

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
NASHVILLE, TENNESSEE
MARCH 16, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Saturday, March 16, 2019 at 1:30 p.m.

Senator Jerry Klein of North Dakota, Acting Chair of the Committee, presided.

Other members of the Committees present were:

Asm. Ken Cooley (CA)
Rep. Matt Lehman (IN)
Rep. Edmond Jordan (LA)
Sen. Paul Wieland (MO)

Rep. George Keiser (ND)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Deborah Ferguson (AR)
Rep. Roy Takumi (HI)
Rep. Daire Rendon (MI)

Rep. Tracy Boe (ND)
Sen. Bob Hackett (OH)

Also in attendance were:

Commissioner Tom Considine, NCOL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, NCOIL General Counsel

MINUTES

After a motion was made by Rep. George Keiser (ND) and seconded by Sen. Paul Wieland (MO) to waive the quorum requirement, the Committee unanimously approved the minutes of its December 8, 2018 meeting in Oklahoma City, OK upon a Motion made by Rep. Matt Lehman (IN), NCOIL Vice President, and seconded by Rep. Edmond Jordan (LA).

MARIJUANA IN THE WORKPLACE: WHAT DO STATES NEEDS TO KNOW AS THE LEGALIZATION OF MARIJUANA INCREASES?

Chester McPherson, Senior Division Executive – External & Gov't Affairs at the National Council on Compensation Insurance (NCCI), first stated that his presentation is not meant to provide legal advice but rather to provide updates on certain issues. NCCI is a licensed rating organization and advisory organization in the workers' compensation space. NCCI is the largest collector and provider of workers' compensation data services and it works with about 40 states in assistance to set and establish loss costs or full rates in the workers' compensation arena.

Mr. McPherson stated that a number of states have been working to legalize marijuana. Last year, Vermont became the ninth state to legalize recreational marijuana and interestingly it was the first state to do so through the legislative process as opposed to a ballot measure. Louisiana has also passed legislation related to marijuana through the legislative process. Mr. McPherson stated that in Michigan in 2018, the legalized use of recreational marijuana was enacted through a ballot initiative. Also, in 2018, Missouri, Utah, and Oklahoma permitted the legalized use of medicinal marijuana through ballot initiatives. However, in 2018, a ballot measure to legalize recreational marijuana failed in North Dakota.

Mr. McPherson stated that Idaho, Nebraska and Kansas are the only states that do not permit the use of marijuana in any form. Those 3 states represent about 6.6 million U.S. residents out of about 327 million total U.S. residents so you can see almost the entire country lives in a state where there is access to marijuana whether it is medical, recreational or some form of limited use through CBD oils. Ten states plus the District of Columbia permit recreational use of marijuana.

New Mexico was one of the first states where NCCI saw courts addressing the issue of whether or not an employer has to reimburse for the use of medical marijuana. Within the workers' compensation space, one of the key issues that is of concern is whether the medical treatment is considered reasonable and necessary, and whether it is legal under state law, and that is the question that states and courts are wrestling with as it relates to the reimbursement of medical marijuana. The New Mexico court of appeals ruled in a number of cases (*Vialpando v. Ben's Automotive Services and Redwood Fire & Casualty (2014)*; *Maez v. Riley Industrial*; *Lewis v. American General Media (2015)*) that the employer must reimburse for the use of medical marijuana within a workers' compensation context. Subsequently, New Mexico adopted a fee schedule related to medical marijuana which provides for reimbursement of medical marijuana in New Mexico and that became effective January 1, 2016.

In 2015, the Minnesota Department of Labor promulgated regulations that made the use of medical marijuana reimbursable as a form of workers' compensation treatment. In a 2016 Connecticut case, *Petrini v. Marcus Dairy, Inc.*, the workers' compensation commission ruled that the use of medical marijuana is reimbursable because it constitutes a necessary and reasonable medical treatment. That decision was appealed but the parties ultimately settled and the original ruling of the workers' compensation commission remains settled CT law. Last week in New Hampshire in *Appeal of Andrew Panaggio*, the court ruled delicately that a carrier does not affirmatively have to reimburse for medical marijuana but within the ruling the court did seem to suggest that it could be reimbursable. That ruling is still being analyzed.

