HB

370

<TARGET><BILL>HB 370</BILL><SUBJECT>HB 370</SUBJECT><COMM>HJUD28</COMM></TARGET>

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: April 7, 2014 **FURTHER REFERRALS:**

Date of Committee Action: 4/14/14

The JUDICIARY Committee considered: **HB 370**

HOUSE BILL NO. 370
"An Act relating to employer drug testing; requiring the Alaska Workers' Compensation Board to adopt regulations relating to the prescription of controlled substances to employees; and limiting the prescription of controlled substances to employees."

HB 370 AWCB CONTROLLED SUBSTANCE PRESCRIPTIONS

Recommends it be replaced with [ ] HCS *or* [✓] CS *for* HB 370 (LEC)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR _____ **[ ] Same Title [ ] New Title**

[ ] attach amendments
[ ] add new referral to _____Committee
[ ] Letter of Intent_____Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
DHS
LWF
LAW
LEG
MVA
DNR
DPS
REV
DOT
UA

***NEW* FISCAL NOTES**
*FN# is assigned by Chief Clerk's Office

*FN#	List by Dept(s):	Fiscal	Indet.	Zero

***PREVIOUS* FISCAL NOTES**

FN#	List by Dept(s):	Fiscal	Indet.	Zero
1	ADM			✓
2	LWF			✓

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
	Pruitt			X	
	Wolf			X	
	Gruenberg			X	
	LYNN			X	
Chair: Wes Keller	Keller	X			
Chair:					

ALASKA STATE LEGISLATURE

REPRESENTATIVE KURT OLSON

- Chair: Labor and Commerce
- Vice Chair: Rules
- Member: Resources, Community & Regional Affairs, Economic Development Trade & Tourism, Fisheries, Legislative Budget & Audit

Session: January – April
State Capitol, Room 24
Juneau, AK 99801-1182
Phone: 907-465-2693
Fax: 907-465-3835

Interim: May – December
145 Main Street Loop, Ste. 221
Kenai, AK 99611
Phone: 907-283-2690
Fax: 907-283-2763

Official Business

MEMORANDUM

DATE: April 5, 2014

TO: Representative Wes Keller, Judiciary Chairman

FROM: Representative Kurt Olson

RE: Hearing Request for HB 370

At your earliest convenience, I respectfully request the floor scheduling of the CS for HB 370 "An Act relating to employer-required drug testing; requiring the Alaska Workers' Compensation Board to adopt regulations relating to the prescription of controlled substances to employees; and relating to the prescription of controlled substances to employees."

Please do not hesitate to contact my staff, Anna Latham, at 465-4530, with any questions or concerns about this legislation. I look forward to hearing from you and discussing the bill in further detail.

Thank you for your consideration.

Email: rep.kurt.olson@akleg.gov

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Official Business

HB 370 Sponsor Statement

"An Act relating to the employer drug testing; requiring the Alaska Workers' Compensation Board to adopt regulations relating to the prescription of controlled substances to employees; and limiting the prescription of controlled substances to employees."

Since the 1990's, prescription drug use has tripled in the United States, and is now considered an epidemic by the Centers for Disease Control. Deaths as a result of overdoses from prescription drugs have quadrupled since 1999, and exceed deaths from heroin and cocaine combined. There has been a growing reliance on prescription drugs to treat chronic pain within the workers' compensation system as well.

For workers' compensation claimants, the use of prescription drugs, and in particular, opioids can lead to addiction, increased disability or work loss, and even death. It has been estimated that at least 200 deaths per year are the result of opioids in workers' compensation cases in the United States.

Not only are long term opiate prescriptions detrimental to employees, they are extremely costly to employers. In 2011, prescription drugs comprised nearly twenty percent of medical costs in workers' compensation claims in Alaska. In cases where the claimant has been prescribed a controlled substance for more than ninety days, the long-term costs to the employer are estimated to range from one thousand to twelve thousand dollars monthly.

HB 370 discourages the use of long-term opioids by restricting powerful narcotics to a 30 day supply for claimants. This serves as a deterrent to long-term use and abuse of opioids by requiring contact with a provider who is prescribing pain medication. HB 370 also enables employers to monitor their employees to ensure that they are not diverting prescriptions, by allowing employees to undergo drug testing if the employee has been prescribed a controlled substance for over 90 days. Not only is there a cost savings embedded in restricting the supply of opioid prescriptions, there is the potential to save human lives.

Email: rep.kurt.olson@akleg.gov

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Official Business

HB 370 Sectional Analysis

Section 1. Amends AS 23.10.620; An employer may require an employee to be drug tested for a controlled substance prescribed to the employee, if the employee has been prescribed a controlled substance listed in schedule IA for more than 90 days as the result of a workers' compensation claim. A negative test result may result in the denial of future payments for the controlled substance by the employer.

Section 2. Amends AS 23.30.005; The Workers' Compensation Board shall adopt regulations relating to the prescription of controlled substances to implement AS 23.30095 (p) and (q).

Section 3. Amends AS 23.30.095; A physician may not prescribe more than a 30 day supply of a controlled substance listed in schedule IA under AS 11.71.140, or a controlled opium, substances in schedule IIIA under 11.71.160, or schedule VA under AS 11.71.180. An employer may not be liable for future payments of schedule IA controlled substances prescribed to an employee if the employee receives a negative drug test result.

Kindly note that a sectional analysis of a bill should not be considered an authoritative interpretation of the measure itself. The legislation is the best statement of its contents.

Email: rep.kurt.olson@akleg.gov

Fiscal Note

State of Alaska
2014 Legislative Session

Bill Version: CSHB 370(L&C)
Fiscal Note Number: 1
(H) Publish Date: 4/7/14

Identifier: HB370-DOA-RM-03-21-14
Title: AWCB CONTROLLED SUBSTANCE PRESCRIPTIONS
Sponsor: LABOR & COMMERCE
Requester: House Labor and Commerce

Department: Department of Administration
Appropriation: Risk Management
Allocation: Risk Management
OMB Component Number: 71

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2015 Appropriation Requested	Included in Governor's FY2015 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Fund Source (Operating Only)							
None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2014) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2015) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed? N/A

Why this fiscal note differs from previous version:

Not applicable, initial version

Prepared By: Scott Jordan, Director — Phone: (907)465-5723
Division: Risk Management — Date: 03/21/2014 10:45 PM
Approved By: Curtis Thayer, Commissioner — Date: 03/21/14
Agency: Department of Administration

FISCAL NOTE ANALYSIS #1

STATE OF ALASKA **BILL NO.** CSHB 370(L&C)
2014 LEGISLATIVE SESSION

Analysis

HB 370 authorizes employers to drug test injured workers for controlled substances listed in schedule IA under AS 11.71.140, and authorizes the Alaska Workers' Compensation Board to adopt regulations under the Workers' Compensation Act pertaining to prescribing controlled substances listed in schedule IA under AS 11.71.140 or controlled opium substances listed in schedule IIIA under AS 11.71.160.

