there for the follow through as well, be sure things are working. Guidelines-- guidelines supportive formularies empower medical providers. I'm just going to watch the time, if I go over, please keep an eye for me. It will allow to expedite case specific authorizations and medical reviews. It forces the concept of considering the picture within the picture within the picture. The specific drug versus the alternate drug options versus the alternatives to drugs. And what I'm talking about here is what is an opioid? What does a pain medication do? It addresses a symptom per se. But if we're just giving a medication, there's some medications that will cure the underlying cause, an antibiotic per se. But a pain medication just masks the symptoms. So what do we need to do? We need to look at the alternatives. So the picture, the small bull's eye, is that opioid. The bigger circle around it, and imagine concentric circles is what other alternative medications can also address the symptom of pain, but the underlying condition, such as an anti-inflammatory. And then you get to the different types-- steroid or nonsteroid. But what's the bigger

picture is what type of medical treatment that's hands on or other surgery, physical therapy, occupational therapy, whatever it be, is going to truly address the underlying condition. So we've got to look at the bigger scope and enable and empower the medical providers. We've also got to decrease the adversarial relationship between patients and physicians. And in the words of Nancy Reagan, allow the doc to just say no when they need to. And that's what we found from doctors across the-- across the country. Do I need to pause?

ALBRECHT: [01:23:40] Senator Matt Hansen has just entered the room. Hello, Matt.

KEN EICHLER: [01:23:44] Welcome. Doctors don't like to be in the hot seat.

ALBRECHT: [01:23:49] Senator Chambers?

KEN EICHLER: [01:23:49] Yes, sir.

CHAMBERS: [01:23:50] I've been listening, and I keep seeing and hearing the term evidence based. Now some people who are great and deep thinkers may look at a cathedral and see it as an architectural marvel. Common people may wonder how they got those huge stones where they are. Were they shaped after they got there or before they got there? What are the stones composed of? Are they artificial, put together by a mixture of various elements? Were they cut out of a core and things like that? That's kind of leading up to what I want to ask you.

KEN EICHLER: [01:24:37] Yes, sir.

CHAMBERS: [01:24:38] When the term--

KEN EICHLER: [01:24:39] I'm the guy who, by the way, when I walk into that cathedral, I want to know how the heck they got those big stones up there and how they balanced them to get to the peak.

CHAMBERS: [01:24:47] Ok. And why an arch is so strong as a weight-bearing structure and so forth.

KEN EICHLER: [01:24:55] Exactly.

CHAMBERS: [01:24:57] Of what does this evidence consist? The evidence consists of what that is continually mentioned when we hear the term evidence based? Of what does the evidence itself consist?

KEN EICHLER: [01:25:13] Great question. Lucy discussed methodology, but I'm not going to go that heavily into methodology. I can provide you with the documentation on the methodology. Evidence based medicine, there are two basic definitions. The traditional definition of evidence based medicine was from Dr. Sackett, and I forget-- do you know what year Sackett came out with that? Was in the ‘60s, ‘70s, ‘80s? Dr. Sackett came out with a definition where it has to be a peer reviewed study. It's got to be a published studied with clinical trials and then there are various other criteria to meet the evidence base. But there's got to be clinical trials, there's got to be studies, there are different types of evidence. Those studies then have to be peer reviewed and be published to meet the Sackett definition of evidence based medicine. So when you look at evidence based medicine, there's lots of evidence from different sources. There are peer reviewed studies that are in the journals. But one of the problem with only relying on peer reviewed studies, which are the highest level and ideally with a random control group as well, but think about it, if we did random control studies on parachutes, who's going to be the trial-- who's going be the random control? The

guys that jump-- or the gals that jump out of the plane and when they pull the cord and nothing happens? You've got to be careful. How many patients are going to be willing to go through random double blind studies for surgeries? Not that many. There was one study a couple of years ago that, for knees, that was interesting because what they did in order to get patients to participate, half the patients-- all the patients went under anesthesia for knee surgery-- for a procedure. I don't remember if it was for a minuscule tear or something along those lines. Everyone went under anesthesia. Everyone came out with a Band-Aid on their knee. Everyone came out with a mark on their knee as though there was an arthroscopic portal done. But only half the patients had the surgery. Why were willing patients-- why were patients willing to be part the study? Because they were told if they didn't improve post the study that if they were in the group that did not have the real surgery they could subsequently have the surgery. So it wasn't life threatening.

CHAMBERS: [01:27:16] OK. To make-- to prevent you from having to give more than what I'm asking, like Will Rogers, he claimed that all he knew was what he read in newspapers. I only read things about this, I never conducted a study, I'm not a scientist, but I did read that in many instances these studies will come up with results that cannot be reproduced or duplicated by others.

KEN EICHLER: [01:27:43] Exactly.

CHAMBERS: [01:27:44] Then studies are based on prior studies. There is an accumulation of these studies. There are extrapolations that occur, then conclusions are drawn and presented. But if the original is shaky, then everything based upon it will be shaky. And that cathedral that you and I marvel at,--

KEN EICHLER: [01:28:04] Collapses.

CHAMBERS: [01:28:04] --might come crashing down.

KEN EICHLER: [01:28:05] It's the old--

CHAMBERS: [01:28:06] Here's what I'm trying to get at. We are legislators. We rely on what people who are supposed to be knowledgeable will tell us. When we put a program in place, however, or in the statute it's going to impact people. And from what I know, I've been a worker. I know workers. They are always at a disadvantage. The employer has the advantage. The doctors, the hospitals, those who work with the employer are interested in profit. I don't care what they say. If they were not making money they wouldn't do what they do. So then we have the worker. If we as the Legislature will create what amounts to a straitjacket, even though it has the sound of what I'm hearing, I want to be sure--

KEN EICHLER: [01:29:01] I can answer that for you.

CHAMBERS: [01:29:02] --that we are not putting another layer of difficulty on the workers. Now how can those of us who are not experts trust what we're hearing? It sounds good to me.

KEN EICHLER: [01:29:14] Let me give you confidence in that. Why can you trust it? Because you've got folks like Lucy who runs her editorial team. You've got folks on my side and my company that run our editorial team. The editorial teams, and we can give you the doc-- both of us can give you documentation on this on who the full editorial teams are. They go through the studies. They rank the studies based upon the quality. It's the old saying; as you said, if it's garbage studies and you build on garbage, you're going to get further garbage. So you've got to be able to transparently rank the studies, you've got to be able to provide the links to the studies, and provide the rankings of the studies. Out-- my company's particular philosophy is, especially in the world of

the Internet, people will find anything and everything out there. It's not that difficult to find information. So our feeling is we want to identify whatever information we feel is relevant. And if it's a poor quality study, we may include it, but we're going to clearly rank it as a poor ranked study so exactly what you said doesn't happen, so that somebody doesn't claim that a poorly ranked studies should have it carry a higher ranking, but we want to provide that. In the guidelines products, in both ReedGroup's and my product, there are links directly from the formulary into the guidelines recommendations which link directly to the studies. I also mentioned there's one other type of evidence based study and that's data driven. The problem nowadays with getting peer reviewed studies, peer reviewed studies are tough to get because somebody's got to fund them. I used to be on the board of one of the largest, right now the largest private employer in New York State which is Northwell Health System. It used to be North Shore Hospital Long Island Jewish. They are now the largest private employer and largest healthcare system. My dad was the treasurer of the research foundation there. And I learned a lesson, and my dad made sure we learned lessons from it, which was, yes, our goal is to benefit the general population in research, but any research out there there's got to be some sort of self-motivation, whether it's a highly financed research institute. Well, where is it self-serving there? Because they want to get the best researchers, to get the best published studies, to get the best press, to get the best benefactors, to get the best donors to further fund the hospital system to keep the cycle going.

