NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
NEWPORT BEACH, CALIFORNIA
JULY 11, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Marriott Newport Beach Hotel on Thursday, July 11, 2019 at 10:15 a.m.

Assemblywoman Maggie Carlton of Nevada, Chair of the Committee, presided.

Other members of the Committees present were:

Sen. Jason Rapert (AR)
Rep. Martin Carbaugh (IN)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Edmond Jordan (LA)
Sen. Paul Utke (MN)
Rep. George Keiser (ND)
Sen. Jerry Klein (ND)
Rep. Lewis Moore (OK)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Colleen Burton (FL)
Rep. Tammy Nichols (ID)
Rep. Deanna Frazier (KY)
Sen. Dan "Blade" Morrish (LA)
Sen. Brian Feldman (MD)
Del. Kriselda Valderrama (MD)
Rep. Michael Webber (MI)
Sen. Shaen Vedaa (ND)
Asw. Ellen Spiegel (NV)
Sen. Bob Hackett (OH)
Rep. Chris Sneed (OK)
Rep. Ryan Mackenzie (PA)
Rep. Wendi Thomas (PA)
Del. Lamont Bagby (VA)

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 Rep. Lewis Moore (OK) to waive the quorum requirement, the Committee unanimously approved the minutes of its March 16, 2019 meeting in Nashville, TN upon a Motion made by Sen. Jerry Klein (ND) and seconded by Rep. David Santiago (FL).

CONTINUED DISCUSSION ON DEVELOPMENT OF NCOIL WORKERS' COMPENSATION DRUG FORMULARY MODEL ACT

Rep. Matt Lehman (IN), NCOIL Vice President and sponsor of the NCOIL Workers' Compensation Drug Formulary Model Act (Model), stated that the Model was first introduced at the NCOIL Spring Meeting in Nashville a few months ago and is based off of Indiana SB 369 which Rep. Lehman sponsored and was signed into law last year.

During that process in Indiana, Rep. Lehman stated that they were looking for a way within the workers' compensation system to address the opioid crisis and lower prescription drug costs. Rep. Lehman stated that in the new draft of the Model he took some language from the legislation that had passed in California and was introduced in Pennsylvania and incorporated it into the Model. There will be some additional changes before adoption and it may be best to have an interim conference call meeting of the Committee before it meets at the NCOIL Annual Meeting in December so that the Committee could adopt the Model on the conference call and have the Executive Committee adopt it in December. Rep. Lehman noted that part of the problem with having the national meeting in December is that some states have deadlines around that time in which legislation must be filed. Accordingly, it is important to have something for states to see before that.

Stacy Jones, Senior Research Associate at the California Workers' Compensation Institute (CWCI), stated that the legislative intent for the California workers' compensation drug formulary was to improve the quality of care, limit over-prescribing of highly-addictive opioids, and control prescription drug costs. Some basic provisions of the legislation require prescribed drugs to be in accordance with the medical treatment utilization schedule (MTUS) which is the American College of Occupational and Environmental Medicine (ACOEM) guidelines which is basically the foundation of the formulary and how drugs are treated in the formulary.

The legislation applies to all dispensed drugs with the exception of non-exempt or un-listed drugs which means that if there is a chronic use of a drug for an injured worker they are not cutoff automatically pursuant to formulary rules. The legislation provides for special fill and perioperative fill which means that during the immediate days after an acute injury fills can occur. The legislation requires medical necessity for brand name drugs so a physician wanting a brand name drug must provide medical necessity on why that branded drug is needed as opposed to a generic. The legislation limits physician dispensing which is primarily where the medical cost comes into more control as there are very specific limitations on when a physician can dispense drugs out of their office. The legislation requires prior authorization for all compounded drugs which is another cost control mechanism. The legislation also requires the establishment of a pharmacy & therapeutics (P&T) committee that will advise the division of workers' compensation on formulary changes. The formulary went live in January 2018.

Ms. Jones stated that CWCI conducted a study in March 2019 measuring the trends of prescriptions and associated payments. The study identified the leading drugs in the formulary, and measured the utilization review (UR) and independent medical review (IMR) volumes and decisions which is basically the dispute resolution process in CA. With regard to the percent of prescriptions by formulary category, there are exempt drugs, non-exempt drugs - which require prior authorization - and drugs not specifically listed - which also require prior authorization. The CWCI study looked at data from 2016, 2017 and 2018 which is based on paid prescriptions during that time period and the data shows an increase in the percentage of exempt drugs, a decrease in non-exempt drugs – which is what the formulary intended to do – and an increase in not-listed drugs which consists largely of legacy claims.

Ms. Jones stated that with regard to the percent of payments by formulary category, the study showed similar trends: a decrease in exempt drugs; a decrease in non-exempt drugs; and a large increase in not-listed drugs. If you look at the list of the top ten

exempt drugs you can see the reason why there has been a decrease in the payments associated with an increase in utilization as the list consists of basic, generic drugs such as Ibuprofen, Naproxen and Omerprazole. Most of the list consists of nonsteroidal anti-inflammatory drugs (NSAIDs) so there has been a replacement of opioids with NSAIDs primarily. Unfortunately, omeprazole is on the list which is used to treat the side effects of NSAIDs, but it was also used to treat the side effects of opioids so the usage is not expected to decrease much going forward.

