SB1414

Measure Title:	**RELATING TO REPACKAGED DRUGS AND COMPOUND MEDICATIONS.**
Report Title:	**Workers' Compensation; Repackaged Drugs and Compound Medications**
Description:	**Restricts markups of repackaged prescription drugs and compound medications to what is currently authorized for retail pharmacies under state law.**
Companion:	
Package:	**None**
Current Referral:	**CPN, JDL**

NEIL ABERCROMBIE
GOVERNOR OF HAWAII

SUNSHINE P.W. TOPPING
INTERIM DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN RESOURCES DEVELOPMENT
235 S. BERETANIA STREET
HONOLULU, HAWAII 96813-2437

February 9, 2011

TESTIMONY TO THE
SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
For Hearing on Friday, February 11, 2011
8:30 a.m., Conference Room 229

BY

SUNSHINE P.W. TOPPING
INTERIM DIRECTOR

Written Testimony Only

Senate Bill No. 1414
Relating to Repackaged Drugs and Compound Medications

TO CHAIR ROSALYN H. BAKER AND MEMBERS OF THE COMMITTEE:

The purpose of S.B. No. 1414 is to amend Section 386-21, Hawaii Revised Statutes, to regulate the amount that can be charged for repackaged prescription drugs and compound medications.

The Department of Human Resources Development is in strong support of this bill. We have found that, in many instances, the amounts being charged for repackaged prescription drugs and compound medications were more than 200% greater than what was being charged by retail pharmacies and Health Maintenance Organizations for the same prescriptions. Under this bill, we would also be permitted to contract for a price lower than the amount provided for in the fee schedule adopted

by the Director of Labor. This provision, along with regulating the amount that can be charged, will reduce medical costs without affecting an injured employee's access to required medications.

ECD/sk

DEPARTMENT OF HUMAN RESOURCES

CITY AND COUNTY OF HONOLULU

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PETER B. CARLISLE
MAYOR

NOEL T. ONO
DIRECTOR

February 11, 2011

The Honorable Rosalyn H. Baker, Chair
and Members of the Committee on Commerce
and Consumer Protection
The Senate
State Capitol
Honolulu, Hawaii 96813

Dear Chair Baker and Members:

Subject: Senate Bill No. 1414, Relating to Repackaged Drugs and Compound Medications

The City and County of Honolulu supports passage of Senate Bill No. 1414, which amends Section 386-21, Hawaii Revised Statutes (HRS), by restricting markups of repackaged prescription drugs and compound medications to what is currently authorized for retail pharmacies under State law. The Hawaii Workers' Compensation Medical Fee Schedule, Section 12-15-55, allows for prescription drugs to be reimbursed at the average wholesale price as listed in the American Druggist Red Book plus forty percent when sold by a physician, hospital, pharmacy, or provider of service other than a physician. All billings for prescriptive drugs must include the national drug code listed in Redbook followed by average wholesale price listed at time of purchase.

The City supports Senate Bill No. 1414, limiting excessive or unnecessary markups associated with repackaging of prescription drugs and compound medications. We do not believe this bill negatively impacts Hawaii's injured workers as they will continue to receive, and the employer will continue to pay for, the necessary medical care, services and supplies as the nature of their injuries require. Rather, Senate Bill No. 1414 will provide standard reimbursement charges for repackaged drugs and compound medications, which are currently not being regulated.

We urge your committee to pass Senate Bill No. 1414. Thank you for the opportunity to present testimony.

Yours truly,

Noel T. Ono
Director

Aloha Pain Clinic

Big Island
68-1845 Waikoloa Road Suite #216
Waikoloa, Hawaii 96738
Maui
53 S. Puunene Ave #100
Kahului, HI 96732
(808) 885-PAIN

February 11, 2011

Re: SB1414 Relating to Repackaged Drugs and Compound Medications

Dear Sirs and Madams,

This letter is in strong opposition to the proposed fee schedule change that will dictate and change reimbursement for all prescription medications dispensed in a workers' compensation case in Hawaii. As a physician who practices on the outer islands and has limited access to ancillary help such as pharmacies, this would be disastrous. Here on the Big Island our nearest pharmacy is over 20 miles away and is inaccessible to most of our patients. Hawaii has historically been known for the worst reimbursement rates. The proposed Hawaii fee schedule change would set a reimbursement rate that would cripple our practice by reducing the reimbursement rate by more than half for practitioners that provide medications in treatment dose.