CHAMBERS: [01:31:27] OK.

KEN EICHLER: [01:31:28] But you've got to be transparent.

CHAMBERS: [01:31:29] Let me ask you this. Opioids have been prescribed for decades, maybe generations. Were there studies that led to the use of these opioids? The prescribing of these opioids? The approval of these opioids across the medical profession? And it became question only

when the problems developed and people suffer as a result of receiving prescribed medication from reputable doctors, filled by reputable pharmaceuticals-- pharmacy-- pharmacists. How do we know that all of this is not driven by profit motive rather than the other? See, I'm boggled. My mind is, which is not as deep as the minds of the people in this room, with how this opioid epidemic could occur when all of the medical professionals, the scientists, the hospitals, the pharmacies were in agreement, which now I would say collusion, and the victims were and are the public. How did all that happen?

KEN EICHLER: [01:32:52] I agree with you that there was a problem. I can't go back and correct. What I can tell you is neither of our companies were addressing the issue then. We are providing solutions. With any type of scenario, let's talk about architectural standards for a minute. What one believes the studies proved to be good architectural standards may be proven to be faulty at some point. Then we've got to fix it. So what this is potentially is a Band-Aid. What I can tell you is these studies that came out that pushed opioids came out of a couple-- at a big pharma, came out of a couple of companies and pushed the propaganda out there. And the federal government went right along with it. That's what the evidence at the time showed. We're working off current evidence. Current evidence does not show that. And what's being reflected here is the current evidence rather than that bad evidence. Can I promise you everything is 100 percent? Who knows what somebody may find down the road. Can I tell you we're giving 100 percent of our effort to do the right thing, to get the objective studies to protect injured workers? Yes, that I can promise you. Can we give you information to show you that that has worked in other jurisdictions? Yes, we can provide you with that. But do I have a crystal ball? None of us could with any confidence say what's going to happen 10, 20, 30, 50 years down the road. But what I can tell you, this is working and it's not hurting individuals, it's benefitting them.

CHAMBERS: [01:34:13] OK, and I'll let you go now, because I don't want to tie up your time.

KEN EICHLER: [01:34:14] I appreciate it. But I'll get you more information if you'd like on that.

CHAMBERS: [01:34:18] Ok.

KEN EICHLER: [01:34:18] So, we talked about the just say no. If anyone's ever-- what physicians tell us is when you go in with a patient who is on existing medications, if it's time to say no or they're on a dangerous dose, and in corporate practice you get what, 10 to 15 minutes, if you're lucky with your doctor, that becomes a half hour to 45 minute conversation that gets escalated. And doctors will often, just to avoid, they'll say yes. But having the formulary and having that printed list on their desk enables them to convert it to the same way they would in group health which is the conversations: look, we've got two options. Here's a preferred drug, here's a nonpreferred drug. I think the preferred drugs is going to work for you. If we really want to go for the nonpreferred we can, but we're going to have to go to the authorization process. Why don't we try the preferred drug first? It eases it. And it also doesn't have a negative psychosocial impact on the patient. Every time there's negative psychosocial impact, the claim goes downhill. There's going to be increased disability duration. There's going to be a lack of motivation. There's going to be increased anger. There's going to be increased litigation. And there are going to be increased costs. And who's the only one that loses in all that? The injured worker. The scope of the ODG formulary, we worked off the FDA Orange Book, FDA approved drugs with therapeutic equivalents. What we also do is we work off statistics. We get feeds, we work directly with the PBMs, the insurance carriers, the research institutes, and the lot, so that we collect all the data. So any drug that is commonly used in workers' comp, and we work off it being statistically significant, meaning if it's greater than one or two percent of the cases have that drug prescribed, we put it into the formulary. I'm going to show you the formulary in a second, because I'm willing to bet nobody around-- very few people in this round table have even looked at the formulary list. Until you get the visual, it's not going to come

together. So that all this currently has close to 350 drugs, which converts to over 45,000 NDC codes. That's the different manufacturers, different strengths, and different doses. So when somebody asks, can an agency do this on their own? Good luck making it workable, because it's one thing to create the drug list, it's another thing to create the coding that is used by the industry and that starts at the point of fill where a pharmacy has to commute with-- communicate with the PBM who has to look at the database of the 46,000 drugs, who has to communicate with a carrier. So the key is to get something that's in place that works that has all the systems associated with it. We have two classifications: preferred drugs and nonpreferred drugs. Unfortunately, before my tenure, they came up with the term "Y and N" drugs; and that was in Texas. I've been begging and pleading, but as a regulatory affairs guy realized we cannot eliminate "Y and N" because it's based into statutes and into regs. And again, I encourage you to enable the agency to make a decision and to write the regs. So we now call them preferred Y drugs and nonpreferred N drugs. The N, or the nonpreferred drugs, simply require preauth. It is not a no; not a no in any way, it means need substantiation, needs authorization, and it's real simple. We go out and we train the docs. Unfortunately what happens is often docs, like anyone else, learn from their behavior modification. When you do something and it works, we learn, we've been rewarded. When we learn something and it increases hassle, little bit of a sting there. But we've got to remember, people talk about cost savings and insurance companies and the whole bit, we've got to talk about cost savings to the doctors as well. Doctors' fees are low and they're mandated to do more and more. Every time there's a dispute, it's costing on both sides of the equation. The doctors' mid-level staff that's going to handle this is making between $35 and $50 an hour when you add on fringe benefits and everything. The insurance adjusters is probably making about the same. So we're talking about a hundred bucks an hour to deal with disputes, but it's hurting the doctor. By eliminating a lot of the disputes, it saves money and makes it more efficient for everyone. Compounds--- we address specifically. As of December 31 or January 1 of this coming year, all compounds will be classified N drugs. And all the states have been notified. And that's an example of proactive updates. Why? Most of the states