Mr. McPherson then discussed some 2019 legislative activity relating to reimbursement issues, coverage issues, and overall the payment of medical marijuana. Hawaii HB 1534 and SB 1523 just recently died during session but those bills would have allowed for reimbursement of medical marijuana within the workers' compensation space. Kansas SB 195 contains a provision for the safe, legal use of medical cannabis but it is not clear if it will pass and how it will impact the workers' compensation space. Maine HB 697 contains a provision to provide for reimbursement in workers' compensation cases. Maryland SB 854 indicates that if an employee is taking or using medical marijuana and gets injured on the job while using medical marijuana, then that employee would not be entitled to receive workers' compensation benefits. New Jersey A 4097

and A 4505 contain provisions to provide for the reimbursement of medical marijuana in workers' compensation cases. New York also has pending legislation on that issue (AB 2824/S2054) and Vermont HB 14 would also permit workers' compensation payment in the medical marijuana space.

A number of states have made it clear through legislation that medical marijuana is not reimbursable in the worker's compensation space: Florida (SB 8-A – 2017); North Dakota (HB 1156 – 2017); and Louisiana (HB 579 – 2018). The Maine Supreme Court ruled in *Bourgoin v. Twin Rivers Paper Co. (2018)*, that employers are not required to cover reimbursement for marijuana. However, there is currently a bill pending in Maine that would permit reimbursement so it remains to be seen how that will play out. In *Hall v. Safelite Group, Inc. (2018)*, the Vermont Department of Labor ruled that even though medical marijuana is legal it should not be construed to require employers to reimburse for that coverage. There is also a bill in VT, HB 14, that would allow for reimbursement. Mr. McPherson stated that as states consider these issues NCCI will continue to monitor them. Mr. McPherson encouraged everyone to visit NCCI's website where it has information available that covers a plethora of issues related to marijuana for employers, legislators, employees, and insurers.

Michael Correia, Director of Gov't Relations for the National Cannabis Industry Association (NCIA), stated that he is not here to discuss the pros and cons of cannabis legalization as the voters have already spoken on the issue. The question that needs to be asked is how you want implementation to work. There are 47 states that have cannabis laws that disagree with the federal government. NCIA's approach is to allow this conversation to be had at the state level. There are many issues that need to be worked out and NCIA's focus is that the conversation should be done with policymakers at the state level rather than the federal level. The states that are anticipated to introduce ballot initiatives related to legalizing marijuana are CT, HI, IL, MN, NH, NJ, NM, NY, RI, and VT.

With regard to the federal level, Mr. Correia stated that this is the first time in 6 years where we have had Democrats control the House so this will be the first time where the legislative process will be able to be fleshed out in terms of bills going through committees and receiving votes so we can have an idea of what Congress is thinking. Last month, the House Financial Services Committee held a hearing on issues related to cannabis and banking. Last week, a bill was introduced related to cannabis and banking and there are over 120 co-sponsors. NCIA cares about legalization and the light at the end of the tunnel, but the main focus is being able to have Congress pass legislation that pushes it back to the states. There are two bills that address that issue, one of which is the States Act sponsored by Senator Elizabeth Warren (MA) and Senator Cory Gardner (CO).

Mr. Correia noted that President Trump has stated that if something was to move through Congress he could support the concept of pushing these issues back to the states and offering them protection on these issues. Mr. Correia further noted that with regard to the 2020 election, many Democrats are going to be taking a very progressive view on this issue. Mr. Correia stated that he is hopeful that the discussions on these issues will move forward and that something can make its way to the President's desk that addresses some of the issues.

Erin Collins, Asst. VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), stated that NAMIC, like many others, is investigating what the cannabis industry and boom means for the insurance industry in particular and to communities at large. NAMIC is looking at the issues in the context of three main areas. First, the impact of medical marijuana and the question being asked relates to carriers being in violation of federal law if they are forced to reimburse for medical marijuana. Questions are being asked regarding whether those carriers would be subject to RICO. There are many who would say that would never happen, however, Jeff Sessions did issue a memo last year indicating that they should enforce the laws of Congress vociferously as it relates to marijuana so it remains to be seen what the exposure is. Second, in the instance of an assigned risk pool, especially in the workers' compensation area, if there are dispensaries or other cannabis oriented businesses that fall into the assigned risk pool, a workers' compensation carrier or other carrier may be assigned that risk without being able to determine if that is something that they are willing to undertake as a business practice in the context of a violation of federal law.