Currently, many Hawaiian physicians, including myself, offer point-of-care dispensing to their workers' compensation patients. As you can imagine, the ability of these injured workers to receive their medication for free at the doctor's office is of enormous benefit. The majorities of our patients are underprivileged and can't afford their prescriptions or a means of transport to and from the pharmacy. Typically, when an injured worker is forced to go to a pharmacy to fill a prescription they have difficulty in receiving their medications due to the awkwardness of the work comp verification process. Work comp patients that receive their meds at point of care are more likely to abide by their course of therapy, reach Maximum Medical Improvement faster, return to work quicker and will be less inclined to involve a lawyer in their case and decreases the indemnity portion of the work comp claim cost, which is on average 50% of the total claim cost.

The proposed fee schedule would prevent me from being able to continue this service to my work comp patients and will decrease the current level of care I am able to provide to these patients. As a result injured workers would be severely limited in their access to the quality health care and no-cost medications that they are entitled to which will in turn, increase the overall cost of the workers' and decrease the likelihood of further state run assistance.

Please join us in ensuring that injured workers continue to receive superior medical care in Hawaii by rejecting the proposed fee schedule that would eliminate my ability to provide this service to my patients.

Thank you,
Rudolph Puana MD

Marriott International, Inc.
Marriott Casualty Claims

3130 S. Harbor Blvd.
Suite 550
Santa Ana, CA 92704
714/545-5261

February 1, 2011

The Honorable Senator Roz Baker

Re: SB 1414

Dear Senator Baker:

Marriott International, Inc. is in full support of Senate bill 1414 and we urge passage of this bill by your Committee of Commerce and Consumer Protection.

It is critical that any effort to expand the cost of workers' compensation for ancillary services in the state of Hawaii be controlled. Failure to do so will continue to impact Marriott and our ability to provide much needed jobs to the citizens of the state of Hawaii.

Thank you for your support of Senate bill 1414.

Sincerely,

Jill A. Dulich
Senior Director, Marriott Claims Services
Marriott International, Inc.

WORKSTAR
INJURY RECOVERY CENTER

91-2135 Fort Weaver Road Suite #170
Ewa Beach, Hawaii 96797

February 11, 2011

Committee on Commerce and Consumer Protection

Senate Bill 1414 Relating to Repackaged Drugs and Compound Medications

Whereas, workers' compensation costs and premiums have fallen steadily over the last decade since the inception of specialty care clinics.

And, whereas, specialty care clinics, by a 2004 Harvard study, have been shown to, deliver the most cost effective care with the best outcomes.

And, whereas, office visit reimbursement in Hawaii is one of the lowest in the nation and has not been increased by in over 15 years despite a ever growing paperwork burden.

And, whereas, dispensing generic medications from the office assists in covering the cost of additional paperwork and the administrative burden of workers' compensation cases.

And, whereas, Hawaii's Workers' Compensation System is one of the most tightly cost-controlled healthcare delivery systems in the world whose rationing and restrictions which are the major reason so many doctors refuse to see injured workers.

And, whereas, mail order prescriptions represent an ineffective means of monitoring and controlling opioids and other, Schedule III and Schedule II, controlled substances.

And, whereas, office dispensing strongly encourages use of generic over more expensive brand medications.

And, whereas, doctors continue to "opt out" of treating workers compensation patients at an alarming rate in our state which is already stricken by a physician shortage.

And, whereas, passing the bill before you will make it impractical for the physician to continue the time-honored tradition of dispensing medications to their patients.

Therefore, be it resolved that the bill before you is unnecessary and inconvenient to patients; and unfair and damaging to the practices of doctors still willing to care for the injured worker and, therefore, must be struck down.

Scot McCaffrey M.D.

HEMIC

Hawaii Employers' Mutual Insurance Company, Inc.

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Pauahi Tower, Suite 1000
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February 10, 2011

The Honorable Rosalyn H. Baker,
Chair, Senate Committee on Commerce and Consumer Protection

The Honorable Brian T. Taniguchi
Vice Chair, Senate Committee on Commerce and Consumer Protection

Re: SB 1414 – Relating to the Repackaged Drug and Compound Medications Bills

Dear Chairman Baker, Vice Chairman Taniguchi, and Members of the CPN Committee

My name is Paul Naso. I am the General Counsel of the Hawaii Employers' Mutual Insurance Company, Inc. ("HEMIC"). I am here today on behalf of HEMIC to testify in strong support of SB1414.