had all compounds requiring preauthorization, but along came Indiana this year. And Indiana, unfortunately the state regulator did not develop regs, she worked straight off the statute, and her interpretation was that any compound that included a Y drug and not an N drug did not require prior authorization. Kind of approached, Commissioner, you know, there's a problem here and the stakeholders approached us and approached her and said there's a problem here the way you're writing it, compounds are going to go through. And remember, a compound is when you take A plus B, or A plus B plus C plus D and combine it into one. It's no longer A or B, it's a new conglomerate of medications and drugs and compounds that are interacting. So there's no FDA approval on that. So we went back to all the states and to the PBMs and all the payers and medical providers across the country and said we want to make all compounds and drugs. Is there an objection? And we did not get a single objection anywhere along the line. So we were proactively responsive, following the evidence, but also following the needs. The same way I think it is-- is it DSUVIA? A severe opioids that's out. DSUVIA hit the market. Within two to three weeks, we had an update to the guidelines and to the formulary having it as an N drug. DSUVIA is a sublingual, goes under the tongue. It's a hundred times or more powerful than the current opioids. If you gave a current opioid at that level, somebody would go into respiratory distress. There is a specific need for this medication. The medication is geared for surgery. It's geared for battlefield, and it's geared for serious accidents. So if somebody is in the battlefield or somebody is pinned in a car and they're in severe pain, you want to bring down that pain level as quickly as possible. This sublingual has a place, but it doesn't have a place in the retail pharmacies. So we proactively addressed it. We did-- we break the formulary out by class-- generic brand and NDC codes, and we also provide the morphine equivalents. There was one slight error in the morphine equivalent slide that Lucy shared with us. We start the flags at 50 morphine equivalents not a hundred. A hundred is the maximum flesh point, but they start at 50 and we can show you that. Proven benefits with workers' comp drug formularies, the preferred drug list, which does not require authorization, does not impact or preclude prescribing, dispensing of medically indicated medications, not listed on preferred drug list

with substantiation of needs. So if it's not a preferred drug, all the doc has to do is provide substantiation. And what we're finding, and Brian, you can probably address this as well, over 90-- is it 95 or 97 percent of the denials for requests for authorization are based upon failure to substantiate. It's based upon the doctors taking what I call the lazy parents approach. What do we say when we don't want to explain something to a child? Because I said so. When the doctor doesn't provide the information, that's when it doesn't--it doesn't get authorized. Using the formulary and using the training we do with the stakeholders, once the state regs are developed, we develop that workflow. We develop the communication. We go into the doctors' offices. We train them. Not only do we train the docs, but the most important person to train in the medical practice; and we learned this lesson when I did the roll out in Louisiana when I still with ReedGroup, was get to the practice manager; get to the CFO. They are the ones who integrate the workflow, so they are the ones that can make sure this works properly. Proven benefits-- documented positive life altering results in multiple states with improved outcomes, improve function, and improve return to work. In Indiana, labor came to the table and supported the drug formulary. Labor clearly said that Indiana is a state where there is work available and they need workers and the union brothers and sisters are not going back to work because they're on drugs that preclude them from going back to work when there are lesser drugs that they can't survive they can't fill their refrigerators when they're used to making six figures in union positions and they're making workers' comp payments because they're not permitted to go back to work because their doctor put them on restrictive drugs, that hurt. So labor supported it and got people back to function. We have documented decreasing use of-- use and abuse of opioids and other high risk medications. Folks are talking predominant about opioids here. Opioids are only a small piece. What about the muscle relaxants, the benzos, and all the other options that really need to be looked at, especially if we're going to wean down from opioids. When one taketh, one has to give. There's a balance there. Formulary is already integrated, at least ours, into almost all the PBMs: industry systems, processes, and procedures thereby minimizing and implementing efforts and costs, so therefore it's just flicking of the switch and turning it on for yet

another state. Whether or not folks want to accept the fact or not, you currently have formularies being used in the state. So your decision is not whether or not there should be formularies, it's whether or not you want to leave the curtain pulled and let it happen behind the scenes, because trust me, Susie the adjuster who's one year out of school is not making medical decisions without consulting something and then using existing formularies that are not standardized, so that every carrier and every PBM has their own. Many are using ours as well as their own, but they're putting customer edits on top of it. So you have a chance now to standardize and making sure everybody's getting equal access across the board rather than being done behind the curtain. Guidelines are also used. Think about it, things are going up to utilization review. You don't want them using-- some of us are old enough to remember this, you don't want them making decisions by the Carnac method where you hold up the folder to your head and guess. You want them to use the evidence; you want them to have the information to make it, and this is a tool to empower that. There's no cost to the state for posting of complementary stakeholder use formulary drug lists. We give the drug formulary away for free to the state and to the stakeholders. We allow it to be posted on the state Web site at no charge. If somebody wants full access to the guidelines, then they subscribe. But the formulary list is provided free, it's updated monthly, with notices of substantial changes going out whenever possible, 45 days prior, for external to review to all the jurisdictions so that they can give comment on it. We can look at the practical sides of the implementation and so that there's proper notice time. Measurable outcomes to document program results and benchmark adherence: it's important to have those. I will help provide them. Just to give you an example of what a formulary list is, and all I did is I went to the first--to our formulary page and sorted it by drug class. And I couldn't give you the whole list of 350-something on a slide, I could do it live. But you will, see as I-- as I sorted it, came up by drug class, A for anti-epilepsy. So it's sorted by drug class, generic names, the innovator brand, which is your first out of the market, [INAUDIBLE]. Here's an example where you'll see, Gabapentin is a preferred drug, but Gabapentin ER, extended release, is a nonpreferred drug, which just means that for the extended release you require preauth. The only

reason cost is here, and by way, on the state version that they post free, there's no cost in the column. The reason cost is there is not for decision making purposes, but for reserving purposes. Has anyone ever touched an insurance file here or handled claims? If not, reserves have to be set as the claim progresses, so they need to know what the average costs are so they can reserve this-- set the reserves accordingly, because monies have to be put aside to cover costs of treatment and medications, hence they need the reserving tools. And as you see here, there's also the morphine equivalent calculator formulary [INAUDIBLE]. But this is just a little excerpt of it. We'll be happy to provide this. And what we teach docs to do is sort the drugs by drug class, print this out and have it on your desk, because what's North [INAUDIBLE] going to do? They're basically prescribing a three classes, and pain medications, anti-inflammatories, and muscle relaxers. And you ask any doc within those three classifications they have three to five drugs that they prescribe most of the time. And in the group health system, Medicare, Medicaid, they know which of those drugs they don't require a preauth on. So we're giving alternatives. So if an extended release opioid is an N drug, there are going to be alternatives that are preferred drugs that are short acting. And as far as the limits on how long they can be prescribed, we find that's generally controlled by state or federal law. You have prescribing laws that control what a doctor can write, at least most states do. How many, how many days supplies, etcetera. So this is an easy to use tool. This is the-- an example, I printed out just a smattering of opioids that are preferred drugs. So docs do have the tool, you can't say no to all opioids. You've got to give them the option. And somebody questioned before about what happens in hospitals. Hospitals are generally considered urgent emergent and urgent emergent care is carved out generally from utilization review, treatment guidelines, and drug formulas. It's just not practical. But here's an example, we'll provide you access to the formulary if you'd like, but just an example, and as you can see, we're clearly blind cost. Some of these drugs are mighty expensive because it's about what's going to work for the injured worker. And the ReedGroup guidelines are the same. They are blind to cost on this. The only thing is basically if a generic is available, you go with the generic. However, there are certain times somebody can't take a generic:

food allergies, colorings, additives. Example, people who are kosher, people who are vegetarian, people who are vegan, people who are allow-- I'm a vegetarian, I can't take capsules unless they're veggie caps because they're made from gelatin. So you've got to give different options to be able to address that and be flexible. Just another example of why drugs for NSAIDs, nonsteroidal anti-inflammatories, so that the docs basically develop their tool kit. And imagine if a doctor prints out these for each class and has it on the desk and shares it with a patient, it totally changes the interaction, and the same can be done with Reed's product. State adoptions in the US, this is specific to ODG. Arizona did something which was interesting. I heard there was conversation about possibly just going opioids. If you do something, I encourage you please, please, please don't do that, you won't be serving the injured workers well, because just addressing opioids is not addressing the bigger picture of the alternatives. So what Arizona did, after two years of studying the issue, or two plus years, is they initially adopted formulary and guidelines for the treatment of pain and chronic pain, which is different than just opioids, and you can do that and do a carve out that way. California uses predominately ACOEM at this point, ReedGroup, but we are the default guideline, as well as ACOEM to challenge or to-- to go against what is the adopted guideline. It's called the strength of evidence where you're allowed to use other evidence to overcome or document why you want to use something different. Indiana just went with formulary only; they're in the process; they go effective January 1. Kansas uses guidelines and they [INAUDIBLE] formularies goes into theirs as well. Kentucky, we're in the process of finishing up the regs and they're once or twice a month working with the team on the regs; as Brian is and some of the other folks nationally. Montana is in final stage of the reg development on formulary. New Mexico is guidelines and formulary. North Dakota is just guidelines. Ohio is guidelines because they are a monopolistic state. They have an entire team and department that cost a multiple six figures a year just to maintain what they have on their formulary. Tennessee didn't have such a rocky road. They had some bumps in trying to reach some of the docs in the rural areas, as did other- -other areas. But Tennessee went with guidelines and formulary. Texas went with guidelines and formulary. Lucy

mentioned the ACOM states as well. The reason you hear us all quote Texas, they're the only state that pulls heavy data; heavy, heavy data. I will talk about some of the [INAUDIBLE]. Numerous states are looking at consideration next year, and we are formulating guidelines. The most actively used we'll use in just about every state where we're not-- except those where we're not permitted and there are none of those. Improving communications-- that's what the goal of formulating guidelines are. We want to engage and empower the employee, the employer, the medical provider, the carrier, TPA, and the PBM. We want to stress hitting common goals of expediting improved outcomes and decreased transactional processes and costs for all. Make it quick, make it easy, get the injured worker what they want. Expedite approvals-- with or without you are. Streamlining: I'd differ-- I'd encourage you to speak to the agency; see how long it takes for UR now. Take a look at how-- UR's utilization review, see how long it takes for utilization review where a formulary is in place and the process is in there. In Kentucky, we were discussing this week, just yesterday as matter of fact, working on the regs, if a drug is denied-- when a drug is submitted for approval, the payer for those drugs it will need preauthorization has two to three days to turn it around. And it's done. And that's common. Three-- it's-- what's the product? Seventy-two hours is the max we're seeing in most states right now?

_____: [01:52:16] Seventy-two hours, three business days.

KEN EICHLER: [01:52:18] Seventy-two hours. Three business days turnaround in approval. And if it goes to expedited, if it's denied on a-- on the utilization review and it goes to a higher level, that's turned around in a matter of days versus I'll bet you right now those are getting clogged up in the system and takes weeks or months where the injured workers' life is being impacted rather than being a productive member of their family, their employer family, and their-- and their society. Documentation of substantiation of medical necessity. We give the roadmap so everybody knows it's an open hand of cards. We'll sit down with the docs and the payers on a noncase specific basis

and get the communication going. It's good for everybody. Get it right the first time. Peer review discussions, facilitating that, engaging the service providers, including physical therapists in the peer review, and engage in mid-level medical providers and utilization review. It's important to remember the different between group health and workers' comp. In group health, bottom line, you get what you pay for. You buy the policy; if it's got a good formulary, great. If it's got a garbage formulary or limited, it's like buying, you know, a very basic Hyundai versus buying a Rolls Royce. You can buy full range in group health and you get what you pay for. In workers' comp that's not the case. Workers' comp, the injured worker is entitled to any treatment, which includes drugs, that can be medically substantiated, causally related. That's why the formularies are so different and that's why we need to have something that works along these systems. Evidence based medicine, we spoke about studies versus data versus tandem. I know in our database we have several million cases and we're able to pull up a diagnosis and show you the most common treatments associated with it and give you the outcome scores on it as well. It's really interesting. And the guidelines for a formulary must serve the dual mandate of safeguarding expedite access to care and limited excess and appropriate. Why guideline supported formulary? Lucy really hit well on this. You need the guidelines behind it. I'll be able to give you this PowerPoint. I'll forward it ahead and be able to share this as well. But a lot of it has been already addressed. One of the important things, people talk about dollars, this can impact patients in a positive way with improved reserve setting cost containment in MSAs. Medicare set asides are done on cases. Are folks familiar with Medicare set asides? When a case in workers' comp is about to be closed and there's potential future medical, Medicare does not want to get hit with that when the person runs through their money after buying a boat, a car, and whatever else they do. So Medicare requires that any type of accident, potentially Medicare set aside is to be done. In workers' comp, they're looking at every medication that's been prescribed for the last two years and you have to set aside money for that medication for the lifetime of the claim. That money comes off the settlement. Claimant, doesn't get that money in their pocket, it's put it in a trust account. When you have drugs that interact with each other negatively, unless