Ms. Collins stated that when discussing cannabis, NAMIC begins and ends with the notion that as an industry, it should not be forced to do something illegal. NAMIC is taking appropriate steps in advocacy to try to work towards that initiative but NAMIC knows that this conversation will be coming to a head at the federal level. The third area is the effect on the homeowner's line and the auto line. In the homeowners context we have to ask the question about whether or not marijuana is property. There have been several cases where individuals have been growing marijuana in their homes, one of which involved an individual having several plants stolen from her home which caused her to file a claim for almost \$50,000. NAMIC has seen that those types of cases are determined by whether the judge decides that state law or the federal controlled substances act is the prevailing statute.

In the auto space, NAMIC is seeing an impact in states that have legalized marijuana. There have been studies from the Insurance Institute for Highway Safety (IIHS) and others that show an increase in collision claims resulting after the legalization of marijuana. Another issue in the auto space is that we don't really know what "impairment" means as it relates to marijuana, nor is there a way to test for that. Ms. Collins applauded the Committee for examining these issues and stated that it will likely have to continue doing so for quite some time as new issues develop.

Frank O'Brien, VP of Gov't Relations at the American Property Casualty Insurance Association (APCIA), stated APCIA is neutral with regard to the public policy question of whether states should legalize recreational or medical marijuana. Having said that, this is a very active area and Mr. O'Brien noted that he will be in Rhode Island next week testifying on many of the issues mentioned by Ms. Collins. Mr. O'Brien stated that we are currently in a very difficult catch-22 situation. Marijuana is a schedule 1 drug at the federal level and a federal crime and APCIA is very concerned about its exposure for participating in "touch the plant" activities. APCIA is pleased to see that Congress is finally starting to wrestle with these issues and looks forward to it finally resolving said issues because as with any other business, the marijuana industry needs the risk-transfer mechanism.

On the insurance side of things, one of the main issues is impairment standards. Right now there is no recognized impairment standard and no recognized test to measure impairment such as a breathalyzer being used to measure blood alcohol levels. That

presents a problem and one of APCIA's concerns is a growing trend in the states to give marijuana a special status. APCIA would like to see a situation where impairment is impairment and APCIA is concerned about moving away from safety-related requirements and a safety-related culture particularly in safety-sensitive positions. One thing that APCIA would like to see that it is working with federal officials on is the development of some sort of impairment standard and some sort of impairment test.

Mr. O'Brien stated that these issues are going to have a lot of attention going forward and one of the things APCIA is concerned about is any type of mandate from state legislators to insurers to either cover marijuana or somehow give it a special status. So far that has not occurred but APCIA remains concerned about it.

Rep. Matt Lehman (IN), NCOIL Vice President, stated that an issue that he believes is going to emerge in Indiana is that it does not have any laws relating to medical or recreational marijuana but Ohio does. Rep. Lehman stated that his community is 6 miles from Ohio and it draws a lot of its workforce from Ohio. Rep. Lehman described the scenario of someone from Ohio having a legal prescription for marijuana and they are injured in Indiana and it turns out there is marijuana in their system and the policy written in Indiana excludes any illegal behavior. Rep. Lehman asked Mr. McPherson if issues like those are being considered by NCCI and other organizations. Mr. McPherson stated that NCCI is not an insurer so it does not insure the risk, it just collects the data and shares it with state departments of insurance. Since this is such a new issue, NCCI does not have marijuana-specific data currently because it does not have a national drug code due its classification as a schedule 1 substance. However, NCCI is working to develop its data call for next year to see whether or not NCCI could obtain information from insurers who cover marijuana or reimburse for marijuana in the workers' compensation space.