I. UNDERSTANDING THE REPACKAGING PROBLEM

"Repackaging" is the practice of breaking a bottle of a large quantity of drugs down to several bottles of smaller quantities. These medications are identified by a number called an NDC (National Drug Code) number.

In 1972, congress enacted the Federal Drug Listing Act. The Federal Drug Listing Act required all registered drug establishments to provide the Food and Drug Administration (FDA) with a current list of all drugs manufactured, prepared, propagated, compounded, or processed by it for commercial distribution.

The significance of this Act was its broad classification of the term "Manufacturer" to include non-manufacturers including repackagers. While this may have been appropriate within the scope and intended purpose of the Drug Listing Act, it has caused the problem that we are facing today.

Because of the FDA's "manufacturing" classification, a repackager (who, again, does not actually manufacture the drugs) has the ability to re-label an existing product with the repackager's own National Drug Code number identifying them as the manufacturer for the product delivered in the bottle. More important, because of its manufacturing classification and right to create a new NDC number, *re-packagers can establish a new wholesale price for the same product*.

So what does that mean? That means if an original manufacturer produces a pill and sets a price (Average Wholesale Price) at, say, $.50 per pill, the repackager can simply relabel bottles of the same pill with a new NDC number and can and has set a new Average Wholesale Price. We have seen instances in Hawaii where a repackager has unreasonably and unjustifiably increased the per pill prices by 1627%.

Now, if the State in setting the fee schedules simply made a distinction between the original manufacturer's AWP and the repackager's AWP, it could address the repackaging problem.

Unfortunately, in its present version, Hawaii law does not make that distinction and simply requires the drug reimbursement rate to be the AWP + 40%, and therein lies the problem. Under the present statutory scheme, repackagers can create their own prices without justification and have used this ability to massively increase profits for the sale of drugs under Hawaii's workers' compensation fee schedule. In states where the repackaging problem was not addressed quickly, repackaged drugs became a major profit center for those involved in selling the repackaged drugs. In Hawaii, repackagers are only now gaining a foothold, after having been shut down in California, Arizona, and Mississippi, among other states.

S.B. 1414 simply makes it clear that the original manufacturer's average wholesale price (AWP) must be used as the basis when calculating reimbursements for drugs under Hawaii's workers' compensation fee schedule (i.e., 100% of the original manufacturer's AWP plus 40% profit).

II. THE COMPOUND MEDICATION ISSUE

As with repackaging, physicians often contract with a company that specializes in producing compound medication in large quantities and provides a supply of these compounded medications for the physician to dispense out of their office setting.

We note that although compounded medications are generally a more sophisticated version of repackaging, some compound medications may be medically necessary. That being said, compounded medications present a challenge in how they are reported and identified for billing purposes.

Unlike repackaged drug manufacturers who create a unique National Drug Code (NDC), compound medications do not have unique NDCs, as they are the combination of several drug products – each with its own NDC.

So when billing them to a payer, compounds are often identified with a "dummy" NDC of all 9s, (99999-9999-99) with an abbreviated description of the combination of products used in the production of the compound medication.

Since there is no assigned NDC and thus no Average Wholesale Price reported to a pricing source, if a state's workers' compensation fee schedule statutes or administrative rules are not clear in

defining compound medications, compounding pharmacies can exploit this ambiguity to their advantage by unreasonably and unjustifiably marking up the costs of such medications.

III. S.B. 1414 IS A COST CONTAINMENT MEASURE

By helping to contain unreasonable and unjustifiable increases in prescription drug costs S.B. 1414 is a cost containment measure.

The unregulated practice of marking up repackaged prescription drugs affects everyone. It doesn't just affect insurance companies; it unreasonably and unjustifiably drives up the cost of prescription drugs for all self-insured entities, including the State of Hawaii, all of the counties in the state, and self-insured companies such as Marriott and Safeway. Ultimately, failing to contain the costs of repacked drugs and compound medications will have a significant effect on employers as their lost cost ratios rise, raising premiums as well.

Finally, a recent study by the National Council on Compensation Insurance, ("NCCI") Inc. shows on a state by state basis the substantial cost increases experienced by states that have failed to contain repackaged prescription drug costs.