There is no fiscal impact to the department anticipated as a result of this legislation.

Fiscal Note

State of Alaska
2014 Legislative Session

Bill Version: CSHB 370(L&C)
Fiscal Note Number: 2
(H) Publish Date: 4/7/14

Identifier: HB370-DOLWD-WC-03-14-14
Title: AWCB CONTROLLED SUBSTANCE PRESCRIPTIONS
Sponsor: LABOR & COMMERCE
Requester: House Labor and Commerce

Department: Department of Labor and Workforce Development
Appropriation: Workers' Compensation
Allocation: Workers' Compensation
OMB Component Number: 344

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2015 Appropriation Requested	Included in Governor's FY2015 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Fund Source (Operating Only)							
None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2014) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2015) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/15

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By: Michael Monagle, Director — Phone: (907)465-6059
Division: Workers' Compensation — Date: 03/11/2014 03:00 PM
Approved By: Dianne Blumer, Commissioner — Date: 03/14/14
Agency: Office of the Commissioner

FISCAL NOTE ANALYSIS #2

STATE OF ALASKA
2014 LEGISLATIVE SESSION

BILL NO. CSHB 370(L&C)

Analysis

HB 370 authorizes employers to drug test injured workers for controlled substances listed in schedule IA under AS 11.71.140, and authorizes the Alaska Workers' Compensation Board to adopt regulations under the Workers' Compensation Act pertaining to prescribing controlled substances listed in schedule IA under AS 11.71.140 or controlled opium substances listed in schedule IIIA under AS 11.71.160.

There is no fiscal impact to the department anticipated as a result of this legislation.

Drug Overdose Deaths Occurring in Alaska [1,2]

Category	2008		2009		2010		2011		2012	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Prescription Drugs	105	78.9	104	79.4	68	80.0	56	51.4	71	57.7
Opioid Pain Relievers	82	61.7	80	61.1	59	69.4	48	44.0	51	41.5
Illicit Drugs	35	26.3	36	27.5	23	27.1	40	36.7	53	43.1
Heroin	7	5.3	7	5.3	4	4.7	12	11.0	20	16.3
Cocaine	26	19.5	24	18.3	15	17.6	14	12.8	19	15.4
Other Illicit	5	3.8	11	8.4	5	5.9	16	14.7	23	18.7
Unspecified Drugs	8	6.0	6	4.6	2	2.4	13	11.9	13	10.6
Total Deaths	133	100	131	100	85	100	109	100	123	100

Footnotes

[1]This table includes deaths where a drug was listed as an underlying or contributing cause on the death certificate. A death certificate may have more than one drug noted.
[2]2012 data is provisional and subject to change.

Source: Alaska Bureau of Vital Statistics
Last updated on 01/22/2014

Opioids Wreak Havoc on Workers' Compensation Costs

August 2012 • Lockton Companies

I OVERVIEW

Prescription drug abuse is the nation's fastest-growing drug issue, an epidemic affecting all of society and workers' compensation in particular. **Prescription opioids are presently the number one workers' compensation problem in terms of controlling the ultimate cost of indemnity losses.** There has never been a more damaging impact on the cost of workers' compensation claims from a single issue than the abuse of opioid prescriptions for the management of chronic pain. Nationally, an estimated 55 to 86 percent of all claimants are receiving opioids for chronic pain relief. However, the overwhelming consensus of evidence-based medicine does not support its long-term treatment protocol outside of very specific cases, most of which involve end-stage cancer treatment.

The aggressive prescribing of opioids to treat chronic pain is a relatively new phenomenon in workers' compensation's 100-year history. Overdose deaths from prescribed painkillers have increased 300 percent since 1999, when the nation experienced approximately 15,000 fatalities, more than cocaine and heroin combined, and they originate from prescriptions, not home labs. The misuse and abuse of prescription painkillers was responsible for more than 475,000 ER visits in 2009, doubling in just five years[1]. Employers' workers' compensation claims are caught right in the middle of the foray.

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> "Prescription opioids are presently the number one workers' compensation problem in terms of controlling the ultimate cost of indemnity losses."

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Pharmacy is growing disproportionately to total medical costs. Pharmacy only accounted for about 2 percent of

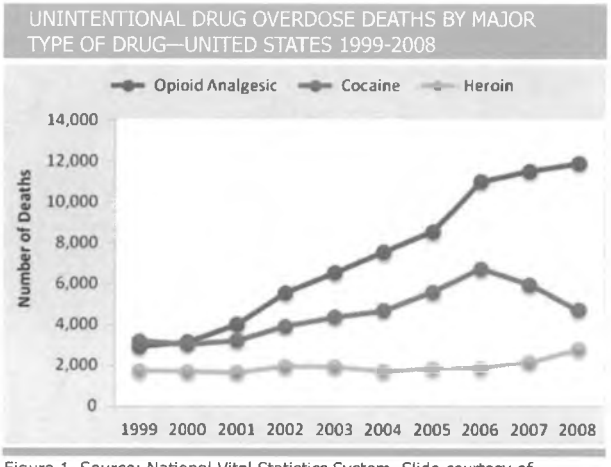


Figure 1. Source: National Vital Statistics System, Slide courtesy of National Institute on Drug Abuse

medical in 1990, grew by 400 percent by year 2001 and almost another 90 percent by 2010. Today, on average, workers' compensation prescription drugs account for 19 percent of total medical spend, which equates to slightly less than 11 percent of "ultimate developed" total incurred claim costs[2]. Opioids themselves account for an average of 25 percent of that pharmacy spend, and 35 percent or greater for claims over three years old. But those are just the direct costs. The indirect impact on indemnity costs is equally dramatic. Claimants on long-term opioid care, greater than 90 days, are not typically going back to work, have become tolerant or even dependent on the drugs, and suffer a multitude of associated illnesses and debilitating side effects secondary to the drugs' use. The Medicare Set-Aside (MSA) calculations become heavily burdened by the chronic use of these drugs of nearly indefinite duration. These losses become exceptionally expensive and very difficult to settle.

Combining the direct and indirect costs of an undermanaged pharmacy benefit program and its impact on indemnity losses caused by longer temporary total disability (TTD), greater permanency ratings, and the treatment of comorbidities, we are looking at total pharmacy representing somewhere in the neighborhood of 20 to 30 percent of workers' compensation ultimate developed claims costs. Pharmacy is no longer of minor importance in the management of workers' compensation claims.

II WHAT DO PHARMACY BENEFIT MANAGEMENT (PBM) STEWARDSHIP REPORTS REALLY TELL YOU?