Rep. Lehman stated that the situation he described seems to be putting people into a box and it may result in the individual described in his hypothetical not having any coverage due to a perfectly legal prescription in his state. Mr. O'Brien stated that is one of the issues that will be discussed in Rhode Island next week because RI is surrounded by a number of states that have legalized marijuana. This is also not only an issue in the workers' compensation space, but also the criminal space, as the head of the RI State Police is addressing the issue during his first week on the job. Mr. O'Brien stated that some of these issues are going to need to be resolved by the courts. The Massachusetts Supreme Court is looking at the issue and there are a number of state legislatures that are considering statutes on this issue, MA and RI being among them. Unfortunately, right now, the situation Rep. Lehman described and the issues surrounding it is a mess.

Mr. Correia stated that regardless of your views on cannabis, there are many policy issues that need to be worked out and states are dealing with that now. Congress needs to change this and they are not willing to do so until they feel that the states can handle it.

Rep. Daire Rendon (MI) stated that Michigan legalized recreational marijuana a few years ago and it still has not gotten its hands around it. In Michigan, trucking, lumber, and farming are huge industries and it is becoming difficult to find people to get into those industries and they are good paying jobs. Rep. Rendon stated that her constituents in those industries are worried sick about how marijuana laws are going to

impact their ability to move their goods and still be able to provide a service and not have their liability compromised. Mr. O'Brien stated that those concerns relate to his comments made earlier regarding safety-related requirements. APCIA believes that Congress needs to resolve this and we need to fish or cut bait on this issue. The catch-22 needs to be eliminated. Once that it is done, the states are then going to have to decide what type of regulatory structure they are going to put in place, and how it will be enforced. Many different policy decisions are going to have to be made by the states and they will be laboratories of democracy.

Mr. Correia stated that he believes the most important thing to determine is what impairment is so policy can be implemented. If a person crashes a truck and they are under the influence of alcohol, they will either show visible effects of being under the influence or the breathalyzer will tell you. With cannabis, you can consume it on Friday and it would still be in your system if you got into an accident on Monday.

Rep. George Keiser (ND) stated that in ND, medical marijuana is allowed as is alcohol and both are statutorily excluded from coverage if you are under the influence of either.

Rep. Tom Oliverson, M.D. (TX) stated that one of the problems that must be dealt with is the fact that unlike any other intoxicant which is legal in the U.S., marijuana is the only one that is simultaneously being reported to have medicinal properties. You don't see the legal recreational use of Vicodin and you don't see the medicinal use of alcohol unless you are recovering from alcoholism and you are in a detox facility. Rep. Oliverson stated that as a physician it frustrates him that the advocates have been fairly disingenuous because they have essentially stated that they'll "take" medical marijuana being legalized but ultimately what they really want is full-fledged legalization. That muddies the waters. Is it a drug to treat disease or is it an intoxicant for recreational purposes? That represents a problem on the regulatory side of things because if I am on a drug that is prescribed to me that impairs me, that is different compared to smoking it in a bar and then driving home.

DISCUSSION ON DEVELOPMENT OF NCOIL WORKERS' COMPENSATION DRUG FORMULARY MODEL

Rep. Lehman stated that the initial discussion draft of the NCOIL Workers' Compensation Drug Formulary Model is based off of a bill he sponsored in Indiana last year that was signed into law last March. Rep. Lehman stated that throughout the past several years, interest from state legislatures in workers' compensation drug formularies has grown significantly as they are seen as a way to: ensure that the treatment provided injured workers is related to and the most appropriate for their work-related injury; combat the opioid crisis; and lower prescription drug costs. Rep. Lehman noted that In Indiana, they decided to utilize the Official Disability Guidelines (ODG) Workers' Compensation Drug Formulary Appendix A as published by MCG Health, but that does not necessarily mean that is what should be included in an NCOIL Model. It's possible that the Model might not even name a specific formulary but could rather direct states to develop their own formularies as some states have done.

Rep. Lehman then provided a brief background on how the bill operates with regard to the interaction between employers, employees, and physicians and the prescription of certain drugs. Essentially, except during a medical emergency, the bill prohibits workers' compensation reimbursement for drugs specified in the ODG Workers' Compensation

Drug Formulary Appendix A published by MCG Health as "N" drugs. Rep. Lehman stated that he looks forward to hearing comments on the initial discussion draft and looks forward to further discussing this issue at the Summer Meeting in July and perhaps beforehand during an interim committee conference call with the goal of ultimately adopting a Model for states to consider.