IV. REPACKAGED DRUGS/COMPOUND MEDICATIONS IS A NATIONWIDE PROBLEM

As noted above, the problem that this legislation seeks to address is a problem facing many states. Several states, such as California, Arizona, and Mississippi, have already refined their statutes and administrative rules to demarcate the difference between original manufacturers and repackagers, clearly defined compound medications, and ultimately contained the unreasonable and unjustifiable increase in prescription drug costs caused by repackaged drugs and compound medications.

The experience in other states has also shown that when a state government closes the repackaging loophole, repackaging firms resort to compound medications to unreasonably inflate drug costs and their profit margins. Therefore, S.B. 1414 seeks to address both practices at the same time.

V. THIS BILL DOES NOT IMPACT PHYSICIAN DISPENSING

This bill is *not* about physician dispensing. We only raise the issue because it was a problem in the California repacking battle because the repackaging practice had developed to a much greater degree and had become a major profit center for California workers' compensation physicians. Because of that, the cost-containment effort in California included doing away with the entire practice of physician dispensing.

That is *not* the case here in Hawaii. Although the repackagers have established a beachhead, they have not yet fully established their business model in the islands.

Therefore, S.B. 1414 does not alter, revise or in any way impact the practice of physician dispensing of prescription drugs. In fact, HEMIC supports physician dispensing. We believe it is a good practice which benefits the treatment of injured workers.

We note that most workers' compensation doctors dispense medications that are not repackaged and getting reimbursed at AWP plus 40%.

There is plenty of room in Hawaii's generous prescription drug fee schedule to allow physicians to make a fair profit on the medications they disperse. But distorting the fee schedule as I described earlier is simply an abuse; an abuse that this legislation will effectively curtail.

VI. S.B. 1414 IS NOT THE PROPER VEHICLE TO DISCUSS THE OVERALL COMPENSATION OF DOCTORS WITHIN THE WORKERS' COMPENSATION SYSTEM

At the hearing on the house bill, opponents of the House version of this bill argued that it will severely impact the ability of doctors to earn their living. S.B. 1414, however, deals strictly with containing the unreasonable and unjustifiable increase in the cost of prescription drugs caused by repackaged drugs and compound medications.

In any case, it should be noted that the DLIR is required by law to update the Hawaii Workers' Compensation Supplemental Fee Schedule for physician reimbursement at least every three years or annually, as required.

Opponents of the House version of this bill also argued that containing the unreasonable and unjustifiable increase in the cost of prescription drugs caused by repackaged drugs and compound medications will cause doctors to leave the island.

As noted earlier, abusing repackaging and compound medication practices to create a new profit center has not yet been fully developed in Hawaii. It is growing, but only within a small group of physicians. Again, S.B. 1414 is about containing the unreasonable and unjustifiable increase in the cost of prescription drugs caused by repackaged drugs and compound medications

Thank you again for the opportunity to present testimony in strong support of SB 1414. I respectfully request your support for these bills.

Sincerely,

Paul Naso, General Counsel
Hawaii Employers' Mutual Insurance Company, Inc.

PN:rm

HAWAII INSURERS COUNCIL
A trade association of property and casualty insurance companies

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Alison Powers
Executive Director

TESTIMONY OF LINDA O'REILLY

SENATE COMMITTEE ON CONSUMER PROTECTION AND COMMERCE
Senator Rosalyn H. Baker, Chair
Senator Brian T. Taniguchi, Vice Chair

Friday, February 11, 2011
8:30 a.m.

SB 1414

Chair Baker, Vice Chair Taniguchi, and members of the Committee, my name is Linda O'Reilly, Workers' Compensation Claims Manager at First Insurance, testifying on behalf of Hawaii Insurers Council. Hawaii Insurers Council is a non-profit trade association of property and casualty insurance companies licensed to do business in Hawaii. Member companies underwrite approximately 40% of all property and casualty insurance premiums in the state.

Hawaii Insurer Council **supports** SB 1414, which would restrict markups of repackaged prescription drugs and compound medications to what is currently authorized for retail pharmacies under state law.

Hawaii's current reimbursement rate for pharmaceuticals is already the highest in the nation for both brand and generic products. The state fee schedule is AWP + 40%, with Redbook being cited as the pricing source. To demonstrate the markups, Exhibit 1 lists commonly dispensed medications that were re-packaged and re-labeled from a physician's office that specializes in the treatment of Workers' Compensation injuries. Exhibit 2 lists the same medication with the applied Hawaii fee schedule reimbursement rate.