Ms. Jones stated that when looking at the list of the top ten non-exempt drugs you see generic Vicodin leading the pack but it is being decreased. You also see an increase in anticonvulsants which are used to treat neuropathic pain so those are increasing as we see the use of opioids decreasing. When looking at the list of the top ten not-listed drugs, the leader is zolpidem which is basically a sleep-aid. Also listed are drugs that are drugs that in a lot of jurisdictions are not probably seen in workers' compensation data but they are compensable for things such as heart disease so that is why they are listed.

With regard to special fills and perioperative fills, special fills are drugs that are primarily opioids that a physician can provide even though it is a non-exempt drug during the initial stage of an acute injury. There is a limitation on both the number of days that they can fill and when they can fill it. The CWCI study shows that special fills represent a very small portion of the overall pharmaceutical utilization. For perioperative fills, those are fills within a certain number of days after a surgery without prior authorization – mostly opioids. Those fills also represent a very small number of the overall medications prescribed and dispensed.

Ms. Jones stated that when looking at the dispute resolution process, the CWCI study looked at how pharmaceuticals are approved, modified, or denied during the UR and IMR process. The study looked at the incremental decisions by formulary category following both UR and IMR. For the UR process – the initial process after a physician requests a certain drug for the treatment of the individual – the study shows that there is a pretty high approval rate and there is not a huge change from 2017 to 2018. There is a small decrease in the approval rate for the non-exempt drugs and there is stability in the not-listed drugs. Looking at the denials and modifications after UR, a modification could be a change in the number of refills from what was requested or a change in the quantity of the drug requested. The study shows that for exempt drugs there is a very low modify rate, a slight increase for non-exempt drugs, and non-listed drugs essentially stayed the same.

Ms. Jones stated that the referral of UR denials and modifications go to IMR so if a physician or the applicant's injured worker's attorney requests that the modification or denial in UR be appealed it goes to IMR. Ms. Jones stated that the study doesn't show a huge change but there is a decrease in those going from UR to IMR which is a good sign if that continues because it will help mitigate some of the conflict resolution costs that are out there in CA. Ms. Jones stated that when looking at the percentage of UR denials and modifications referred to IMR as a proportion of all pharmaceuticals, it is a very small number. It looks like a large number when you look at the raw numbers that go to IMR but overall, it is a very small proportion.

Ms. Jones stated that when the denials and modifications go to IMR, the study shows that there is a pretty high uphold rate which means that the IMR physician agrees with

what the UR physician said with regard to whether or not the drug was medically necessary for the individual. The study does not show a huge change from 2016 to 2018, the biggest drop being a small decrease in the percentage of non-exempt drugs being upheld. Ms. Jones stated that when looking at how often pharmacy is approved, modified, and denied, the study shows that the approves after UR are roughly 95% for exempt drugs before and after the formulary; a decrease in the non-exempt drugs; and a slightly smaller decrease in the not-listed drugs. Looking at the approvals after IMR, the study shows a pretty high approval rate for the medication for non-exempt drugs which are the drugs with ingredients that are specified in the formulary as not exempt under the ACOEM guidelines that are underlying the formulary.

In summary, Ms. Jones stated that the study shows a greater utilization of NSAIDs; lower utilization of opioids; an increased utilization of exempt and not-listed drugs; a high degree of volume of agreement across the dispute resolution chain; and the P&T committee is working to develop other aspects of the formulary that hopefully will contain some of the costs and utilization patterns.

Christine Baker & Len Welsh of Baker & Welsh, LLC delivered a joint presentation. Ms. Baker noted that under the leadership of former CA Governor Jerry Brown, she spearheaded CA workers' compensation reforms. A series of bills took effect in CA to improve medical care delivery, remove waste, friction and fraud, and use the savings to increase benefits for employees and reduce workers' compensation rates for employees. It was a win-win. The formulary was part of the reform legislation enacted which occurred from 2012 to 2016. Ms. Baker stated that the reforms were accomplished by way of labor and management getting together which was a beautiful integration of interests aiming towards improving healthcare quality and delivery; using evidence-based guidelines for presumptive first-level treatment decisions; establishing protocol – a hierarchy of decision making – for escalating to other treatment regimens based on individual circumstances; reducing over-care, i.e. by calling for less invasive, evidence-based care first before surgery is decided upon; and eliminating litigation over issues that belong to the healthcare experts, not lawyers and judges.

Ms. Baker stated that the foundation for the reforms was standardized reference material for first level, evidence-based treatment; a drug formulary fully integrated with treatment parameters; and most importantly, securing trust in the efficacy and integrity of guidelines for medical treatment, which fundamentally depends on addressing the use of drugs as part of treatment. Mr. Welsh stated that formulary issues should be considered in light of how much they can benefit from being integrated into medical treatment guidelines. That is the lesson that CA teaches. Some principles that guided the development of the guidelines and the formulary concepts were: a.) evidence-based; b.) peer-reviewed and nationally recognized; c.) address the full range of tests and therapies commonly utilized particularly for injuries of spine, arm and leg; d.) reviewed or updated at least every three years; e.) developed by a multidisciplinary clinical team; and f.) cost less than $500 per individual user to subscribe. Those were the principles that were used in the study to select what would be the best model to use.