Abbie Hudgens, Administrator of the Tennessee Bureau of Workers' Compensation, stated that TN adopted a similar workers' compensation drug formulary to Indiana's. Ms. Hudgens stated that TN chose to enact a workers' compensation drug formulary because TN has a problem with opioid use. Several years ago, TN had 1,600 people die from opioid overdoses and that provided an impetus both for workers' compensation and the state as a whole. The workers' compensation drug formulary was part of the 2013 reform which was a large reform for the entire TN worker's compensation system. In that statute was a requirement to have treatment guidelines and TN considered the formulary as part of the treatment guidelines. The statute did not spell out the exact parameters of the formulary but rather said that the Administrator would, in consultation with the medical advisory committee, make a decision on the formulary. Accordingly, several months were spent getting input from several different organizations and rules were ultimately developed. The rules did go before the government operations committee before being finalized. The decision was ultimately made to go with the ODG workers' compensation drug formulary.

Ms. Hudgens noted that they did include provisions in the regulations providing for an expedited hearing so if someone was trying to get prescribed an "N" drug and there was a delay about getting it approved, a hearing can be conducted and currently the average is 1.7 days before an answer is given. Interestingly, once people got used to the formulary, now there is only about 1 hearing per quarter. Another provision in the regulations was an absolute requirement that all compound drugs had an "N" rating and had to be reviewed. That provision was implemented because it was identified when reviewing TN statistics that compounded drugs were raising the price of drugs in TN. Ms. Hudgens stated that the most astounding percentage in TN was that compound drug usage went down 90% upon implementation of the formulary.

The reduction in opioids is more difficult to quantify because the state has implemented an aggressive program relating to opioid use and abuse called Tennessee Together. The program states that for acute care you cannot have more than a 3 day fill. Also, in other states they call it a prescription drug monitoring program (PDMP) but in TN it is called a Controlled Substance Monitoring Database Program (CSMD) and its very rigid in that it is not discretionary – doctors must put prescriptions in the system within one day and they must consult the CSMD before they write a prescription. Ms. Hudgens stated that all of these things together have helped TN, and for workers' compensation specifically, the formulary has been effective.

There are a couple of things that are very important to know as to why the formulary has been effective and what some difficulties are. One of the biggest difficulties is getting the word out and helping doctors understand what's coming. Ms. Hudgens stated that a fairly long lead-in time was given in TN before the formulary was effective and that was helpful, but the biggest issue is education in order to try and get the attention of physicians. Additionally, it was important to get assistance from other states. TN relied mainly on 4 other states that had a formulary in addition to the International Association of Industrial Accident Boards and Commissioners (IAIABC) and the Southern

Association of Workers' Compensation Administrators (SAWCA). States are sort of one big family when it comes to workers' compensation and that is an important aspect for this committee to consider moving forward with this issue.

Ms. Hudgens stated that morphine equivalents certainly did decrease upon implementation of the formulary. There was also some concern in TN about what would happen to someone who was in some sort of difficulty and they did not get their drugs in time so a feature called a first-fill was implemented which provides those people the ability to get a 7 day prescription regardless. Ms. Hudgens stated that overall, the formulary has worked very well in TN.

Brian Allen, VP of Gov't Affairs at Mitchell, stated that he has been involved in some way in the development of most of the formularies adopted across the country. Mitchell provides a full continuum of services within the workers' compensation system, starting with first reports of injury up to the time the claim is settled, managed pharmacy care, building solutions for pharmacies, and utilization review. Accordingly, Mitchell has experienced workers' compensation drug formularies from many different angles. Mr. Mitchell stated that Texas adopted workers' compensation reform legislation in 2005 but it took until 2011 until the formulary was actually implemented for a number of reasons.

From 2011 to 2014, the number of injured workers receiving "N" drugs fell by 83%, and "N" drug prescriptions fell by 85%. Interestingly, other drug prescriptions fell 14% which was believed to be caused by the formulary guiding physicians on more appropriate medications so there was less defensive prescribing going on and more focus on what really works. Additionally, after Texas implemented its formulary, no more changes were made to their pharmacy rules; no changes were made to the fee schedule and no legislative changes dealing with how to prescribe opioids were made. That means there was a stagnant legislative and regulatory environment so the data was very telling. One thing that Texas found was that in 2009 they had over 15,000 people on over 90 morphine equivalents per day and that number fell to less than 500 in 2015.