Most Employers Do Not Know What They Don't Know

The crisis is made worse by the fact that most, if not nearly all, employers simply don't know what they don't know about workers' compensation pharmacy and how seriously impactful this lack of knowledge is to their bottom line. Pharmacy Benefit Management (PBM) stewardship reports are typically not quantifying the severity of the problem when they do not represent both direct and indirect savings.

Ask most CFOs and corporate risk managers how much influence prescription drugs have on their cost of claims, and the answer will typically be "a very small percentage." They will, however, state that they are saving large sums of money from discount pricing, as communicated by their third-party administrator. Typical pharmacy stewardship reports are inadequate and not representative of the complete picture. They tell the favorable money-saving discount story that

the employer is anxious to hear. In nearly all cases, there is an absence of factual data on pharmacy clinical utilization or absence thereof (the control of inappropriately prescribed medications, unreasonable dosage, duration of use, etc.). There is usually too much fluff and not enough substance for effective employer decision making. Remember, managed care reports represent only those prescriptions processed through the pharmacy benefit management provider, which may only be between 50 to 60 percent of the total pharmacy spend. We have yet to see a stewardship report include a slide on "Total Estimated Losses in Net Savings through PBM Leakage." The cost of leakage will normally be greater than the PBM savings from network discounts, as leakage represents the absence of clinical utilization controls.

Without near-term clinical intervention into a claim involving both early and high-dose prescribing of opioids, the savings from drug repricing is but a fraction of the total potential savings in ultimately developed total claims costs.

So What Is the Problem?

The problem is that executive information provided to employers by their TPAs and managed care organization's (MCOs) is falling short of telling the whole story. We have found that TPAs simply do not know what the employer is actually spending on pharmacy. The reason is that between 40 and 50 percent of pharmacy is dispensed and billed by physicians, or the claimant filled their prescriptions without a pharmacy card, and the pharmacy sold the script to a third-party, who subsequently bills the TPA. In these cases, the paper bills seldom go through the pharmacy benefit management company, where formulary controls and clinical edits may be applied. There are some exceptions out there, with TPAs having the sophistication to extract pharmacy from physician-embedded billings and out-of-network paper bills and consolidate that information into the claimant's pharmacy file. They are, however, few in number. When combined with consensus data, our marketplace data as a whole suggest a mere 60 percent of pharmacy is running through PBMs. CorVel Corporation, a TPA that integrates its bill review and pharmacy platform, in its exhibit below, "visibility" refers to the actual identification of all pharmacy, including paper bills. Penetration only refers to the percent of total pharmacy going directly through the PBM. Employers whose TPAs report penetration in the high 80s or greater should view that as a big red flag and ask for proof.

Physician dispensed drugs cost anywhere from 10 to 300 percent more when prescriptions are not run through the PBM[3].

Employers must consider that 40 to 60 percent of pharmacy without point of sale controls is very costly. Has your TPA or MCO designed a specific program to address this leakage?

Generic vs. Brand Penetration Report

When evaluating the effectiveness of a PBM to increase savings through the use of generic substitution, there are three significant reports that a TPA, carrier and other payors must consider: **1) generic substitution; 2) generic efficiency; and 3) upcoming patent expiration dates.** Employees should specifically understand these reports and what they do and do not represent.

The PBM Penetration Report

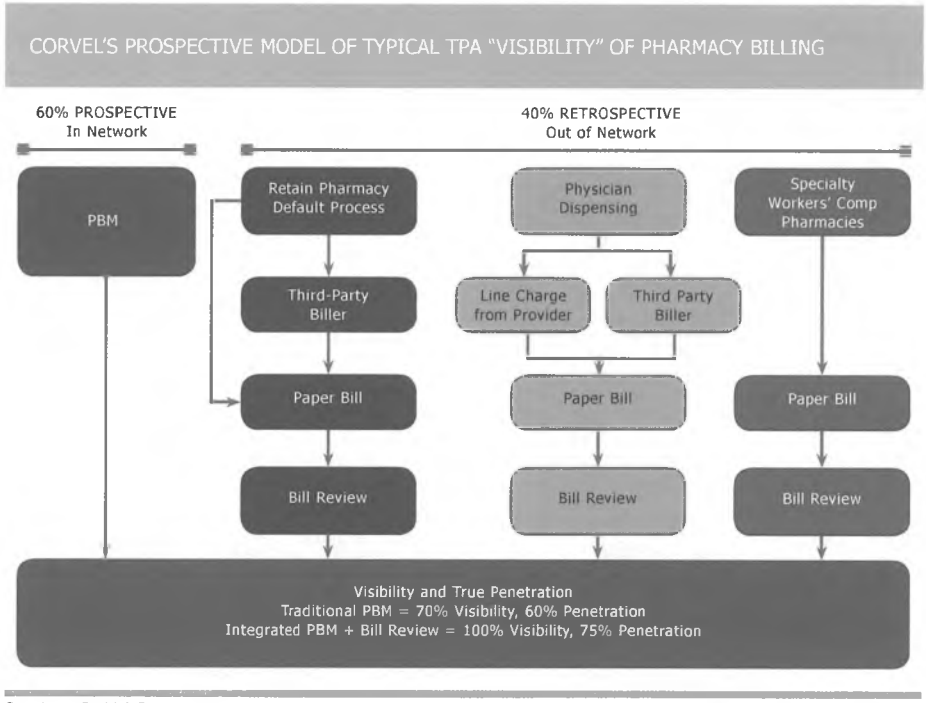
PBM Penetration reports, also known as retail pharmacy Network Utilization reports, are crucial to evaluating the performance of a workers' compensation PBM; if pharmacy is not running through the PBM, the employers simply will not realize the savings from their structured program.

PBMs have varying methods of encouraging this utilization, but it is only through a measure of Network Penetration that these methods can be proven to work. In order to perform this measurement, the TPA typically must provide the PBM with copies of its out-of-network or paper bills, so that the PBM may use these to calculate its degree of success at promoting network participation.

Example Payor with $10M in Annual Drug Spend at a Fee Schedule

	PBM 'A'	PBM 'B'
Effective discount rate	-15%	-10%
Calculated Savings off fee schedule	$1,500,000	$1,000,000
Actual penetration rate	50%	90%
Actual savings off fee schedule	$750,000	$900,000

It is also crucial that a TPA understands how competing PBMs define what is included in the measure of Network Penetration. Therefore, the following questions should be asked of your TPA:



Courtesy CorVel Corporation

1. Are first-fill prescriptions included in the calculation?
2. Are prescriptions that are not actually processed online ever considered to be "network" transactions?
3. What prescriptions are excluded from the calculation, and under what circumstances?