you get the doc to agree to the proper medication regime, and using a formulary does that, patients lose money when the set asides are done because instead of the three medications, the five medication, there may be 20 or 30 medications that are set aside for their lifetime. And trust me, those are six figure-- five and six figure numbers. It's huge amounts. And there are combinations of drugs that if taken will kill you. I was on a call with the associate medical director for CMS and that was the exact discussion is if you force us to set aside, it gives the message that these drugs are OK. Are U.S. CMS going to take responsibility for the deaths? We're a little out there. The flows-- syou'll be able to look at this, how it benefits everyone. We talked about the "because I said so" approach. Most requests are reasonable and appropriate. We're just controlling a small percentage of cases. Don't let that small percentage throw you, because if we applied that to laws in our state, the criminals would run the country. So we have to have processes to control the outliers and it's our responsibility as members of society, as I was well schooled by an attorney after a really bad day. Most inappropriate and unnecessary care is requested by a small percentage, I mentioned it. UR requests due to lack of documentation. And most UR denials are upheld. If you're going to put anything in, I would encourage you, one of the good things that Indiana put in their statute is a utilization review must be done by an URAC-accredited company. And the gentleman who does government affairs for URAC, U-R-A-C, will be more than willing to come into you from Washington. Aaron does a brilliant job of presenting and telling you why that benefits injured workers. [INAUDIBLE] care and meds all impact function and outcomes. The basic. Suboptimal outcomes, negative psychosocial and behavioral responses, prolong functional impairment, activities of daily living work activities, want to get people back to those things, to be part of their families, decreased motivation, becoming the patient, becoming the diagnosis, not good for somebody. Focus on functional restoration while considering treatment options, we pretty much discussed this. I borrowed this from my buddies over at Sedgwick. Sedgwick is the largest TPA in the country or internationally. Now, they were just acquired. I forgot what the numbers were. But I encourage you to take a look at this. This is the flow chart for what happens when a prescription

comes in. Sedgwick is a TPA but not a PBM. They use external PBMs and they'll work with you folks as well as others. And it talks about what happens when a workplace injury happens, you've got the initial doctor visits, they write a script. What happens with that script? It goes for coverage information. The pharmacy, this isn't the point of the pharmacy, the pharmacy is going to check coverage information. Pharmacists don't fill prescriptions out of the goodness of their heart. They fill them because they're selling them and they're going to do anything and everything they can to get that paid. So they will file a PBM [INAUDIBLE] process they request for authorization. If they can't find a PBM, they will find an outsource company such as StroneRiver or one of the others which will pick up the prescription guaranteed and paid. However, if there's no coverage information, it stops, or if there's no coverage, prescription doesn't get filled. If once it's provided, if they get a yes, it's coverage and they know who's paying, it goes to the next level. Is it on the formula? They're going to check the formulary drug list. If it's a preferred drug, it skips this whole part, which is their review system, and it goes right to "yes", the prescription is processed and the injured worker is done. If however it's a nonpreferred drug and the doctor did not substantiated it, or did substantiate it, it's going to go for review to see if it was substantiated. If it's not substantiated-- if it is substantiated, it goes to "yes" and goes right out. If it's not substantiated, it goes back in, the prescription gets declined. A message goes to the treating physician and a message goes to the carrier immediately. So it gives you an idea of how the flow incurred happens and why the PBM is so important and how the drug formulary, believe it or not, this process can take milliseconds, literally. Once the doc-- once the p-- once the pharmacy enters it into their system, it instantaneously pulls from the database and communicates with the PBM and the result can be literally less than a second. So it can happen quickly. Studies-- oops.

ALBRECHT: [01:59:45] Are you getting close to wrapping it up?

KEN EICHLER: [01:59:46] I am.

ALBRECHT: [01:59:46] It's been about 30 minutes.

KEN EICHLER: [01:59:48] Yes. For some reason I lost the screen here-- from current source. Let me try this. I guess you guys had a message to the screen there. I'll tell you really quick. This was just some studies-- for some reason-- we'll see if this-- you know, we've got different studies from the Journal of Occupational Environmental Medicine. We've got the article abstracts for you. There was a study done at Johns Hopkins which also shows the improved outcomes that claims duration was 13 percent longer and 37.9 percent higher when a drug formulary [INAUDIBLE] guidelines were not applied. And this was done by Johns Hopkins independently. We don't fund any studies. Workers Comp Research Institute, I encourage you to be in touch with them. I've called them already. I know you're not a comp scope state, so you're not in all their studies, but they are interested to help provide you information, as well as I'd encourage you to speak with NCCI. I believe this is an NCCI state which does data collection and rate setting. NCCI already has the information built into their database, so they can do an analysis on the impact in the state as they currently do it for other states. I also have the NCCI map, which you can't see here unfortunately, which shows you the state adoptions. Texas, I wish you could see, Texas is the only one that collects data really well and they do studies. The last study that was released was in 2016. I've seen a draft of the 2018 updates on the formulary impact, but I'm not allowed to share it yet. I respect confidentiality. But I'll give you some of the highlights, and again from PowerPoint you'll be able to get right to the study. I will put you in touch with the regulators and the legislators if you'd like. But medical provider-- Texas by the way is an opt in state not an opt out state meaning workers' comp is not required in the state of Texas. You have the option of opting into workers' comp or you can opt out. And with the formulary with certain other reforms here's what they found-- medical provider participation and treatment of workers' compensation is at a record high in the state of Texas. Doctors find the system easier to use and more effective. Nonpreferred drugs fell 85 percent. That's

really important. With engagement support of the medical community and all stakeholders, the number of nonpreferred prescription fell by 85 percent improving prescribing of unnecessary high-end medications. No nonpreferred drugs were in the top 10 most prescribed drugs in Texas. This is an astounding number. The number of claims receiving nonpreferred opioids with greater than 90 morphine equivalents, which is the danger zone really, according to CDC, dropped from almost 15,000 patients in 2009 preformulary to less than 500 patients receiving. That's a 97 percent decrease in the use of the serious dangerous opioids. And I convert those numbers to how many lives, 15-- that's 14,500 lives that were positively impacted. Twenty-seven percent total pharmacy costs drop. The numbers don't get thrown by cost savings. Convert that more to how many lives, how many prescriptions; don't look at cost because there's not-- there's a cost savings audit, but there are other costs associated. This-- you can't see it now, I just did a screenshot of the state formulary which we provide free. And then I have the hands-up questions slide is the last one.

ALBRECHT: [02:03:19] Good. Very good.

KEN EICHLER: [02:03:21] I'm sorry if I went a little over. The questions from Senator Chambers kind of threw things up.

ALBRECHT: [02:03:24] No, you did good.

KEN EICHLER: [02:03:24] So here's the hands-up question-- some questions.

ALBRECHT: [02:03:26] Gotcha. So do we have any questions for Mr. Eichler? Yes. Senator Crawford.

CRAWFORD: [02:03:34] Thank you.

KEN EICHLER: [02:03:36] Senator Crawford.

CRAWFORD: [02:03:36] Thank you, Chairwoman. So can you just clarify for us the-- you said some states passed a formulary and some have passed guidelines. So can you just-- we have seen the example of formulary. Can you just give an example of a state that has the guidelines and what that looks like that's different.