In conducting the study, Rand Corporation pretty much landed on ACOEM guidelines which far and away seemed to model more of the characteristics that CA wanted to see in an evidence based model. There were some statements made about the need for improvements and ACOEM pretty much jumped on those so then CA basically selected ACOEM. First, it was a slow process as they had to build it from scratch so they went

through the process of selecting the best guideline model out there for medical treatment and the next step was to come up with a formulary and integrate that into the guideline model. Mr. Welsh stated that looking at the ACOEM guidelines and what they do for the practitioner, they provide the clinician with a completely analytical framework for what the practitioner is dealing with both in selecting and rejecting a treatment. They provide a first-level default to what you would want to use to treat the patient with a certain condition. They speed up the process and in fact there is now a digital interface that allows you to essentially instantaneously search for the treatments that match up with the condition. The point is that you want to do this rapidly, efficiently, and easily and you want the worker to be getting what is believed to be the best state of the art treatment as indicated by medical evidence. Last but not least, there has to be a drug treatment model as part of it so you cant really leave treatment decisions out of consideration of the drugs that may accompany those decisions.

With regard to how CA selected the formulary, Ms. Baker stated that they were very evidence based in making policy in CA. The RAND study evaluated five distinct formularies: data from Washington state Department of Labor and industries; the Reed Group ACOEM; the work loss data from ODG; the Ohio Bureau of Workers' Compensation; and the Department of Health Services. Ms. Baker stated that they were open to determining what would work best in CA and a key item in that formulary was integrating the formulary to the guidelines. Ms. Baker stated that they established by evidence based criteria as rigorous as those criteria underpinning the MTUS. They facilitated the provision of appropriate medical care to the injured worker by providing a list of the most effective medications, which not only benefits the patient but also minimizes unnecessary disputes and associated medical costs. They really wanted a flow of drugs to move through that were safe and as long as they were linked to the treatment guidelines, they knew that that care could be provided with a presumption of care and could flow easily without delays or interruption of care. They fully integrated with MTUS so that drug prescription, too often a separate consideration, is fully a part of the overall medical treatment plan for the patient – that sped up the delivery of care.

Mr. Welsh stated that the point is integration and evidence based. Regular state of the art updates are critical and in CA there is a special committee created by statute to do that. The formulary also needs to be easily understood and used by the treating physician and select the drugs that are most effective when treating a condition or trying to address an injured worker. Mr. Welsh stated that it is great to have a model that works and CA has gone well down the pathway of making the model work but there are some cultural problems, among others, in that the idea of adhering to guidelines whether in medical treatment or drug treatment decisions is not a concept that all practitioners subscribe to. Some feel that when you adopt a guideline model that it is limiting their discretion and there is perhaps a perception that practitioners are going to be limited in their choices or the guidelines are actually going to get in their way.

Mr. Welsh stated that he and others believe that once they understand what the guidelines do and how easy it is to access the information they provide then they are going to see that they will actually help their practice, not hinder it. But people have their way of doing things and you have to address where they are and take the time to help them understand how they can improve their own practices. It is also not just a matter of the medical practitioner but also claims adjusters. In CA, claims adjusters don't have access to the guidelines and formulary by law – the physicians and most nurses do. Granting claims adjusters access to the guidelines and formulary is something that is

being considered in CA. Mr. Welsh stated that he and others believe that the more broad range of access there is to the treatment model, the more people are going to adopt it and utilize it. You do need to have the claims adjuster understanding what the physician is doing as the physician makes his or her choice. The guidelines help smooth that process. Mr. Welsh stated that there has been a lot of work done in CA to plow this new ground and there has been a lot of success so far. The figure is almost $2 billion dollars per year in frictional costs that has been chopped out of the system since these reforms began in 2012 and that has been documented by the CA Bureau of Workers' Compensation. It is believed that medical care is improving and that anybody that is considering a national model should be looking as much as they can at what has worked and has not around the nation.

Daniel Blaney-Koen, Senior Legislative Attorney at the American Medical Association Advocacy Center (AMA), stated that controlling costs and ensuring the right treatment at the right time are two of the primary issues he will address during his remarks. The AMA wants to ensure that overall, the formulary provides sufficient information to the physician and other healthcare professionals at the point of care, and also ensure sufficient choices in the treatment decision. A decision on whether or not to prescribe a medication is integral to the overall treatment plan. Also, if a medication is not exempt then there should be a clear, transparent and efficient appeals process to be able to adjudicate whether or not the patient ultimately receives that treatment.