Clinical Savings Report

It is a poorly kept secret that the more drugs that are processed, the more money a PBM makes. In fact, the business model for both pharmacies and PBMs is dependent upon the sale of drugs. Consequently, the PBM industry has been compared to the "fox watching the henhouse" when it comes to the curtailment of prescribing, especially with regard to opioids. Hence, this is truly a case of "buyer beware" when it comes to the evaluation of PBMs. If the expectation is to simply provide a discount off of fee schedule, then there are plenty of providers that can offer an efficient processing platform at a low-cost model (keeping in mind the statements in the previous section regarding network penetration). On the other hand, if the expectation is for the PBM to provide the payor with the tools necessary to curtail over utilization of prescription drugs and to identify potential fraud, waste and abuse via a clinical pharmacy program, then both the program and its measurement must be clearly defined and understood.

III THERE IS A CRISIS IN OPIOID PRESCRIBING PROLIFERATION AND THE SUBSEQUENT MISUSE AND ABUSE OF THESE OPIOIDS

Opioids Influence on Impacting both Pharmacy and Overall WC Costs?

The financial impact of pharmacy, especially opioids and opioid/acetaminophen combination analgesics, is becoming clearer as new research data is being published at an increasing rate. Previously, pharmacy was only looked at in terms of its percentage to total medical spend. As we have addressed thus far, that percentage has been communicated as artificially low due to substantial underreporting of total filled prescriptions through the PBM.

> "Workers prescribed even one opioid had average total claims costs four to eight times greater than claimants with similar claims who didn't get opioids."

Its total impact on claims is just now being estimated from large population data. Potentially, the authors believe savings from combining (1) the reduction in overexpenditure in total pharmacy, (2) the potential reduction in costs of treatment for addiction recovery and morbidities secondary to opioid use, and (3) the reduced number of disability days and permanency ratings from those claimants on long-term pain management, and (4) proactive management of Medicare Set-Aside settlements, could potentially equate to 8 to 15 percent of total incurred costs.

That's a powerful incentive to gain control of pharmacy.

The recent Hopkins-Accident Research Fund Study (2012) [4,5] found "workers prescribed even one opioid had average total claims costs four to eight times greater than claimants with similar claims who didn't get opioids." Other research has documented similar results [6,7].

There are a multitude of costs directly linked to prescribed opioids. Many can occur after only a short-term use following an injury and then increase in frequency and severity as the claim ages. These increased costs can be summarized into the following categories:

- Increased frequency of emergency room visits from overdose
- Death
- Addiction treatment
- Comorbidities (illness)
- Abuse and misuse of prescribed drugs

It is estimated that about 35 percent of patients receiving long-term treatment with opioids may be addicted[9]. Addiction is individual in nature. It can affect some patients after only a few weeks and not others after many years of chronic use.

Medical research suggests opioids, as a pain management tool, can only reduce a patient's pain by 30 to 40 percent. Therefore, it is common for opioids to be prescribed in combination with other, non-opioid, analgesics such as acetaminophen.

Research from 1998-2000 showed acetaminophen was the leading cause of acute liver failure in the United States[8]. Extra Strength Tylenol was reformulated just for this reason. Yet, it is not unusual to find numerous claims involving the long-term use of acetaminophen at or well exceeding maximum FDA recommended dosage. Combine the daily intake of acetaminophen at high levels with alcohol consumption, which would not be uncommon, and liver toxicity increases proportionally. Liver failure may result in the need for liver transplants for which the employer is responsible.

The list of comorbidities secondary to opioid therapy seems endless. The following are the most typical side effects and are frequently found with those on long-term therapy [9, 10].

- Respiratory depression (very common)—slow, shallow breathing causing sleep apnea, which can result in heart attack and stroke.
- Hyperalgesia (the patient becomes more sensitive to pain)
- Serious fractures
- Depression
- Infertility
- Decreased libido
- Erectile dysfunction
- Bowel obstruction
- Chronic constipation
- Immunosuppression
- Myocardial infarction

- Tooth decay (from dry mouth)
- Testicular atrophy
- Chronic obstructive pulmonary disease

Each of the above disorders becomes secondary to the prescribing of drugs for pain relief and in and of themselves become compensable medical conditions, rapidly increasing the medical and indemnity cost of claims. These expenses are not necessary in the treatment of most workers' compensation claimants.

If the employer and TPA understand and integrate countermeasures into their claims management program to address the following facts, significant improvement can be experienced with claims outcomes[11]

- Evidence of long-term efficacy of chronic noncancer pain (≥ 16 weeks) is limited and of low quality. Opioids are effective for short-term pain management. But for many patients with chronic pain, analgesic efficacy is not maintained over long time periods.
- With daily opioid use, physical dependence and tolerance can develop in days or weeks.
- Successfully tapering chronic pain patients from opioids can be difficult, even for patients who are motivated to discontinue opioid use.
- Estimates vary. Between 4 percent and 26 percent of patients receiving chronic opioid therapy have an opioid use disorder.
- Opioids have significant risks besides addiction and misuse. These risks include respiratory depression and unintentional overdose death.
- No randomized trials show long-term effectiveness of high opioid doses for chronic, noncancer pain. Many patients on high doses continue to have substantial pain and related dysfunction.
- When treating chronic pain, dose escalation has not been proven to reduce pain or increase function, but can increase risk.

The Impact of Opioids on Pharmacy Spend on Claims Open Greater Than 2-3 Years

A study by the NCCI in 2009 determined that although opioid use declined over time, its use could continue for many years. A more recent study[12] found that high use of opioids in the first quarter following an injury is related to that injured patient continuing to receive opioids in subsequent quarters. One conclusion that may be drawn from this study is that early intervention to ensure guideline compliance may also lead to a decrease in use in subsequent years.

The Impact of Pharmacy, and Opioids in Particular, on Medicare Set-Aside Calculations and Settlements

The 80:20 "Paretto's Rule" applies to many things, including workers' compensation. Approximately 20 percent of a claim's medical cost is for pharmacy, while the claim is open, and 80 percent for medical expenses. When the claim moves to the closure stage and a Medicare Set-Aside (MSA) is required, this percentage is inverse; 80 percent of the MSA cost is pharmacy, and the numbers can

be staggering, so staggering that many self-insured companies want to leave the medicals, or at least the pharmacy, "open" and settle the indemnity.

CMS regulations coupled with the increased use of opioids in older claims (up to 40 percent of medical cost according to the NCCI's 2011 data) are the major cost drivers. An effective PBM program will apply clinical protocols to get ahead of the claim and ensure that therapy is within guidelines and cost-effective measures are in place well before time for an MSA.

IV HOW SHOULD CHRONIC PAIN PATIENT CLAIMS BE MANAGED?