Mr. Allen stated that Ohio, which has a proprietary formulary, released a study last year which stated that the number of injured workers meeting or exceeding the threshold for being clinically dependent on opioids decreased 59% since 2011. Mr. Allen noted that there are different types of formularies and two are commercially available: ODG, and the American College of Occupational and Environmental Medicine (ACOEM) guidelines. ACOEM has been used in CA and NY. OH, WA, and AR developed their own formularies, with AR utilizing its School of Pharmacy to develop the formulary. Nebraska is currently considering a targeted formulary related only to opioids and that is pending in the legislature.

Mr. Mitchell then discussed some features that Mitchell believes are key ingredients to workers' compensation drug formularies. Formularies should be evidence based and there should be some proven science behind it. The focus must be on outcomes. If you are not building a formulary that is focused on what is going to be right for the injured workers and what is going to drive good outcomes, you probably should not be building a formulary. It really is all about delivering the best care possible to the injured worker and making sure they get better faster and get back to work or at least achieve the highest level of functionality that they can. Formularies can also control some cost-driving outliers such as physician dispensing, compounded medications, and brand name drugs with generic equivalents. Formularies also should be easy to use. If a

physician cannot understand it, it is not going to be used. The formulary should also be accessible to providers and users at little or no cost, and there must be simple utilization review processes along with a dispute resolution procedure.

Ken Eichler, VP of Gov't Affairs at ODG by MCG Health, stated that formularies are actively used in every state. The question is not whether or not to allow them, but rather whether you want to look behind the curtain and legislate and regulate to protect injured workers. The goal of workers' compensation formularies and guidelines is to "do no harm" while improving quality of care and outcomes. The formularies the Committee is discussing are evidence based and they started in Texas and that was because the state asked for an extrapolation from the guidelines into a table for easy lookup by clinical practitioners. The Centers for Disease Control (CDC) and Prevention states that improving the way opioids are prescribed through clinical practice guidelines, which is the basis for formularies, can ensure patients have access to safe, effective treatment while reducing the number of people who misuse, abuse, or overdose from these powerful drugs. The CDC also stresses the importance about informing agencies, providers, and medical/professional organizations about evidence-based practices that can improve patient outcomes.

Mr. Eichler stated that there are two main types of formularies, one of which is the group health commercial model. There, the bottom line is "you get what you pay for." If you buy a stripped-down Hyundai, you will get stripped down drug-coverage. If you buy a top of the line Rolls Royce with every bell and whistle, you will get the best coverage you can and your drugs will be covered. In group health you have covered and non-covered, and tiered drugs. It's black and white and if you don't pay for it you don't get it. Workers' compensation, however, allows for any treatment – and drugs are no more than another form of treatment – that is medically appropriate and causally related to the injury. Prescription benefits for all are available regardless of cost. Preferred drugs generally do not require prior authorization vs. non-preferred drugs which simply require prior authorization with substantiation of the medical necessity. It is important to have legislation with formularies because legislation ensures increased transparency and equal benefits for all instead of individual organizations setting different benefits for different employees. Workers' compensation should be administered level-handedly.

With regard to ODG's formulary, there are currently over 355 drugs which converts to over 45,000 NDC codes – the codes assigned by manufactures. As of March 1, 2019, there were over 168 preferred drugs recommended as first line, and 187 non-preferred drugs requiring substantiation of medical necessity for authorization as a safeguard for injured workers. The goal is to expedite prescriptions for injured workers and expedite improved outcomes. Mr. Eichler stated that during meetings in Indiana with regard to the formulary, labor spoke up saying they supported a formulary because there were so many jobs in Indiana and so many workers that couldn't go back to work simply because they were prescribed opioids, muscle relaxers, and other drugs that created safety-sensitive issues. Therefore, formularies are a labor issue to help people get back to work and allow them to have quality of life. Formularies will also empower medical providers and streamline communications; expedite case specific authorizations and medical reviews (most states are legislating 2 to 3 days as compared to Ms. Hudgens' statement earlier regarding an average of 1.7 days); and decrease transactional processes, friction & costs for all. Formularies are already integrated into most PBM & industry systems, processes and procedures nationwide, thereby minimizing implementation efforts and costs.