Mr. Blaney-Koen stated that the claims review process should also be between healthcare professionals and ideally, the AMA supports that it be between physicians of the same specialty in the same practice to be able to have conversation with equal expertise. For example, if a physician's judgment is to prescribe a medication for a muscular skeletal pain, the person on the other end of the phone call should also understand the treatment for muscular skeletal pain – two orthopedic surgeons for example. With regard to the Model, Mr. Blaney-Koen stated that there is a need for state flexibility and physician and other healthcare professional input. While a national formulary might be a starting point for some, the AMA believes that a formulary really needs to take into account state-specific needs. Moreover, it should be developed with input from physicians and other healthcare professionals, pharmacists, and others who are treating patients in that state. The workers' compensation agency developing the formulary should have the benefit of the expertise and deliberative process from a P&T committee that is well established. That P&T committee should also be free of conflict – free of conflict, for example, from the pharmaceutical, PBM and health insurer industry as it is important to make sure P&C committee decisions for the formulary have the benefit of ensuring not just the direct potential conflicts of interest but even the perception of conflicts of interest to make sure that those decisions of what medications are in a formulary are truly decided on the benefits of medical treatment.

Mr. Blaney-Koen stated that the formulary should be transparent. In many states it is probably the exception rather than the rule that the physician and other healthcare professionals have information about what is the exempt and non-exempt information in a formulary at the point of care. If they have that information then the appeals process would probably be greatly reduced, so to the extent that efforts – whether regulatory or statutory – can further that information being available at the point of care, that would benefit everybody and reduce the cost of the appeals process and the IMR process. If 80% to 90% of those decisions are upheld in CA then if the physician knows at the point

of care perhaps that is an opportunity for the physician to provide the exempt medication at the beginning.

Regarding cost, Mr. Blaney-Koen stated that we know that much has been made in the news and elsewhere about the opioid epidemic and the workers' compensation industry has particular interest in ensuring increased access to non-opioid and non-pharmacologic pain care. Nationally, there has been a 33% reduction in opioid prescriptions from between 2013 and 2018, and there was a 12.5% decrease just between 2017 and 2018. It is heartening to see that in CA there are many non-opioid options on the formulary. It is known that the use of restrictions and arbitrary thresholds is something that a lot of workers' compensation agencies and states have adopted but the AMA would ask a different question – whether or not those restrictions have led to increases in access to non-opioid pain care and other types of benefits. If the formulary does not have those then the formulary needs further revision to make sure that those options are available.

Mr. Blaney-Koen stated that the AMA understands that formularies are a tool to reduce cost but the pharmaceutical benefit needs to be integrated into the overall treatment plan. The use of guidelines such as ACOEM or other guidelines that are put forward by the medical industry is encouraged by the AMA. Mr. Blaney-Koen stated that his remarks are general principles and reform ideas for the Model and the AMA thinks that there are several revisions that could help the Model take advantage of programs that appear to be working not only in CA but elsewhere. The AMA would be happy to provide specific revisions to the Model in the interim period between now and the Committee's next meeting.

Mitch Steiger, Legislative Advocate at the California Labor Federation (CLF), first thanked the Committee for its work in fully discussing and analyzing proposals such as the Model as it is important to do so before it is sent to states for consideration. Having been in the labor movement for 20 years, Mr. Steiger stated that he has seen its thoughts on healthcare in general and prescription drugs specifically really shift. Before the Affordable Care Act (ACA), the focus was on employers not spending enough on healthcare and treatment and over time after the ACA took effect and the opioid crisis started the labor movement did a 180 and you will now not find many labor advocates stating that we don't spend enough on healthcare whether its group health or workers' compensation.

Mr. Steiger stated that when the issue of a formulary in CA showed up around 2014 the labor movement was generally open to it as the opioid crisis had been ravaging its membership for a long time and the labor movement saw it up close and personal when the CA workers' compensation reforms started in 2012 by speaking personally to a lot of the workers who stated that opioids ruined their lives and presented a lot of problems that a formulary seemed to provide a lot of solutions to. Accordingly, the labor movement was definitely open to the idea but at the same time it was not exactly something that its members were clamoring for as phone calls were not being received with requests to limit treatment options. The labor movement, therefore, went into it optimistically but cautiously with the goal of ensuring that some broad concepts were in the legislation that would guide the specific regulatory process.

Mr. Steiger then reviewed the four big concepts. The first was to not eliminate access to medically necessary pain management. Realizing a big goal of the formulary was to

deal with opioid over-prescription it was important to make sure that it not be too abrupt in cutting workers off or making it too hard for them to get treatment. That is really where most of the labor movement's problems with the workers' compensation system happened was when workers could not get the medically necessary treatment that they need so it was important to ensure that the formulary did not make that problem worse. By the same token, it was important to make sure that workers who were on a drug that was allowed under the old system and may not be allowed under the formulary that there was a gradual tapering and not a shift to a new drug.

Third was to protect off label use that a lot of the workers spoken to, especially those with complex claims such as back pain that didn't respond to the guidelines and MTUS, stated that a lot of the time the only thing that worked was something "weird" such as Botox injections in their back which at the time was unheard of but a lot of workers found benefit from that. Therefore, it was important to make sure the formulary did not cut off access to that type of treatment when it was the only thing that worked for an injured worker. Fourth, it was important to make sure that the formulary was updated in a timely fashion so that as new drugs came on the market, especially those that offer a lot of benefit to a lot of workers, that that would still be something that would be on the formulary as soon as reasonably possible so that workers could benefit from that.