First, Make Sure All Is As It Appears

The hydrocodones, oxycodones, and morphine sulfates seen time and again with long-term claims may not always be actually taken by the patient, may be taken in higher dosages than prescribed or even taken alongside illicit substances. The Workers' Compensation Research Institute, in a study involving 17 states, found that fewer than 7 percent of treating doctors conduct baseline and periodic urine drug screens. That number has apparently doubled in recent years but is still a very low percentage given the following concurrent research facts:

- 71 percent of workers' compensation claimants on chronic opioid therapy greater than three months are not taking their pain medication as prescribed due to misuse or abuse [13].
- 38 percent of patients were found to have no detectable level of prescribed medication; 29 percent had nonprescribed medication; 27 percent had drug levels higher than expected; 11 percent had illicit drugs. (Based on a sample of 939,000 drug screens)[14]

Does your PBM/TPA ensure all opioid-prescribed claimants are being routinely drug tested?

What Is the PBM's Role?

Ideally a PBM will have access to all data involving pharmaceuticals, which includes not only those prescriptions processed online via the PBM but also those prescriptions processed through a third-party biller, processed via a group healthcare PBM (and available through the states' PDMP databases), or dispensed by a physician or delivered via an implantable drug delivery device, such as an intrathecal morphine pump. Each PBM may have different methodologies to obtain this data, but the end result should be to provide you with a complete picture of what your claimants are receiving in terms of number of opioids, number of physicians, total dosage, duration, etc. Only with this kind of 360-degree view can your PBM evaluate guideline compliance.

What Is the Adjuster's Role?

There is no short supply of evidence-based medical treatment guidelines for the long-term treatment of chronic pain for adjusters to follow[15].

The adjuster's primary role is to stay on top of claims with prescribed opioids, either within the first 10 days of an acute injury or where these opioids are being prescribed beyond 45 days. What this translates to is:

- Not overriding formulary denials without specific justification and seeking medical guidance from internal professional staff to assist in making override decisions.
- Engage the PBM as often as necessary if medical reports show the onset of illnesses not normally associated with workers' compensation claims and are typically side effects from prolonged opioid use.
- Follow PBM recommendations for engaging the treating doctor in modifying prescribing patterns.
- Ensure physician-patient agreements are in place where opioid use extends beyond 30 days.
- Encourage the treating doctor to make use of tools for assessing the risk of opioid addiction in advance of prescribing opioids.
- Ensure the opioid prescribing doctor conducts a baseline urine drug test, where opioids are being prescribed beyond 30 days, and for patients under age 65, periodic, unannounced random urine drug tests are conducted.
- Only approve referrals to qualified pain specialists.
- Above all else, engage and challenge the treating doctor as to the validity of continuing opioid prescribing ,where periodic medical reports do not indicate progress in work and life skills functions and reduction in pain.

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Interpretation of Opiate Urine Drug Screens

Summary

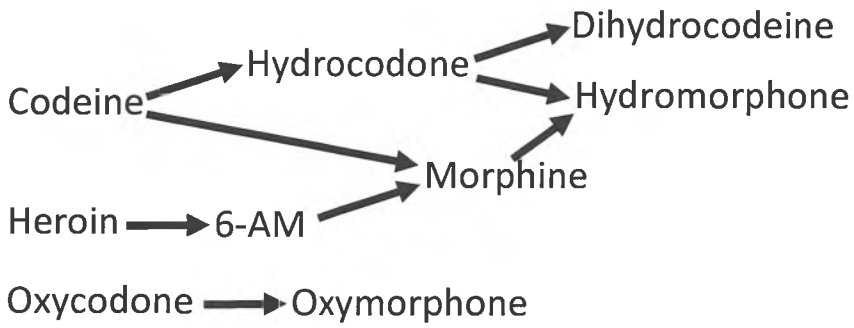
- Urine drug testing is highly reliable, but false positives can rarely occur for some drugs. As always, clinical judgment is necessary when interpreting test results.
- The length of time a drug can be detected in the urine varies due to several factors, including hydration, dosing, metabolism, body mass, urine pH, duration of use, and a drug's particular pharmacokinetics. (See table below for some "average" times for different drugs.)

Length of Time Drugs of Abuse Can Be Detected in UrineDrug	Time
Alcohol	7-12 h
Amphetamine	48 h
Methamphetamine	48 h
Barbiturate	
Short-acting (eg, pentobarbital)	24 h
Long-acting (eg, phenobarbitol)	3 wk
Benzodiazepine	
Short-acting (eg, lorazepam)	3 d
Long-acting (eg, diazepam)	30 d
Cocaine metabolites	2-4 d
Marijuana	
Single use	3 d
Moderate use (4 times/wk)	5-7 d
Daily use	10-15 d
Long-term heavy smoker	30 d
Opioids	
Codeine	48 h
Heroin (detected as morphine)	48 h
Hydromorphone	2-4 d
Methadone	3 d
Morphine	48-72 h
Oxycodone	2-4 d
Propoxyphene	6-48 h
Phencyclidine	8 d

-- Mayo Clinic Proc. 2008; 83(1)66-76

- Sometimes the specific drug ingested is not detected, but instead one of its metabolites is found.

Opiate/Opioid Metabolism



- Two types of urine drug tests are used for HealthPartners patients – immunoassay and gas chromatography-mass spectrometry (GC/MS).
- The first test done is the immunoassay. This can be susceptible to false positives, so when a positive result is obtained it is confirmed by GC/MS.or the pain management urine drug screen,/MS is done for these drugs regardless of the immunoassay screen result: morphine, codeine, oxycodone, oxymorphone, hydrocodone, hydromorphone. The GC/MS confirmation assays are highly reliable and specific tests with very rare interferences.
- Fentanyl (Duragesic) is not easily detected in either urine or serum. Our current system does not allow accurate determination of the presence of this drug. HealthPartners may purchase new equipment that will make this possible within the next year. Until that happens, <u>you will not be able to tell whether a patient is using fentanyl (Duragesic patches) based on the results of the urine drug screen</u>.

Discussion

Current urine drug testing methods were designed to identify illicit use of drugs in the forensic or occupational setting. In this setting, high specificity was needed to avoid a false positive result and this was carried out by using a relatively high cutoff concentration needed to trigger a positive result. In the setting of pain management compliance testing, both drug pharmacokinetics (how the body acts on a drug) and testing limitations that affect the results of urine testing must be understood for proper interpretation.

Although the name "opiate" is often used to describe any member of the class of drugs that acts on opioid receptors, the term "opiate" properly refers to the natural alkaloids found in opium poppy resin (*Papaver somniferum*), which include morphine, codeine and thebaine. The term "opioid" refers to the synthetic and semi-synthetic opioid receptor drugs, including heroin, hydromorphone, hydrocodone, oxycodone, oxymorphone, buprenorphine, fentanyl, and methadone.