Mr. Eichler noted that the preferred drug list does not preclude prescribing of all drugs, it just buckets them into those that may require pre-authorization and basic substantiation. Formularies decrease the adversarial relationship with patients and physicians, enabling physicians to “just say no” when indicated without fear of backlash. There are documented positive life altering results in multiple states with improved outcomes, function and return to work. There is also a documented decrease in use and abuse of opioids, and with the ODG formulary, there is no cost to the state for posting a complementary “stakeholder use” formulary drug list on the website. There are also measurable outcomes to document program results and benchmark adherence.

Mr. Eichler stated that the entire process is very simple once the formulary is implemented, and it really does not differ that much from what happens without a formulary except it provides stopgaps for authorization. A patient should never have a negative experience of going to the pharmacy and being denied because that negative touchpoint is going to be a downturn in the overall attitude of the claimant and a bad touchpoint for the claim. Mr. Eichler stated that there is a lot of data and research on formularies from organizations such as the Workers’ Compensation Research Institute (WCRI), SAWCA, IAIABC, and NCCI. NCCI actually prices out the impact of formularies for states. NCCI also prepared a study at the request of some states and it shows the potential cost savings. Formularies are not about cost savings but cost savings represents a decrease in the number of drugs prescribed which translates into improved quality of life.

Mr. Eichler stated that Texas is the most closely studied and cited state that has implemented a formulary because Texas does the best job in the country with regard to collecting data as they have the resources and budget to do it. Importantly, Texas currently has more medical providers participating in the workers’ compensation system than ever before and Texas is an opt-in state. Also, in Texas no non-preferred drugs are in the top 10 most-prescribed medications. There are a significant amount of opioids that are preferred drugs that are short-acting so the formulary enables patients to get the right drugs quickly and to avoid the bad drugs. Further, in Texas, the total opioid prescription costs for non-preferred drugs combined with those on the preferred list dropped from \$43.2 million in 2009 to \$18.5 million in 2015. Mr. Eichler closed by noting that there is complementary state stakeholder access to ODG’s formulary on its website.

Joe Guerriero, Sr. VP for MDGuidelines at ReedGroup, stated that ReedGroup is a trusted provider of clinical content, leading edge software, absence management outsourcing services and data analytics to employers, insurers and healthcare organizations. ReedGroup serves over 3,000 clients in multiple sites across the globe including many Fortune 100 companies. ReedGroup is a subsidiary of Guardian Life Insurance Company. The MDGuidelines/ACOEM platform is used by virtually all major group disability insurance carriers as well as many workers’ compensation carriers. Of particular note, in addition to work in the workers’ compensation systems in CA, NY, NV, and TX, ReedGroup’s guidelines and drug formulary are used exclusively in the workers’ compensation programs of the Veterans Administration, the Department of Defense, and Federal Occupation Health. Mr. Guerriero thanks the Committee for inviting ReedGroup to comment on the important work of the Committee.

Mr. Guerriero stated that in the summer of 2014, he was approached by a number of stakeholders in the workers’ compensation industry about the possibility of having

ReedGroup publish a drug formulary. Chief among those stakeholders was Dr. Robert Goldberg, MD, FACOEM and Chief Medical Officer at HealtheSystems, a FL-based PBM company. Since there were a handful of formulary options already available for use in the workers' compensation system, Mr. Guerriero stated that he pushed back and asked why ReedGroup should go through the time and effort of building a formulary. The replies were all pretty much the same – “the industry should do better on behalf of injured workers”; “what is presently being used in the market may not be medically responsible”; “and that ReedGroup now had the “platform upon which to build a medically responsible, patient-centric formulary.” The platform being referred to was the clinical practice guidelines from the ACOEM which ReedGroup had acquired a year earlier. The ACOEM clinical practice guidelines are both highly respected and widely-used, and would later serve as the foundation for the drug formulary ReedGroup launched in 2015.