Mr. Steiger stated that when the regulatory process started one of the goals that the labor movement wanted to focus on was to learn from the experience of workers in other states. A lot of research was conducted by talking to workers in Washington state, Texas, and some of the other states with formularies to see what their experience was. No one really had a negative experience to relay which was encouraging and helped ease some concerns about what it would be like to live in a world with a formulary.

Mr. Steiger stated that one issue that he would highlight for anyone considering moving in this direction is to take a hard look at the dispute resolution process and make sure it works as well as it can. The big workers' compensation reform done in 2012 centered around that. Prior to that reform, if there was a dispute over treatment it went through the CA workers' compensation appeals board courts where there were judges who were not doctors making these decisions and it led to an absurd, terrible spectacle of workers spending a year and a half in court to get a prescription for opioids approved. One worker spent 18 months trying to get aspirin approved. No sane person would think that makes sense so if there are issues like that in the dispute resolution process it is really important to make sure they are taken care of before you build a formulary on top of something with that many flaws. The system works much better now and that is part of the reason why the formulary seems to be having the success that it does. The UR and IMR process now is far more preferable than the former process and it is almost impossible to imagine building a formulary on top of the old system.

Mr. Steiger stated that another big issue to highlight is how the process of getting out of the formulary works. The system in place now has not been in place for that long so there are a lot of specific questions left to be answered but it is clearly something that happens a lot as there are a lot of cases where the non-exempt drugs are not what the worker needs or that even the exempt drugs are not what the worker needs to get the maximum benefit. The process needs to be something that physicians can understand, and workers and their attorneys can understand so that the worker doesn't find themselves without access to those drugs. That is an important guiding principle to have in the back of your mind when talking about a formulary. Probably all of us at some

point in our lives have been in a place where we were in excruciating physical pain and we needed some sort of pain management to get through that and it is difficult to imagine going through that without access to the drugs you need, or being told that you have to wait 14 days for it. It is not a theoretical exercise as it is something that happens to a lot of the labor movement's members every day. Right now in CA thousands of workers are probably going through that so it is important to ensure that the formulary does not just allow them to get the treatment they need but that it happens as quickly as it possibly can.

Mr. Steiger stated that the final point is to be very careful with the research both pre and post formulary where numbers show that certain drugs are not being prescribed as much as they were so there is an unspoken implication that that is a victory – spending less on prescription drugs or prescribing fewer opioids. In some sense it is but hidden in those numbers are a lot of individual workers who may or may not be getting the care that they need and therefore while such broad data is extremely helpful, to the extent possible the research should involve talking to actual workers. Mr. Steiger stated that a lot of his job is answering calls from injured workers whose life is falling apart because they cant get the treatment that they need. No workers' compensation system completely prohibits that but there is always room for improvement to make even the best system work better. By talking to injured workers and listening to their stories you can then figure out what is causing the problem such as doctors struggling with the formulary and perhaps benefiting from a more electronic system, or the electronic system may be causing the problem. As encouraging as the data is, there is still a lot to learn to make sure the formularies work as well as they can for workers.

Thomas Naughton, President of MAXIMUS Federal Citizen Services, stated that MAXIMUS is an IMR organization that has worked with CA since it implemented its IMR program in workers' compensation and has also worked with Arizona and Montana, and soon New York. In one of its programs MAXIMUS also manages all appeals for the Medicare Part D program nationwide. Therefore, MAXIMUS has a lot of experience with workers' compensation dispute resolution as well as pharmacy and prescription dispute resolution. MAXIMUS is supportive of the implementation of a formulary as well as formulary guidelines. Medicare has a formulary and states should take the time to look at the way Medicare does things as it could be very helpful to states.

Mr. Naughton stated that when setting up the program, it is important to make sure it is most effective and New York is in the process of setting up an entirely electronic prior authorization process for their prescription formulary. That process not only makes it more efficient but also more transparent meaning that the systems can be set up where a physician submits a prescription and the system will then tell the physician "if you want this prescription this is the information you have to submit." So if the physician does not have that information to submit at that time she cannot submit the prescription or else she will be told by the system that the request is denied until the information requested has been provided. Therefore, it works not only as preventing unnecessary prescriptions that are going to be automatically denied, it educates the physicians as to what they need to do to ensure they are doing everything they need to do to ensure the injured worker gets the prescription that they need.

With regard to the prior authorization process, Mr. Naughton stated that many states will have initial denial, allow the claims administrator to engage in a UR, and then have an IMR. Although those timeframes are faster than regular medical disputes, it still takes a

lot of time and folks generally want to know whether they are going to get their prescription as quickly as possible. MAXIMUS does not believe it is necessary to have an initial denial, a UR, and then an IMR. Rather, MAXIMUS believes that: a.) the IMR program is in agreement with UR a lot of the time so you do not need both (the CA data shows this); and b.) it should not work for any of the claims administrators or employers but is rather an independent organization that provides independent physicians that are specialty matched information to make the decisions and that will provide cost savings and time savings to the program.