Drug	Half-life (hr)	Metabolites	Concentrations above the cutoff will screen positive for
morphine	1.5 - 6.5	normorphine, **hydromorphone (<2.5%)**	Opiates
codeine	1 - 4	**morphine**, **hydrocodone (<11%)**, norcodeine	Opiates
oxycodone	4 - 12	**oxymorphone**, noroxycodone	Oxycodone
oxymorphone	3 - 6	6-hydroxy-oxymorphone	Oxycodone
hydrocodone	3.5 - 9	**hydromorphone**, norhydrocodone, **dihydrocodeine**	Opiates
hydromorphone	3 - 9	hydromorphol	Opiates

* **bolded** metabolites are identical to pharmaceutically available drugs

Assay Technologies

The pain management urine drug screen offered within the HealthPartners Family of Care consists of two steps. First, a qualitative (positive/negative) immunoassay screen is completed, including tests for opiates (300 ng/mL cutoff), oxycodone (100 ng/mL cutoff), amphetamine, barbiturate, benzodiazepines, cocaine, methadone, PCP, propoxyphene, and THC. These drugs are reported as positive if they are present at a concentration above the designated cutoff (see Regions Hospital Laboratory Toxicology website on *myPartner* for specific cutoffs and drugs detected) and confirmed as positive by GC/MS. For the pain management panel only, regardless of the screen results, GC/MS confirmation for the following drugs are completed and reported individually as positive/negative with a detection limit of 100 ng/mL: morphine, codeine, oxycodone, oxymorphone, hydrocodone, hydromorphone. This allows for higher sensitivity and specificity along with offering results for each drug individually.

In general, immunoassay technologies are susceptible to interfering substances (false positives) and cross-reactivity (true positives for non-target drugs, due to structural similarity) to varying degrees. Accordingly, each result needs to be interpreted in the context of the clinical picture and in conjunction with our confirmatory method of gas chromatography/mass spectrometry (GC/MS). The immunoassay for opiates is primarily targeted to detecting morphine, hydrocodone, dihydrocodeine, codeine, 6-acetylmorphine (metabolite of heroin), and hydromorphone. Due to that assay's insensitivity for oxycodone, the oxycodone assay is utilized to detect oxycodone and oxymorphone. The GC/MS confirmation assays are highly reliable and specific tests with very rare interferences.

Detection Windows

The window to detect the presence of a particular drug in a person's urine is highly dependent on multiple factors, such as:

- **Hydration** - More dilute urine from high fluid intake may cause dilution of drug and therefore a negative result due to levels present but below the cutoff. Conversely, a patient may greatly reduce fluid intake in order to concentrate their urine when trying to mask inappropriate reduced intake of their prescribed drug.

- **Dosing** - If a patient is on a low dose or has a long interval between doses, the level of drug in their urine may be too low to be detected by the immunoassay or confirmation assay, i.e. below the cutoff. Similarly, the time between the last dose of a drug taken and the collection of the urine specimen may affect if the drug is present at concentrations adequate to produce a positive result.

- **Metabolism** - Metabolism is unique to each individual, determined by genetic and environmental factors. Genetic polymorphisms of the CYP450 2D6 enzyme can cause individuals to be poor or rapid metabolizers of opioids and other drugs metabolized by those enzymes[1]. Additionally, environmental influences further complicate metabolism. For example, co-administered drugs that are also metabolized by CYP450 enzymes used by the opioids or that inhibit CYP450 2D6 cause decreased metabolism, see Table below. Conversely, rifampin and dexamethasone are known to induce CYP450 2D6, causing increased metabolism of opioids with a resulting shortened detection window. Other factors affecting metabolism include age, sex, ethnicity, and renal or liver impairment.

TABLE 3. **Cytochrome P450 2D6 Substrates, Inhibitors, and Inducers**

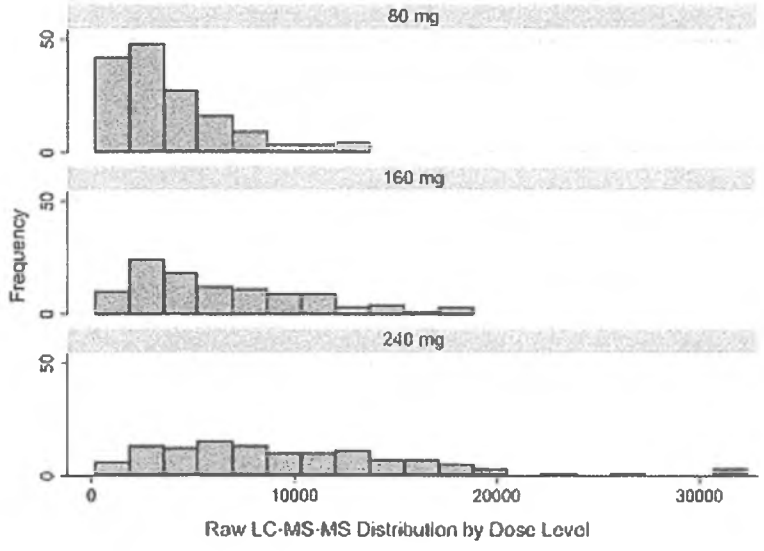
Substrates		Inhibitors		Inducers
Antiarrhythmic agents	*SSRIs*	*Antiarrhythmic agents*	*Antihistamine*	*Antibiotic*
Encainide	Fluoxetine	Amiodarone	Chlorpheniramine	Rifampin
Flecainide	Fluvoxamine	Quinidine	*Histamine H_2 receptor antagonists*	*Glucocorticoid*
Lidocaine	Paroxetine	*Antipsychotic agents*	Cimetidine	Dexamethasone
Mexiletine	*Tricyclics*	Chlorpromazine	Ranitidine	
Propafenone	Amitriptyline	Reduced haloperidol	*Other drugs*	
Sparteine	Amoxapine	Levomepromazine	Celecoxib	
β-Blockers	Clomipramine	*SNRI*	Doxorubicin	
Alprenolol	Desipramine	Duloxetine	Ritonavir	
Carvedilol	Doxepin	*SSRIs*	Terbinafine	
Metoprolol	Imipramine	Citalopram		
Propranolol	Nortriptyline	Escitalopram		
Timolol	*Other drugs*	Fluoxetine		
Antipsychotic agents	Amphetamine	Paroxetine		
Aripiprazole	Chlorpheniramine	Sertraline		
Haloperidol	Debrisoquine	*Tricyclic*		
Perphenazine	Dextromethorphan	Clomipramine		
Risperidone	*Histamine H_2 receptor antagonists*	*Other antidepressant/ antianxiolytic agents*		
Thioridazine	Metoclopramide	Bupropion		
Zuclopenthixol	Phenformin	Moclobemide		
SNRIs	Tamoxifen			
Duloxetine				
Venlafaxine				

SNRI = serotonin-norepinephrine reuptake inhibitor; SSRI = selective serotonin reuptake inhibitor.
From Indiana University School of Medicine,[2] with permission.