KEN EICHLER: [02:03:56] When they adopt the guidelines versus-- what's interesting is most of the states adopt the formulary initially, then adopt the guidelines afterwards because they're going to be used anyway since it's behind the scenes. But Indiana just adopted formulary. They didn't feel they could get guidelines passed. And like yourselves, they wanted to address the drug issue so they felt the guideline-- the formulary was the way to address the drug issue. Montana has a melded guideline. Lucy and I had worked together on that back when I was a Reed, and what they did is they took almost nine- or ten-year-old Reed guidelines-- income guidelines rather, and supplemented that with pieces of the Colorado guideline and created the new Montana guideline. That's seriously outdated because they don't have the ability to update it on their own. So they went with formulary only now and they're folding in other sections of guidelines as well. Kentucky just had a mandate to do guidelines and formulary for HB2 from last session. They were mandated to do the formulary effective 2019 and the guidelines effective 2020. That was backwards. But the legislators wanted something urgently on the drug front. So why did they do one versus another? It's a matter of what they think they can get passed. The only states that only went with formulary is ones that didn't want to go through the battle that they may on treatment guidelines and wanted something in place quicker. So when you adopt just formulary because the guidelines it's an extrapolation, you're getting a soft guideline behind it so it's not just somebody said, oh let's put this drug on the list. I'm sorry I can't be--

CRAWFORD: [02:05:39] That's fine.

KEN EICHLER: [02:05:40] --can't answer more specifically answer.

ALBRECHT: [02:05:42] So in a follow-up to Senator Crawford's question, what-- what negative consequences are there for the patient if there's just the formulary and not guidelines for the doctors to follow or the healthcare professionals?

KEN EICHLER: [02:05:58] I don't say that there's a negative consequence, because at least you're taking a step to address part of the problems. I think where the patient loses out is on that extra push for the doc to give the best possible medicine. When I say medicine, the best possible treatments according to current studies. Unfortunately there are several docs out there, and we see it especially in states like Nebraska where you have a lot of rural docs that may not be attached to a university type setting that are practicing more old school medicine than current practices. You've got docs in states that have a lot of rural populations with docs that are retiring at much older ages, that are treating every member of the family from cradle to grave. So those docs take a softer approach per se. It's, sure, what you want? Yeah, here darling, let me write that out for you. You don't want to go back to work? Here, you can stay out another two weeks. You don't want to go to school today? Here's that kind of thing. It's a different embodiment so that the patient won't be hurt by just going with formulary, but they will be greater benefitted if you were to do guidelines as well. The reason some just go with formulary is you're going to get more pushback along the way with guidelines. We've seen guidelines tried in the state. And going with formulary first gives you a chance to dip your toe into the water, get a feel for it, see that it works, and then it's easier to go full blown. The compromise is the Arizona scenario. They went with guidelines and formulary for the treatment of chronic pain and pain. So it was only for pain, but this way when a utilization review was done and

it was addressing opioids or tapering, they could also address the physical medicine, the physical therapy, the other thing, cognitive behavioral therapy, and encompass it. But if you can't get that past that, formulary is better than nothing. It's a first step.

CRAWFORD: [02:07:50] So, just to clarify, excuse me.

ALBRECHT: [02:07:51] Go ahead, Senator Crawford.

CRAWFORD: [02:07:53] Thank you. Thank you, Chairwoman Albrecht. So just to clarify, so the formulary is just the list of drugs. The guideline might include-- you should-- this is a case where you should use physical therapy first.

KEN EICHLER: [02:08:05] Not should. What you're describing is what-- and I use the household terms, because I have had to inherit that; people call that laundry list medicine-- call that cookbook medicine.

CRAWFORD: [02:08:15] OK.

KEN EICHLER: [02:08:16] Where it's you do this, you do this, you do this, you do this. That's cookbook. Doctors don't like to be told what to do in what order. I prefer to refer to guidelines as laundry list medicine. Because what it does is it gives you a list of all the possible treatments, the doctor searches for the treatment, simply copies the recommendations on it, and then the recommendations and the guidelines it will tell them what they need to substantiate if it's not recommended treatment or if they're gone beyond the recommended period of time. So the doc picks the treatment. Treatment should be decided between the doctor and the patient, not by a guidelines company. We should just give them the references to support it. Are any of you attorneys

perchance? OK, so we've got two attorneys in the room. Imagine guidelines companies to be the LexisNexis or the Westlaw of medicine. LexisNexis and Westlaw are search tools to get to the case law. We are search tools to get to the evidence. But what we do, both us and Reed, is we take the evidence, we distill it, we rank the evidence, we transparently rank it so that you can see the ranking, and we then translate it into terms that work for worker's compensation so the people understand it, but be able to also cite the evidence and include the articles.

ALBRECHT: [02:09:31] I have another question. In your line of work, you obviously work with a lot of the states. Right?

KEN EICHLER: [02:09:35] I am privileged to do so.

ALBRECHT: [02:09:36] To do so. But is there anything at a federal level? I guess that's what I've been kind of watching for is that is there going to be something, a blanket over the whole country over these opioids?

KEN EICHLER: [02:09:47] You asked the right guy because I'm on the federal task force.

ALBRECHT: [02:09:50] OK. So what's happening at that level?

KEN EICHLER: [02:09:52] There was a push a couple of years ago by the feds by the Department of Labor and others to try and federalize or explore federalizing the workers' comp system. There was extreme, extreme pushback from the jurisdictions. Everybody believed their state was different and their patients were different. I personally have mixed feelings about that. But the feds have backed off. The feds are not pushing federalization of the programs. What the feds are doing right now through ODEP, O-D-E-P, which is part of the Department of Labor. They have a program

called The Seed, S-e-e-d, initiative where this-- the federal government is developing toolkits for potential use and tweaking by the states on the state level. They've also given-- are giving out over $100 million in grants right now, on the retained grants to further return to work programs partially using guidelines and formularies. What the feds can do and what they're doing, it's happening on a federal level and on a state level, there are certain mandates coming out from CDC and others on prescribing levels. On what level of opioids you can prescribe. And both the guidelines line up with those. There are state laws moreover, on how much doctors can prescribe. How many-- how many tablets at a time, what the volume is, how frequently, and what the requirements are. The feds could not possibly control that. That really needs to be done on a state level. If that's something that you folks are interested in looking at, we would-- several of us in the industry, and we're always reminded, workers' comp is 2 percent of the insurance medical spend; 98 percent is spent group health, Medicare, Medicaid. So we'd be happy to pull in our counterparts to help you see what's-- what the prescribing patterns are or what the laws and rules are across the country, as well as bring in APEN, which is a pharmacy group to help you look at that.

ALBRECHT: [02:11:42] Any other questions?