Mr. Naughton stated that if states are considering IMR it is important to not allow the employers or claims administrators to contract with an IMR of their choosing, rather the states should contract with the IRO and if states want to have the impact that CA and other states are having they should contract with one IRO, not multiple IRO's. Contracting with one IRO allows the IRO to develop a relationship with the state where the data is shared. MAXIMUS shares a lot of its data with CA and CA has used it for a number of fraud takedowns the past few years and also used it to educate. Mr. Naughton further stated that guidelines are good but they are only guidelines so it is important to have formulary exception processes for injured workers and to allow independent physicians to look at those formulary exceptions to see if the injured worker falls into them.

On behalf of the American Association of Payors, Administrators and Networks (AAPAN), Robert Holden stated that AAPAN believes that the Model should contain more language regarding a state agency-developed formulary. AAPAN also believes there should be some additional discussion and language regarding stakeholder outreach of a formulary, in particular the transition period to the formulary. Lastly, AAPAN believes that the formulary needs to complement medical treatment guidelines. Mr. Holden stated that AAPAN submitted written comments on the aforementioned concepts and looks forward to working with the Committee as it further develops the Model.

Ken Eichler, Vice President of Government Affairs at ODG by MCG Health, first thanked the Committee for working on the Model, particularly Rep. Lehman and Rep. Ryan Mackenzie (PA) who were champions of this issue in their own respective states and stood up to opposition. Mr. Eichler stated that the question is not whether or not to adopt a formulary in a state but rather whether or not to legislate and regulate it. Whether or not you realize it, formularies are used in every state. In many states where formularies are not formally adopted, legislated or regulated, they are done behind the curtains so to speak. This is an opportunity to bring it in front of the curtain to create transparency, protect injured workers and to protect state commerce.

Mr. Eichler stated that he was at a meeting of the National Institute for Occupational Safety and Health (NIOSH) yesterday that focused on the opioid and prescription drug crisis - formularies were a popular topic. Interestingly, there were very few objections to formularies and the labor movement did not oppose. In Indiana, the labor movement testified about the importance of formularies getting injured workers back to work and the fact that the prescriptions that are being given preclude injured workers from going back to work. It is proven that formularies expedite and facilitate the delivery of care.

Mr. Eichler stated that formulary bills are do no harm bills as they protect everyone by creating transparency. Regarding many drugs not being listed on a formulary, in most

states most of the drugs that are not listed in CA are actually listed. Recent state adoptions including Kentucky have identified that eight to ten of the top prescribed drugs are preferred drugs and on the drug lists, so formularies are not going to slow down the process at all. It has been mentioned that drug formularies are used in other forms of insurance and it makes it easier for the doctors if they have a list as there is no mystique about it. There is a printed list that can be shared with an injured worker so at the time of the patient encounter it does not become a hostile situation – the doctor can "just say no."

Regarding P&T committees, one of the features in CA vs. IN is that IN does not have the resources of a huge department and budget that CA does – most states don't. Therefore, the Model allows states to specifically either work how CA did or do a more slimmed-down program like IN and other states. Regarding peer to peer and UR, Mr. Eichler stated that states implementing formularies are coming up with innovative peer to peer options, one of which just came out of Kentucky where physicians currently are in a like-to-like/same-specialty system but going forward they will now have the option of deferring to a second-tier provider such as a physician's assistant in their office or a nurse practitioner or if it is a question of physical therapy on the guidelines, a physical therapist – with the approval of the treating physician – can engage in the peer to peer. The regulations further create situations where the treating physician names the time and date of the peer to peer review for the phone conversation to cut out the problem of missing each other. Overall, the Model is a tool to create transparency and better the outcomes for injured workers.

Asw. Maggie Carlton (NV), Chair of the Committee, asked what CA has seen for what the timeframe is for an appeal to get an injured worker a drug not on the formulary. Ms. Baker stated that if the drug is not on the formulary it can get approved by UR if there is sufficient documentation by the doctor. If the claims adjustor continues to refuse it goes on to IMR and there are timelines of 14 days for a decision. Mr. Naughton stated that he believes it is 14 calendar days and it may be ten, and noted that it will soon be reduced to five to seven days.

Rep. David Santiago (FL), Vice Chair of the Committee, asked Mr. Blaney-Koen to follow up his earlier comment regarding a formulary needing to be flexible to adapt to state specific needs with examples of what such needs might be. Rep. Santiago also asked Mr. Blaney-Koen to follow up on his earlier comment regarding the P&T committee needing to be free of conflicts, and noted that he believes that there may be conflicts in the medical field as well – not just the pharmaceutical and insurance industries.