Exhibit 3 lists commonly dispensed compound medication and the charges national observers have seen associated with them. Compound medications present their own

unique challenge because as their name suggest, compound medications are a combination of several drug products, and do not have a unique National Drug Code (NDC). As a result if left unregulated, compounding pharmacies can continue to create "dummy" NDCs and inflate charges.

States of California, Arizona, and Mississippi have experienced abuse until markups on repackaged prescription drugs and compound medications were regulated. Since Hawaii's reimbursement rates are already the highest in the nation, we respectfully request your support of SB 1414, which would restrict unreasonable increases of prescription drug costs to our people and business communities.

Thank you for the opportunity to testify.

Exhibit 1

AWP Comparisons

Drug	QTY	Re-Packaged AWP	Common Retail Pharmacy AWP	% of Mark Up
ACETAMI/CODE 300/30MG	60	$35.78	$17.83	100.7%
ACETAMI/CODE 300/60MG	60	$69.19	$56.20	23.1%
ACETAMINPHEN/CODE 300/30MG	30	$17.89	$8.91	100.7%
ALPRAZOLAM .5MG	30	$49.02	$25.33	93.5%
CELEBREX 200MG	30	$166.16	$132.92	25.0%
DIAZEPAM 5MG	30	$102.70	$5.94	1627.9%
DOCUSATE SODIUM 100MG	30	$39.14	$5.94	558.5%
ETODOLAC 50MG	30	$51.18	$45.04	13.6%
FLUOXETINE HCL 10MG	30	$185.55	$74.13	150.3%
FLUOXETINE HCL 20MG	30	$190.32	$80.04	137.8%
GABAPENTIN 300MG	30	$57.98	$39.89	45.4%
GABAPENTIN 300MG	120	$231.99	$159.55	45.4%
GABAPENTIN 600MG	30	$98.63	$75.60	30.5%
GABAPENTIN 600MG	60	$220.29	$151.20	45.7%
GABAPENTIN 600MG	120	$440.59	$302.40	45.7%
HYDRO/APAP 10/650MG	30	$52.31	$15.96	227.8%
HYDRO/APAP 10/650MG	60	$104.62	$31.92	227.8%
HYDRO/APAP 5/500MG	30	$34.49	$12.58	174.7%
HYDRO/APAP 5/500MG	60	$68.97	$25.11	174.7%
HYDROC/APAP 5/500MG	120	$137.94	$50.22	174.7%
HYDROC/APAP 7.5/500MG	30	$43.11	$15.45	179.1%
HYDROC/APAP 7.5/500MG	60	$86.22	$30.90	179.1%
HYDROCODONE/APAP 7.5/750MG	30	$38.54	$10.67	261.4%
IBUPROFEN 400MG	30	$8.84	$5.15	71.6%
IBUPROFEN 400MG	60	$17.67	$10.30	71.5%
IBUPROFEN 800MG	90	$39.33	$27.43	43.4%
LUNESTA 2MG	30	$251.10	$200.88	25.0%
LUNESTA 3MG	30	$251.10	$200.88	25.0%
MELOXICAM 15MG	30	$205.84	$145.35	41.6%
MELOXICAM 7.5MG	30	$134.62	$94.94	41.8%
METHOCARBAMOL 500MG	30	$22.23	$15.24	45.9%
NAPROXEN 500MG	30	$65.94	$33.78	95.2%
NAPROXEN 500MG	60	$131.88	$67.56	95.2%
PROMETHAZINE 25MG	30	$16.81	$14.43	16.5%
RANITIDINE 150MG	60	$244.96	$88.80	175.9%
TIZANIDINE 4ML	30	$65.22	$41.75	56.2%
TRAMADOL 50MG	60	$93.27	$50.03	86.4%
TRAMADOL 50MG	120	$186.54	$100.06	86.4%
TRAZODONE HCL 50MG	30	$64.13	$13.24	384.3%
TRIAZOLAM .25MG	30	$56.40	$20.25	178.6%
ZOLPIDEM 10MG	30	$167.01	$137.22	21.7%