Other Factors

The detection window of a drug is also affected by: duration of use, body mass, urine pH and a drug's particular chemistry, i.e. half-life and volume of distribution. If a negative result is obtained for a drug prescribed to the patient, the entire clinical picture must be taken into consideration to determine if the patient was: 1) not taking the drug, 2) taking a lower dose than instructed, or 3) taking the drug properly but the results were negative due to one of above factors. Similarly, if a positive result is obtained for a drug not prescribed to the patient, the entire clinical picture must be taken into consideration to determine if the patient was taking the non-prescribed drug, has a false positive result (applies to immunoassay only) or if the drug is simply a metabolite of a prescribed drug (as applicable).

The following figure exemplifies the amount of variation possible in the concentration of drug present in individuals taking the same dose of a drug[2]. In this example, 36 healthy participants that had taken no drugs in the previous 30 days were given one of 3 doses (n=12 per dose) of OxyContin®. The following shows the combined distribution of multiple urine specimens taken from each individual days 3 and 4 after dosing began:



Interpretation Cautions

- Interferents, sensitivity and cutoffs vary by immunoassay, see Reference 3 for a review of immunoassay types and interferents; EMIT assays are used by Regions Hospital's Toxicology lab, which serves the entire HP Family of Care.
- Hydromorphone has been shown to be a minor metabolite in chronic pain patients receiving high amounts of morphine.[4,5]
- Hydrocodone has been shown to be a minor metabolite detectable in patients on high amounts of codeine[6]; as the metabolite of hydrocodone, hydromorphone may also be detectable in these cases.
- A small amount of codeine may be evident with morphine administration due to manufacturing impurities (up to 0.04% of parent dose); high amounts of morphine should be present in these cases.[7]
- A small amount of hydrocodone may be evident with oxycodone administration due to manufacturing impurities; high amounts of oxycodone should be present in these cases[8]
- Ingestion of poppy seeds or herbal teas containing Papaveris fructus may cause a true positive opiate (morphine, codeine) results.[9,10]
- Oxymorphone has a longer half-life than oxycodone; a patient prescribed oxycodone may only have oxymorphone detected in urine.
- Heroin is metabolized to morphine, which may be detectable after its use.
- The dose taken cannot be extrapolated from drug screen results, even if a quantitative result is obtained.

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Questions: Please reply to this e-mail, and your questions(s) will be directed to the author of this Pearl, Kalen Olson, PhD, Clinical Laboratory Director.

Wasted Dollars, Wasted Lives—How Opioid Overprescribing and Physician Dispensing Are Harming Claimants and Employers

By Joseph Paduda • President, CompPharma, LLC

Workers compensation pharmacy costs are much higher than they should be. With $1.4 billion going to pay for narcotics that deliver little benefit to workers comp claimants, and $1.7 billion spent on highly inflated costs for drugs from physician dispensers, it is clear that hundreds of millions of dollars in employer premiums are wasted on drugs that do little to benefit claimants but greatly enrich physician dispensing companies.

Opioids in Workers Comp—Inappropriate, Expensive, and Addicting

Employers and insurers will spend $1.4 billion on narcotics this year for workers compensation claimants, with the vast majority of those dollars paying for opioids such as OxyContin®, Percocet®, and Actiq® (fentanyl)—drugs that are not indicated for the vast majority of workers comp injuries.

There's very little credible evidence that long-term opioid use is appropriate treatment for workers comp injuries. These are drugs that were primarily developed—and approved by the FDA—for treating end-stage cancer pain. But there is ample evidence that long-term opioid use leads to longer claim duration, long-term disability, higher costs, and higher medical expenses.

Along with the questions around the benefits of opioids for work-related injuries, the research indicates that few prescribing physicians—a mere 1 in 20—are complying with best practices, namely:

- Assessing the patient's initial and subsequent functionality, pain level, and risk of depression
- Requiring patients to complete and sign an Opioid Agreement
- Ordering random urine drug tests to assess compliance and potential use of street drugs and other drugs

Solutions do exist, yet far too few payers or regulators are aggressively addressing the problem.

How Did We Get Here?

Opioids are synthetic versions of opium-derived drugs originally developed for treating patients with end-stage cancer. Remarkably effective at reducing pain in many instances, many were meant to last only a few hours to deal with "breakthrough" pain. In the long term, they can provide relief from chronic pain when used appropriately within guidelines.

In the late 1990s, at least 20 states passed new laws, regulations, or policies, moving from the near prohibition of opioids to allowing usage without dosing guidance. The laws were based on weak science that, in turn, was based on experience with cancer pain.

Now, those same drugs are widely prescribed for musculoskeletal injuries, where their usefulness is, at best, highly questionable. A 2009 study (Franklin et al, *Clinical Journal of Pain,* Dec. 2009) found that less than a third of patients taking opioids for low back pain improved by at least 30% in pain function; even fewer (16%) saw improvement in functionality. At least two separate studies indicate the negative effect of narcotics on disability duration. Industry reports seem to indicate that the longer injured workers are on narcotics, the longer they are off work and the greater the

likelihood of addiction rehabilitation ("Narcotics in Workers Compensation," NCCI Research Brief, Dec. 2009).

The California Workers Compensation Institute (CWCI) reported that average claim costs of workers receiving seven or more opioid prescriptions for back problems without spinal cord involvement were three times greater than those for workers who received zero or one opioid prescription. The workers receiving multiple opioid prescriptions were 2.7 times more likely to be off work and had 4.7 times as many days off work (Swedlow et al, "CWCI Special Report," 2008).

Solutions

The inherent but often-ignored consequence of overuse of opioids is a dramatic increase in the risk of addiction and dependency. The harsh reality of addiction liability is that a very high proportion of claimants who have been on opioids for more than 90 days are at high risk for addiction. Sadly, many insurers don't want to screen for addiction because they don't want to "own" that addiction. That ignores the fact that the insurer *already* owns the addiction; it is just choosing to treat that addiction with the drug of choice rather than employ an intelligent, evidence-based approach to resolving the problem. The price tag for ongoing opioids usage runs $1,000 to $12,000 per month plus associated costs for treating side effects, extended disability duration, and settlement expense.

The question is not "Do you want to own the addiction?" but rather "*How long* do you want to own the addiction?"

Discouraging overprescribing is one step; providing guidance for primary care providers on the safe and effective use of opioids for chronic noncancer pain must be the priority going forward. Payers must take a strong stance, advocating for treatment agreements where patients are screened, randomly drug tested, and offered addiction/dependency treatment when the daily dose reaches 120 MED (morphine equivalent dose) and pain and function have not substantially improved. While there are no silver bullets, treating addiction with outpatient medically assisted detox, drug therapy, and cognitive behavioral therapy must be a priority. Inpatient programs may also be helpful.

Legislative and regulatory changes have started to address opioid prescriptions in workers compensation claims. Colorado is currently paying physicians to manage chronic pain based on a code-based reimbursement for review of drug screens and the implementation and monitoring of opioid agreements. Washington State has passed legislation requiring that prescribing physicians comply with best practices including drug testing and completion of Opioid Agreements.