Mr. Blaney-Koen stated that yes, there are conflicts in the medical field and as a first step all conflicts should be disclosed as not all conflicts would require someone to preclude themselves. But all conflicts should nevertheless be disclosed so that the state, P&T committee, or ethics board would be able to evaluate whether or not that conflict would require that individual to recuse him or herself from a decision of whether a medication should be included. It is possible that that individual would have to recuse him or herself for a specific drug class but necessarily all of the medical decisions on a formulary. That goes for the healthcare professionals on a P&T committee, and for a representative or an employee of a PBM for example that is on a P&T committee – that is a conflict that could potentially require recusal from many more decisions. Conflict does not necessarily automatically require recusal or removal from a decision but it should absolutely be disclosed and transparent.

In terms of the state-specific question, Mr. Eichler made a great point that not all states have the same resources. So a state may want to use the ODG guidelines as a starting point but for a variety of reasons a state may want to make certain changes to that in concert with working with labor and management. Not all of the medications or other decisions that would go into creating a formulary would be the same for IN as they would for CA or Illinois. One national guideline might be a starting point but should not be the endpoint.

Rep. Lehman noted that in the current draft of the Model, references to a specific formulary were removed. States need to be very specific on what fits them the best. Rep. Lehman believes the Model is in a good position to answer the question of what formulary to use in that it is up to the states to decide. Rep. Lehman noted that there was also a concern raised regarding the number of days within which a decision must be reached regarding a UR decision. The current draft requires five days and Rep. Lehman stated he has interest in moving it up to three days. Ms. Jones stated that in CA there is the opportunity to request an expedited review which requires a decision to be made within 72 hours.

Rep. Mackenzie stated that while working on this issue in PA one thing they looked at was using a hybrid model – adopting a national guideline and formulary and then doing state specific actions just as contemplated in the Model. Rep. Mackenzie asked Ms. Baker and Mr. Welsh how the RAND study was used in the CA process – did it become the definitive statement on which model was going to be adopted or did a CA department or agency or the legislature weigh in on that recommendation. Ms. Baker stated that the department weighed in as the RAND study was advisory only and its purpose was to evaluate, with certain criteria, the options for CA. Ms. Baker stated that most of the formularies were good and CA wanted to integrate theirs with their guidelines – that was the ultimate decision and it was done by the agency. Rep. Mackenzie asked if that was initiated by legislation or regulation. Ms. Baker stated that it was initiated by legislation – the legislature directed the agency to conduct a study to evaluate which was the best formulary product and then the agency could make that decision.

Rep. Wendi Thomas (PA) asked if research was conducted as to how quickly injured workers got back to work. That would help the argument for formularies if injured workers are getting back to work faster and the conversation is not just about cost savings. Ms. Baker stated that since multiple workers compensation reforms were enacted during the timeframe mentioned earlier it was very difficult to isolate that statistic. Overall, wage losses are improving for workers and there are ongoing wage loss studies and we know that if there is less wage loss they are returning back to work.

Rep. Lehman thanked everyone for their participation and stated he looks forward to making some changes to the Model, having an interim committee conference call, and adopting the Model in December.

“STATE OF THE LINE” – AN UPDATE ON THE STATUS OF AND TRENDS IN THE WORKERS’ COMPENSATION INSURANCE MARKETPLACE

Jeff Eddinger, Senior Division Executive – Regulatory Business Management at the National Council on Compensation Insurance (NCCI), stated that his presentation today is an abbreviated version of what is given at NCCI’s annual symposium and anyone who

wants to see that can view it on NCCI's website. Mr. Eddinger stated that for workers' compensation net written premium for private carriers and state funds, it is up 8% for the latest year to $48.6 billion dollars. That large increase is actually due to reinsurance so when looking at direct written premium it is flat. Net written premium has increased more than 40% since 2010 and this is the first time it has exceeded the peak of 2005 prior to the great recession where it hit $47.8 billion dollars.

Direct written premium decreased by only 0.6% and there is a little bit of variation by state. Kentucky had the biggest increase where a self insured fund converted to a private carrier so that is what caused that. There are some offsetting factors that are keeping the premium flat in workers' compensation. Payroll is up about 5% but loss costs are down almost 9%. Carrier pricing is up less than 1% and other factors are up about 3% so the overall change is almost nothing.

Mr. Eddinger stated that when looking at payroll you can see the separate impacts of wages and employment. Most of the increase is due to wages as they are up 3.3% and they increased across all sectors of employment. Employment is up about 2% and for the last few years or so construction is up more than other sectors. The loss costs for NCCI states are down 10% in 2019 which is the largest single year decrease followinga 9.7% decrease the year before. The loss costs impacts have been relatively stable for the past 15 years basically keeping within plus or minus 5% but the cumulative decrease during this period is almost 40%. Mr. Eddinger stated that for the most recent rate-filing cycle showing approved changes by state as of March, only one state (Hawaii) had an increase in loss costs. Fourteen states experienced double digit decreases. That pattern was similar last year as well.

Mr. Eddinger stated that NCCI files loss costs but the carriers file final rates so when we talk about carrier discounting that is the pricing they attach to the loss costs. The impact of that has continued to be very small and flat for the past six or seven years. However, there is a cyclical nature of carrier pricing. The discounting exceeded 20% below NCCI loss costs back in 1998 and 1999 and in the next cycle it was much more moderate with discounting off of loss costs being about 8% in 2000 and 2010. Now it is very close.