KEN EICHLER: [02:11:46] One-- one important thing that came up, you're asking about updating the guidelines. That's very important about the state reviewing. The state must review updates to guidelines. We update our guidelines, right now, monthly. And whenever guidelines updates or formulary updates go out, they go out to the states. The reason it's so important, and I'll get shot for bringing this up, but you folks need to know, there was a case in Pennsylvania a couple of years ago called the Protz case, P-r-o-t-z. You definitely going to want to look at that. The Protz case was a case of unlawful delegation. What happened was the state of Pennsylvania had adopted the AMA guidelines and said the most current version. When they adopted it, it was the third edition. And they did it by statute not by reg. So what happened is as AMA went from three to four, four to five,

five to six, there was no review by the state at all. So several years had elapsed and they were working on the most current version. A very clever plaintiff's attorney filed suit and said, no, no, no, this is unlawful delegation, that the state has to review. They can't delegate to another state or out to another entity. In this case it was the AMA. So what-- there's been subsequent-- overturns and back and forth. But the lesson learned everywhere is that any time you're delegating to an outside entity, whether it's another jurisdiction or if it's private company, a state needs to review the updates and approve them in a reasonable amount of time whether it's annually, whether it's quarterly, whether it's monthly. And part of that is that's why we send our updates out to the jurisdictions. It gives them a chance to review it and also act as external peer reviewers. What the agency would need to do this, because you also asked is, is the agency equipped? With no disrespect meant, the agency is very well equipped, but also faces a problem like [INAUDIBLE] senators on a committee--would fight--would face in making decisions and passing laws whereas they're passing regs is you need to gather the information, you have to find the industry experts. We don't know what we don't know until we seek it out. This agency is definitely equipped to seek out the right information. Through the IAIABC and other organizations, they will be hooked up if it goes forward with the other jurisdictions, with the appropriate vendors nationally and locally, and then we'll learn how it was done elsewhere. So they definitely have the ability, but what they will probably need to do, because if I'm correct, the state does not have a medical director.

_____: [02:14:13] That's correct.

KEN EICHLER: [02:14:15] That's correct. States that don't have medical directors often rely on a medical advisory board that they create representing stakehold-- representing medical professionals from the various disciplines to convene, to select the actual formulary, and then to review the updates as they go. And it's very important for you to have in place. And if you-- if you're going to do a statute, I'd encourage you to require reasonable periodic review of updates.

ALBRECHT: [02:14:46] Very good.

KEN EICHLER: [02:14:46] Because you don't want to undo something that's--

ALBRECHT: [02:14:47] Right. You'd want--

KEN EICHLER: [02:14:48] --you've worked hard on.

ALBRECHT: [02:14:50] --flexibility [INAUDIBLE}, I suppose. OK, any other questions? No other comments? We'll move on to public comment. Thank you so much for being here.

KEN EICHLER: [02:14:58] Thank you.

ALBRECHT: [02:15:00] A lot of information.

KEN EICHLER: [02:15:02] And just for all of you, if you need certain things from any of us, we're all available, as well as well as other industry folks.

ALBRECHT: [02:15:08] Perfect. And you're going to get us this information?

KEN EICHLER: [02:15:11] Yes, I will, the PowerPoint.

ALBRECHT: [02:15:13] Very good. Thank you. Now we're taking public comment.

ROBERT HALLSTROM: [02:15:29] Chairman Albrecht, members of the committee, my name is

Robert Hallstrom, H-a-l-l-s-t-r-o-m, I appear before you today as registered lobbyists for the Nebraskans for Workers' Compensation Equity and Fairness, and the National Federation of Independent Business. We are supportive of the adoption of drug formularies. Our organizations have requested the promotion of legislation to do so, both on a broad basis with regard to all prescription drugs from about probably six years ago when that legislation was first introduced. And then more recently, Senator Lowe introduced LB408 which was more narrowly drafted to address only the opiate situation. I have handed out my written testimony. It touches on the fact that drug formularies are not new to the health profession. It touches on the fact of the states that have adopted drug formularies and the experiences that they've had both in terms of-- as the previous witnesses had indicated, reduced nonrecommended drugs and significant reduction in opioids from the adoption of those formularies, as well as the reasons for and the benefits that have been derived from the adoption of a drug formulary. In my testimony, I referenced the fact that Nebraska Medicaid has put a limit on the number of pills that can be prescribed to Medicaid patients. The CDC has come out with some guidelines for prescribing opioids for chronic pain. And the Nebraska Legislature certainly has not been bashful in this area either with regard to the legislation that was championed by Senator Howard in the area of prescription drug monitoring program. I would note, however, our position is that that is a significant law, but it only addresses a portion of the problem or addresses a piece of the puzzle in terms of looking primarily at the doctor shopping aspect of opioid use and the epidemic in that the issue of overprescribing by individual practitioners is something that still needs to be addressed. Certainly also major in this area was LB931 from last session that also addressed the issue of opioid prescribing to minors. I think in LB931 there were findings by the Legislature in the Final Reading version of that bill indicating in most cases acute pain can be treated effectively with nonopiate options in short term use of opiates for more severe or acute injuries is appropriate. I think, since Mr. Eichler invoked Carnac, I would indicate Allen, Eichler, and Shannon, three people who obviously know more about this subject than I do. But what I'd like to do is boil it down for the committee. We have a problem. I think the Legislature has been

receptive to that fact that we have a problem with regard to the opioid epidemic. We need to take a look at how we can address that with regard to not just the PDMP and the issue of minors, but also injured workers. When we look at the problems that result from not having a drug formulary or something as sufficient and efficient and beneficial as that is the employers have problems in terms of lost productivity from workers who either have problems with opioid addiction or dependence who are on the job, those who are injured and are delayed in their return to work. Those both have significant adverse and economic impacts on the employers. And similarly with the issue of the employees, the risk of addiction through the overprescribing of opioids their delayed return to work and a significant impact that it also has not only on the employee but on their families are all things that I think from the statistics and the results of the studies that you've heard from the witnesses previous to me have indicated that the states that have adopted formularies have seen significant improvements in the area where the problem exists which is overprescribing of opioids. I think I'd just like to reiterate, and I know the committee's been here for quite some time, but the distinction that was pointed out between group health drug formularies and workers' compensation drug formularies, because I think that's important, we've traditionally looked at group health drug formularies as being driven by cost factors or cost savings. And I think the message was driven home fairly significantly by the witnesses before me in terms of looking at the right treatment at the right time, effective and appropriate medical treatment for the injured worker. And particularly in the midst of the opioid epidemic, it's vitally important that we move and we move quickly to try and resolve some of the issues that-- that have been raised for your consideration. I think when we look at this, some of the things historically that we've looked at and we've heard, I'll harken back to Dr. Bozarth, who I greatly respected and unfortunately passed away since testifying on LB408. Dr. Bozarth was a representative of the Nebraska Medical Association. In meetings with our organizations regarding drug formularies, and he was one of the people who had first said that providing cover for practitioners, particularly in the rural areas, was significant because you're sitting next to your patient at a high school football or basketball game and they're telling you the