Exhibit 2

Hawaii State Fee Schedule applied

Drug	QTY	Re-Packaged AWP at Fee Schedule	Common Retail Pharmacy AWP at Fee Schedule	% of Mark Up
ACETAMI/CODE 300/30MG	60	$50.09	$24.96	100.7%
ACETAMI/CODE 300/60MG	60	$96.87	$78.68	23.1%
ACETAMINPHEN/CODE 300/30MG	30	$25.04	$12.48	100.7%
ALPRAZOLAM .5MG	30	$68.63	$35.46	93.5%
CELEBREX 200MG	30	$232.62	$186.09	25.0%
DIAZEPAM 5MG	30	$143.78	$8.32	1627.9%
DOCUSATE SODIUM 100MG	30	$54.80	$8.32	558.5%
FLUOXETINE HCL 10MG	30	$259.77	$103.78	150.3%
FLUOXETINE HCL 20MG	30	$266.45	$112.06	137.8%
ETODOLAC 50MG	30	$71.65	$63.06	13.6%
GABAPENTIN 300MG	30	$81.17	$55.84	45.4%
GABAPENTIN 300MG	120	$324.79	$223.37	45.4%
GABAPENTIN 600MG	30	$138.08	$105.84	30.5%
GABAPENTIN 600MG	60	$308.41	$211.66	45.7%
GABAPENTIN 600MG	120	$616.83	$423.36	45.7%
HYDRO/APAP 10/650MG	30	$73.23	$22.34	227.8%
HYDRO/APAP 10/650MG	60	$146.47	$44.69	227.8%
HYDRO/APAP 5/500MG	30	$48.29	$17.58	174.7%
HYDRO/APAP 5/500MG	60	$96.56	$35.16	174.7%
HYDROC/APAP 5/500MG	120	$193.12	$70.31	174.7%
HYDROC/APAP 7.5/500MG	30	$60.35	$21.63	179.1%
HYDROC/APAP 7.5/500MG	60	$120.71	$43.25	179.1%
HYDROCODONE/APAP 7.5/750MG	30	$53.96	$14.93	261.4%
IBUPROFEN 400MG	30	$12.38	$7.21	71.6%
IBUPROFEN 400MG	60	$24.74	$14.42	71.5%
IBUPROFEN 800MG	90	$55.06	$38.40	43.4%
LUNESTA 2MG	30	$351.54	$281.23	25.0%
LUNESTA 3MG	30	$351.54	$281.23	25.0%
MELOXICAM 15MG	30	$288.18	$203.49	41.6%
MELOXICAM 7.5MG	30	$188.47	$132.91	41.8%
METHOCARBAMOL 500MG	30	$31.12	$21.34	45.9%
NAPROXEN 500MG	30	$92.32	$47.29	95.2%
NAPROXEN 500MG	60	$184.63	$94.58	95.2%
PROMETHAZINE 25MG	30	$23.53	$20.21	16.5%
RANITIDINE 150MG	60	$342.94	$124.32	175.9%
TIZANIDINE 4ML	30	$91.31	$58.45	56.2%
TRAMADOL 50MG	60	$130.58	$70.04	86.4%
TRAMADOL 50MG	120	$261.16	$140.08	86.4%
TRAZODONE HCL 50MG	30	$89.78	$18.54	384.3%
TRIAZOLAM .25MG	30	$78.96	$28.34	178.6%
ZOLPIDEM 10MG	30	$233.61	$192.11	21.7%

Exhibit 3

Commonly dispensed Compound Medications produced by compounding pharmacies and associated Charges

Dummy NDC	Compound	Billed Charge	AWP + 40%
99999-9999-99	MEN 1% CAM .5% CAP .05% 60GM COMPOUND	$223.83	$27.34
99999-9999-99	LIDOCAINE 10% GEL, 60GM	$219.35	$16.09
99999-9999-99	MEN 1%, CAM 0.5%, CAPS 0.05% 60GM	$226.07	$30.18
99999-9999-99	MEN 1% CAM .5% CAP .05% 10GM COMPOUND	$53.30	$6.06
99999-9999-99	MEN 1% CAM .5% CAP 0.05% 120GM COMPOUND	$291.00	$54.73

GEICO
geico.com

- Government Employees Insurance Company
- GEICO General Insurance Company
- GEICO Indemnity Company
- GEICO Casualty Company

TIMOTHY M. DAYTON, CPCU, GENERAL MANAGER ALASKA & HAWAII
711 Kapiolani Blvd., Suite 300 ■ Honolulu, HI 96813-5238 ■ Email: tdayton@geico.com
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Senate Committee on Commerce & Consumer Protection
Conference Room 229 State
Friday, February 1, 2011, 8:30 a.m.
SB 1414 – Relating to Repackaged Drugs