Regarding the components of carrier pricing, Mr. Eddinger stated that in recent years the components have pretty much offset each other so it has been a mix of very small, downward dividends, moderate downward scheduled rating credits, and upward loss costs departures. The combined ratio which is losses and expenses added together divided by the premium – a combined ratio of 100% would mean that you are breaking even as you are taking in exactly enough money to pay claims – for 2018 is projected to be 83%, the lowest it has been in many years dating back to the 1930s. This is the fourth straight year of combined ratios under 100% and in 2014 the combined ratio was exactly 100%. These results are really unprecedented in the workers' compensation system and we are in uncharted territory when it comes to these results.

Mr. Eddinger stated that when looking at the components of the combined ratio what is really driving it is the loss ratio so we are seeing good experience. The loss ratio dropped from 49% to 43% and all the other components remained exactly the same. Regarding investment gain in workers' compensation insurance transactions, the 2018 estimate is 9%, down from 12.6% the previous year – still below the long term average of about 13%. Investment gains are not as cyclical as the underwriting results looked at before. They are pretty good considering the low interest rate environment we have

been in now for a while. When looking at the operating results we are basically combining the underwriting results with the investment results so an 83% combined ratio gives you a 17% underwriting gain and adding that to a 9% investment gain arrives at a 26% operating gain for the latest year, almost four times the long term average. In fact, the last six years have been above the long-term average of about 7%. However, it is very cyclical, so you really need to look at a long term average to get the full picture of the results.

Mr. Eddinger then discussed what is driving the losses. Workers' compensation lost-time claim frequency is down another 1% for the latest year and decreases the previous three years have exceeded the long term average by about 4%. Over the last 20 years, claim frequency is down more than 50%. The moderate decrease in frequency for the latest year is likely caused by a strong economy, job growth, inexperienced workers entering the workforce. Also, a severe winter resulted in more slip and fall injuries than had previously been seen. Be that as it may, claims frequency is down again.

Looking at the claims severity – or the average cost per claim – for indemnity/wage replacement, it is up 3% in 2018 to $24,600 for lost time claims which is pretty much in line with wage inflation. It was more than 4% the prior year. NCCI has seen increases in both severity and medical moderate in recent years. Since indemnity is wage replacement you would expect it to move in line with wage inflation and from 2008 onwards that is true because the gap has remained pretty much the same but prior to that that was not true. Indemnity severity grew faster than wages from 1998 to 2008 (2% per year). However, since then it is only growing 1% faster. Over the past five years, most states also show an increase in indemnity claim severity. The decreases in certain states were caused by certain reforms enacted.

Mr. Eddinger stated that for medical lost-time claim severity, the latest year shows an increase of 1% and the prior year showed an increase of 4%. It is a similar story as it was for indemnity in that in the latest ten year period, medical severity is moving in line with the medical price index. Prior to that they had been going up much faster than the medical price index – more than 4% per year. The story you want to take away for indemnity and medical severity is that they have moderated in recent years and claim frequency continued to go down.

Regarding the residual market – where business get coverage when they cannot find coverage in the voluntary market – the story is that it has remained extremely stable with about $1 billion dollars of premium over the past seven years. When you turn that into a residual market share – in other words a percentage of total premium – it has been about 7-8% over the last six years which has proven to be a very manageable level. The combined ratio in the residual market – which is where the worst of the worst risks are, although most states require that the residual market be self-funded – even though the current year shows 107%, over the past four to five years it is close to breaking even. Overall, the results are the best they have been in many years and the residual market is stable so it shows the system is working very well.

Rep. Lehman asked if NCCI is seeing any impact on costs in states that have adopted fee schedules. Rep. Lehman stated that IN is seeing from the carrier side very aggressive back to work programs and ramped up loss control but they are also seeing a fee schedule on hospitals and that reduced their rates in IN by about 8%. IN is now looking to possibly adopt a fee schedule for other providers. Mr. Eddinger stated that

most states do have fee schedules and have had them for years and the activity surrounding them has been no more than it has been in prior years. Mr. Eddinger stated that he believes Virginia just implemented a fee schedule, but little tweaks here and there can result in costs savings which is something that NCCI frequently sees.

Asw. Ellen Spiegel (NV) stated that with regard to the information about the direct written premium change, Nevada was the second highest increase and accordingly asked what the increase was attributed to and whether it was overall premium that is written or on a per-employee basis. Mr. Eddinger stated that the information showed the overall premium in the state and he does not have any specific notes on the Nevada increase. Mr. Eddinger stated that he would follow-up with Asw. Spiegel after the Committee's meeting.

Rep. Santiago asked if NCCI is seeing states experience significant cost savings from adopting and/or implementing formularies. Mr. Eddinger stated that NCCI recently published information on formularies and offered to share it with Rep. Santiago after the Committee's meeting.

ADJOURNMENT

There being no further business, the Committee adjourned at 11:30 a.m.