pain that they're going through and the need to have yet another opioid prescription and you can tell them take cover, if you will, by the fact that there's a drug formulary that's been adopted by the Legislature that the doctor may say doesn't allow me to and that's fine if that's how they can get cover. But again, I distinguish the fact that the formulary does not say you can't. Doesn't tell you you can't tell your patient that that's what they tell you. But I do want the Legislature, the committee here to know that that is a distinction, it is a formulary that provides that roadmap for what the best treatment is for that patient. And if the doctor chooses to tell the patient I can't do it because the state tells me I can't, so be it. And if that reduces the overprescribing problem that we have, that's great. The other issue that Dr. Bozarth talked about was the fact that prescribers have insufficient training. And I think that may be-- I don't question or suggest to this committee that doctors are out there over prescribing willy-nilly just for the heck of it, It may be an aspect of-- of insufficient training, as Dr. Bozarth had testified, and I think as others have testified in terms of the trainings that's provided in this particular area of pain management. But if you look at that, then I think you can see the significance of the drug formulary as Mr. Eichler pointed out on the screen here, seeing the list of yes and no drugs and being able to look at that and determine what is appropriate or most appropriate for the treatment of the injured worker at that time. In the interest of time, what I just close in saying is that we would pledge to work with this committee. You're going to hear, no doubt, from some other interest groups today that have differing opinions on how this ought to be addressed. I think the experts from the field, who I appreciate the efforts that were made to get them in, have provided some suggestions from Indiana and some other states that certainly should be considered. I do want to note in terms of provider input, we have testified before, as has the Workers' Compensation Court, particularly Mr. Morton, who's had a predecessor now in office, that the Workers' Compensation Court has traditionally sought input at two stages when they are directed to adopt rules and regulations. The first is to provide input or seek industry input informally before the actual rule is submitted or proposed. And then when they have their mandated hearing under the Administrative Procedures Act to also allow for public comment at that point.

And I would suggest that we could even put something into statute that would direct the Workers' Compensation Court, if the providers or other parties have any feelings that the Workers' Compensation Court might break from their-- from their normal tradition. But the last thing that I would like to see happen is that we take no action. If we pass a bill, even if we have a deferred or delayed effective date to give parties the time to come in and make sure that our regulations are Nebraska specific, whatever that might mean, the easier path might be to adopt one of the nationally recognized evidence based drug formularies. But however we need to do it, I think we need to put people's feet to the fire and get something put on the books in this very important and necessary area. And I'd be happy to address any questions that you might have.

ALBRECHT: [02:25:14] Questions for Mr. Hallstrom? I have a quick question. When we talked about this awhile back, do you know if there's any physicians that have been working on a formulary or guidelines to certain drugs?

ROBERT HALLSTROM: [02:25:25] Senator, it seems to me from two years ago, when LB408 was first introduced, that there was some discussion that the physicians had an independent group and that was the flavor of the day to delay doing anything at that point. And I think they can speak better to that than me. I think their input had to do with some of the Department of Health guidelines that have come out. And that certainly is positive. But I don't think it's-- it's carried over into the area of workers' compensation and employers and employees like the drug formulary would do as has been proposed by Senator Lowe's bill and bills like that in the past.

ALBRECHT: [02:26:06] And would you be able to speak to the work comp area? Have they made significant changes in the past five years or are they still on the same path that they've been on for the last 10 or 20?

ROBERT HALLSTROM: [02:26:20] Senator, I don't have any specific data, but I would assume the same problems exist in terms of overprescribing and the impact that those addictions or dependencies have on injured workers in terms of their ability to return to work, become productive, and so forth.

ALBRECHT: [02:26:40] Very good. Other questions? Seeing none, thank you for being here.

ROBERT HALLSTROM: [02:26:43] Thank you.

ALBRECHT: [02:26:46] Do we have anyone else that would like to come forward?

MATT SCHAEFER: [02:27:04] Good afternoon, Chairwoman Albrecht, members of the committee. My name is Matt Schaefer, M-a-t-t S-c-h-a-e-f-e-r, appearing today representing the Nebraska Medical Association. As it did in 2017, when LB408 was brought, the NMA still opposes the creation of the workers' compensation drug formulary. There really is no need in Nebraska to create another expensive layer of government that gets in the way of a patient and his or her physician making decisions that will return the patient back to the job. What really would it accomplish here in Nebraska? Just about every testifier mentioned that states with formularies see a reduction of the number of prescriptions of nonpreferred drugs, which makes total sense because they're making nonpreferred drugs harder to prescribe, so of course you're going to see a reduction. So that really doesn't tell us anything taken alone. And I really didn't see a whole lot of hard data, and maybe it's in handouts that were presented to you or in a confidential study, about whether there are healthier outcomes for workers in those states with drug formularies, whether they're getting-- or whether there's fewer days return back to work, especially balanced against the increased costs to the state to set up the system, to annually update it, to train providers how to use it, subscription fees that'll be required of physicians and hospitals or any other outpatient clinic to access the lists,

and then, of course, most importantly the frustration or suffering or pain incurred by patients who have to switch drugs or can't access a drug, even if it's within three days, that's still-- that's still something. I didn't really see too much really balancing out those factors presented in any of the presentations. Going back to 2017, some proponents of the bill did say it was about reducing drug costs in addition to addressing the opioid crisis. And after reviewing those transcripts and seeing where we are today, I'm convinced that there substantially less need today to implement a formula-- a formulary than there was two years ago. Recent rankings put Nebraska in the middle of the pack when it comes to workers' compensation insurance premium rates. And averages fine. I mean, it means that workers are getting the care that they need, but the care isn't needlessly expensive. And in states with dramatically higher insurance premium rates, some of them have formularies, including California which has the most expensive premiums. In turning over to the opioid issue, we're in quite a bit different place today than we were two years ago. Since that bill hearing in 2017, the Legislature has required physicians to educate patients about the risk of addiction, among other requirements of education, supplies for children have been limited to seven days, and the NMA and the Department of Health and Human Services has released a pain management guidance document, it's right here, that helps our healthcare community make better evidence based decisions that will likely result in fewer patients using addicting painkillers. Interestingly, the transcripts from the 2007 hearing raised all four of those issues and all four of those have been tackled or at least have been started to be addressed. And the work isn't over. An October 16 press release from Governor Ricketts announced a $10.9 million grant-- or set up grants that will be focused on opioid prevention and response. And perhaps most importantly, efforts led by Senator Howard have resulted in the most robust prescription drug, drug monitoring program in the entire country. Taken together, this is the way we are going to find and keep injured workers from filling multiple prescriptions for opioids, not an arbitrary list created by the government that says a physician should prescribe this versus not prescribing that drug. Thank you for your time.

ALBRECHT: [02:31:30] Any questions? Thank you for being here, Mr. Schaefer. Any other folks that would like to testify-- not testify, give us your information? See none, I do have two letters, one from Joni Cover, CEO of the Nebraska Pharmacists Association, and Theodore D. (Tad) Fraizer, Law Offices of Fraizer and Fraizer, for American Insurance Association. Both were in support of, proponents to the LR383 hearing. So with that I think we're done for the day. And thank you all for coming, especially those that are getting on airplanes. Thanks for being here, everyone.