Mr. Guerriero stated that the key thing to think about when discussing drug formularies is that the drug formulary in and of itself is basically just, in the traditional sense, a list of drugs. With the assistance of the physicians and Pharm.D's at HealtheSystems, and the research team that builds the ACOEM guidelines at the University of Utah's Rocky Mountain College of Occupation and Environmental Medicine, ReedGroup began building a formulary based on the premise that determining the clinical appropriateness of drug therapy is not merely a matter of sorting the good apples from the bad. ReedGroup believed that whether or not a drug is appropriate depends as much on the patient and the specifics of their injury as it does the risk-benefit profile of the drug itself. Even ibuprofen, a drug that in many instances is a safe option for pain management, can have serious or even fatal adverse effects if prescribed at excessive doses or for the wrong patient. As Dr. Goldberg stated during the early stages of building the formulary, “there is nothing wrong with a red delicious apple, but if you try baking it in a pie, it will fall apart.” His point was that decisions regarding prescription drug therapy must be made in the right context, or the outcome may be less than optimal. With that in mind, ReedGroup constructed its ACOEM-based formulary in a manner that ties drug recommendations to the injured or ill workers' condition and phase of treatment.

Mr. Guerriero stated that ReedGroup's approach towards a drug formulary is that the most responsible drug formulary that one can look at adopting or including in overall legislation is one that really takes to heart the relationship between the doctor and patient that is sacrosanct.

Robert Nydam, Project Director at MAXIMUS, stated that one of the main things that MAXIMUS does is provide healthcare dispute resolution services to government entities across the country both at the state and federal level. Since the inception of the Medicare Part D prescription drug program, MAXIMUS has run the appeals program. MAXIMUS also administers the independent medical review (IMR) program associated with workers' compensation in CA. With regard to the CA IMR program, as of January 1, 2018, CA adopted a prescription drug formulary for workers' compensation. Accordingly, there is now data available a year into the program. It is still too early to draw any conclusions but what MAXIMUS has seen thus far is that in 2016 and 2017 the number of healthcare appeals in workers' compensation associated with opioids ran about 13% of IMR appeals. In 2018, that number went up slightly to 14% but the takeaway is that when you first introduce a formulary you can expect some new friction as you have to give folks time, especially on the provider side, to adjust.

Mr. Nydam stated that it is important to understand what a formulary is and is not. At its most basic level, it is a list of drugs and to be successful a formulary really must be part of a system. A set of evidence-based guidelines alongside a formulary is essential. A good analogy is that if you have a recipe and all you have is a list of ingredients but no instructions on how to cook the meal, the meal will probably not taste good. Another aspect to consider when introducing a formulary is that MAXIMUS believes it is vital for states to have a dispute resolution process in place. A formulary is going to provide you with a path of what is true and proper for the large majority of patients but there are going to be exceptions and you need to have a process for those exceptions to be presented and considered; if not, the risk is that someone's unique clinical situation is not going to get the attention that it deserves. A dispute resolution program also provides those in the provider community who may have concerns about the introduction of a formulary the opportunity to be heard.

Sen. Bob Hackett (OH) stated that he is a strong supporter of the formulary but what made OH successful with it was that the prescriptive authority of physicians was lowered. Mr. Allen stated that OH was ground zero for the opioid epidemic and noted that the formulary coupled with the prescriptive authority was important. Mr. Allen noted that Texas did not change its prescribing authority and only implemented the formulary which shows that there are different options for different states depending on the state's needs. There is no silver bullet to combat the opioid crisis. Sen. Hackett stated that OH first started with acute pain provisions only and then introduced chronic pain provisions later. Mr. Allen stated that typically happens and a good analogy is that of a lake filled with people addicted to opioids. You can't drain the lake until you dam the river feeding the lake so you have to go after acute pain first to slow it down and then you have time to go after chronic pain.

Mr. Eichler stated that ODG has heard from state legislators that when drafting a formulary bill it is important not to create conflicts in the prescribing laws because it will end up in a legal battle and that will undermine the formulary. The formulary can give recommendations but it does not control medical provider licensure and accordingly it has to defer on that.

Rep. Lehman closed by stating that the discussion held today was very valuable and hopefully by the Summer Meeting in July a new version of the Model can be ready and discussed for the Committee to agree upon.

ADJOURNMENT

There being no further business, the Committee adjourned at 2:30 p.m.