Texas now requires physicians to seek preauthorization before prescribing narcotics such as Soma, Oxycontin®, Lidoderm®, and fentanyl to claimants. Anecdotal reports indicate that prescriptions for these drugs have fallen off considerably since this closed formulary went into effect in September 2011. It will be interesting to see the results after a year or so. While the adoption of Official Disability Guidelines (ODG) is welcome indeed, payers and employers still have to address the population of claimants currently addicted to narcotics.

The American Insurance Association has developed a comprehensive approach that includes these practices as well as implementation of prescription drug monitoring programs that communicate across state lines. Some pharmacy benefit managers have developed data mining tools that identify at-risk claimants and physicians who appear to be overprescribing opioids.

These initiatives are very, very welcome. To quote Gary Franklin, MD, medical director of Washington State's workers compensation program and the driving force behind the state's opioid legislation, "This is a 'hair on fire' issue." If your hair is not yet on fire, you're either bald or not paying attention.

Physician-Dispensed Drugs—A $1.7 Billion Problem

Using industry research as a baseline, physician-dispensed drugs likely account for at least $1.7 billion—over a quarter of all workers comp pharmacy expenses. That percentage—and the cost—is growing dramatically every year. The problem is simple: the cost for drugs dispensed in physicians' offices is typically three times the retail pharmacy price for the same drug. This equates to 2% of total workers comp medical expense or about 1% of workers comp premiums.

Advocates for physician dispensing claim that their business increases "compliance," the chance that the patient will actually take the medication. However, there's no empirical research to back up those claims. More telling, physicians dispense drugs only to workers comp and auto patients, where reimbursement is much higher; group health and Medicare/Medicaid plans won't pay the inflated costs for physician-dispensed repackaged drugs.

And it's not just price that's a problem. What physician dispensing advocates don't discuss is the increased risk for their patients. If workers compensation claimants receive

care for their occupational injury from physicians they don't normally see, there may be an increased risk of dangerous drug-to-drug interaction. Patients usually can't recall with complete accuracy the drugs they are taking or the dosages of those drugs, so the physician can't be sure that what they are prescribing is entirely safe.

When the injured worker fills a prescription at a pharmacy, the pharmacist can access its comprehensive electronic database of medications and dosages the patient has previously filled, providing an additional level of safety. This doesn't happen when the prescriber is also the dispenser. Pharmacies also have tools to avoid patient safety issues, including contraindications and early refills.

On the cost side, the evidence is incontrovertible—physician dispensing dramatically increases employers' costs. A report by the Workers Compensation Research Institute (WCRI) found that the average payment per claim for prescription drugs in the Massachusetts workers compensation system was $289, or 30% lower than the median of the 16 study states. One of the main reasons for the lower prescription costs in Massachusetts is a ban on physicians dispensing medications directly to their patients.

In contrast, WCRI also found that the average payment per workers comp claim for prescription drugs in Florida was $565, or 38% higher than the median. The primary reason for Florida's higher prescription costs? Over half of all workers comp prescription dollars are spent on repackaged drugs, with prices typically *three times* the cost of the same drug in a retail pharmacy.

How It Works

Drugs dispensed by physicians are almost always provided by drug repackagers, a niche industry that buys pills in bulk and repackages those pills into their own bottles. A quirk in the FDA's regulations enables companies that repackage pills to be classified as "manufacturers," and that allows them to determine their own price for those pills. Repackagers assign an NDC, or National Drug Code, to their repackaged drugs. In turn, they determine the Average Wholesale Price (AWP) for each NDC.

Almost all state workers comp pharmacy fee schedules are based on AWP; this allows repackagers to set their own prices and requires employers and insurers to base their payments to the physicians who dispense drugs on that (usually hugely inflated) AWP.

Solutions

Today, Texas, Massachusetts, and New York essentially ban physician dispensing by greatly limiting physicians' ability to dispense drugs. Other states allow physician dispensing but require repackagers to base their price on the "underlying NDC"; that is, the price set by the original drug's manufacturer. Georgia, Mississippi, and California have dramatically lowered costs with this solution. ■

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ANALYSIS OF ALASKA HOUSE BILL 370
AS INTRODUCED MARCH 3, 2014

House Bill (HB) 370, if enacted, may result in savings for workers compensation system costs in Alaska. The magnitude of the savings is uncertain and will depend on how effective the provisions are in reducing the prevalence of controlled substances and opioids in workers compensation cases. The potential savings may be offset to some extent by the additional costs of administering drug tests.

Summary of HB 370

If enacted, HB 370 would implement the following changes:

- Employers would be able to require drug testing of injured workers who are prescribed a controlled substance in schedule I-A[1] (Controlled Substances) for more than 90 consecutive days.
- Physicians would not be able to prescribe more than a 30-day supply of a Controlled Substance, or a controlled opium substance in schedule III-A[2] or V-A[3] (Opioids).

Commentary

If enacted, HB 370 may reduce the number of prescriptions written and filled for Controlled Substances and Opioids in Alaska. There are numerous studies that document the costly impact of the inappropriate use of these types of drugs in the treatment of workers compensation (WC) claims. NCCI anticipates savings on system costs if this provision is successful in reducing the prevalence of these drugs in WC cases. However, the potential savings may be offset to some extent by the additional costs of administering the drug tests.

In the information that follows, NCCI relies primarily on two data sources:

- Detailed medical call data used to calculate the distribution of medical payments is based on NCCI's Medical Data Call for Alaska for Service Year 2012.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Alaska from Policy Years 2009 to 2011 projected to 7/1/2014[4], which is 75.4%.

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[1] Schedule I-A is defined in AS 11.71.140
[2] Schedule III-A is defined in AS 11.71.160
[3] Schedule V-A is defined in AS 11.71.180
[4] As HB 370 does not contain an explicit effective date, NCCI assumed an effective date of 7/1/2014 for this analysis

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In order to provide some context as to the percentage of costs that may be impacted by the provisions of HB 370, Alaska's WC prescription drug payments represent 5.3% of total WC medical payments. In addition, Controlled Substances and Opioids represent 31.5% of total WC prescription drug payments in Alaska. Hence, Controlled Substances and Opioids represent 1.7% (=5.3% x 31.5%) of total WC medical payments in Alaska and 1.3% (= 1.7% x 75.4%) of total WC benefits in Alaska.

(1)	Controlled Substances and Opioids as a Percent of WC Prescription Drug Payments in Alaska	31.5%
(2)	Prescription Drug Medical Cost Distribution	5.3%
(3)	**Controlled Substances and Opioids as a Percent of Medical Costs in Alaska = (1) x (2)**	**1.7%**
(4)	Medical Costs as a Percent of Overall WC Benefit Costs in Alaska	75.4%
(5)	**Controlled Substances and Opioids as a Percent of Overall WC Benefit Costs in Alaska = (3) x (4)**	**1.3%**

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