Chair Baker, Vice Chair Taniguchi and Members of the Committee

My name is Timothy Dayton and I am General Manager for GEICO, Hawaii's largest motor vehicle insurer. GEICO supports SB 1414. The Bill as written does not specifically spell out the intent of the Legislature as it relates to benefits paid under the Personal Injury Protection (PIP) on a motor vehicle insurance claim. Although HRS 431:10C specifically limits charges for PIP benefits to those allowed under Chapter 386, it would be helpful to specifically reference motor vehicle insurance to eliminate any ambiguity or dispute. I have attached proposed language for Section 1 of this Bill which I believe would provide sufficient clarification of legislative intent.

I have also attached a specific example showing the difference in charges for a prescription purchased from a pharmacy compared to billing for purchase of the same drug repackaged. The prescription charges in the attached example are for the same drug (CELEBREX), the same Doctor prescribing the drug, the same

patient and the same auto insurance claim. The charge for the purchase from Longs for 30 tablets was $134.99. The charge for the same 30 tablet prescription repackaged was $232.62.

The difference is neither logical nor justified. GEICO encourages the Committees to approve this legislation with clarification as it relates to motor vehicle insurance.

Thank you for the opportunity to submit this testimony.

Timothy M. Dayton, CPCU

SECTION 1. The legislature finds that regulating markups of repackaged prescription drugs and compound medications will help to contain unreasonable increases of prescription drug costs in Hawaii's workers' compensation insurance and motor vehicle insurance systems as repackagers expand into states, including Hawaii, where costs of repackaged drugs and compound medications are not regulated.

The legislature further finds that Hawaii's current reimbursement rate for pharmaceuticals is the highest in the nation for both brand and generic products.

The purpose of this Act is to close a loophole in Hawaii's workers' compensation insurance and motor vehicle insurance laws to reasonably restrict markups of repackaged prescription drugs and compound medications to what is currently authorized for retail pharmacies under state law.

PLEASE DO NOT STAPLE IN THIS AREA

I certify all charges are in accordance with HAR 16-23-116 and any related rules.

GEICO
711 KAPIOLANI BLVD 300
HONOLULU, HI 96814
ATTN: CLAIMS DEPARTMENT

D7 059560 P4358

HEALTH INSURANCE CLAIM FORM

PICA ☐☐ — PICA ☐☐

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
☐ (Medicare #) ☐ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☒ (ID)	[redacted]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted] DONNA J	3. PATIENT'S BIRTH DATE MM DD YY [redacted] SEX M ☐ F ☒
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street): [redacted]	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☒
7. INSURED'S ADDRESS (No., Street)	
CITY: [redacted] STATE: HI	8. PATIENT STATUS: Single ☐ Married ☐ Other ☒
CITY	STATE
ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]	Employed ☒ Full-Time Student ☐ Part-Time Student ☐
ZIP CODE	TELEPHONE (INCLUDE AREA CODE)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☒ YES ☐ NO PLACE (State) HI
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☒ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: 0308757180101010	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 07 26 2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY
05 21 2010		
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: [redacted]	17a. I.D. NUMBER OF REFERRING PHYSICIAN: BM9810222	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 847.0 3. 847.1
2. 847.2 4. 729.1

22. MEDICAID RESUBMISSION ORIGINAL REF. NO. CODE

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
CELEBREX 200MG NDC# 66336-0727-30 AWP $166.16											
07 22 2010 07 22 2010	11	1	99070		1234	232 62	30		1B		
[redacted]					1234	[redacted]					
[redacted]					1234	[redacted]					

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO	28. TOTAL CHARGE $ 563 30	29. AMOUNT PAID $ 0 00	30. BALANCE DUE $ 563 30
[redacted]	[redacted]				

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
[redacted] 07 26 2010	[redacted]	INDUSTRIAL PHARMACY MANAGEMENT PO BOX 512518 LOS ANGELES, CA 90051 (949) 777-3100

AUTORX

PHARMACY INVOICE

PO Box 271589
Salt Lake City, UT 84127-1589
(866) 428-8679
Federal Tax ID 35-2194964

07 of 456 p958

INVOICE NO.: 1872720

INVOICE DATE: 10/25/2010

Bill To:

Fht-9x12-222-924
GEICO
PO BOX 509119
SAN DIEGO CA 92150-9119

Card Holder / Injured Person	
Patient:	[redacted] DONNA J.
Policy No.:	
Claim No.:	0308757180101010

Fill Date	Rx No.	NDC Drug Name	Compound	Refill	Qty	Days Supply	Prescriber ID	Amt Due
[redacted]								
10/20/10	0258902	00025152531 CELEBREX CAP 200MG	N	0	30	30	BM9810222	
		Dispensing Pharmacy: 259 (HI) Longs Drug Store Phone: 808-676-8116						$134.99
[redacted]		Dispensing Pharmacy: 259 (HI) Longs Drug Store Phone: 808-676-8116						
[redacted]		Dispensing Pharmacy: 259 (HI) Longs Drug Store Phone: 808-676-8116						
[redacted]		Dispensing Pharmacy: 259 (HI) Longs Drug Store Phone: 808-676-8116						
							TOTAL AMOUNT DUE:	[redacted]

Please remit payment to AutoRX at the address printed above.

I certify charges are in compliance with Hawaii Administrative Rule 16-23 and the Medical Fee Schedule defined by HRS 431:10C-103.. AutoRx certifies that these charges are billed in accordance with Chapter 386, HRS and any related rules.

IPM
INDUSTRIAL
PHARMACY
MANAGEMENT, LLC

Testimony of Industrial Pharmacy Management, LLC

Before the Senate Committee on Commerce and Consumer Protection

Friday, February 11, 2011 at 8:30 am
Conference Room 229

Re: SB 1414
Relating to Repackaged Drugs and Compound Medications

Chair Baker, Vice Chair Taniguchi, and Committee members:

Thank you for the opportunity to testify. Industrial Pharmacy Management, LLC opposes Senate Bill 1414.

IPM provides billing and management services to Hawaii physicians who treat and provide medications to workers who have been injured in on the job accidents. Although IPM understands employers' concerns about the rising cost of workers' compensation insurance premiums, this measure not only is unlikely to result in any reduction in premiums, but also has significant potential to harm both injured workers and their employers. Moreover, as drafted, the bill does not set any usable standard for the pricing of medications.

1. **This bill creates an incentive for physicians to refuse to treat employees who have been injured in industrial accidents.**

While this bill is styled as an attack on "repackagers" who are allegedly expanding into Hawaii, as a practical matter, it will reduce reimbursement to physicians who have expanded their practices to include provision of drugs and supplies in an effort to recoup income they have lost as insurers have slashed reimbursement rates for medical care.

Attached to this testimony, you will find a copy of an article describing a multi-state UCLA study of the impact of medical fee schedule changes on provider participation in workers' compensation systems. Its goal was to determine the effect of low-multiple fee schedules on physicians' willingness to treat injured workers entitled to workers' compensation benefits. For purposes of the study, "low multiple" was defined as a workers' compensation fee schedule that was at or below 125% of the Medicare Resource Based Relative Value Scale ("RBRVS"). With physician charges capped at only 110% of the RBRVS, Hawaii was one of only five states that

20377 SW Acacia Street • Newport Beach, CA 92660 • tel 800.803.7776 • fax 949.777.3157

met the definition for neurologists and one of only three states that met the definition for orthopaedists. Indeed, Hawaii's physician reimbursement levels for workers' compensation patients are among the three lowest in the entire United States. Lower reimbursement rates are found only in Maryland, which reimburses physicians for services provided to workers compensation patients at only 109% of the RBRVS.

The results showed that in several states where pre- and post-adoption data was available, reductions in physician reimbursement brought a dramatic decline in participation. In Texas, neurologist participation in the workers' compensation system fell from 63% to only 10% after a fee schedule imposing lower physician reimbursement was adopted. Neurologist participation in Hawaii continued to decline more than a decade after it first adopted its low-multiple fee schedule in 1995.

The decline in physician participation was attributable not only to low reimbursement rates, but also to the significant increase in practice expense that is imposed by participation in the workers' compensation system. The study revealed that workers' compensation participation after the adoption of a low-multiple RBRVS fee schedule was strikingly less than for lower paying alternative such are Medicare and Medicaid, apparently because of the additional administrative and regulatory burdens associated with workers' compensation that are not sufficiently compensation by low RBRVS fee schedules. An analysis of physician offices in the Los Angeles metropolitan area showed that hourly practice expense for physicians' offices accepting workers' compensation patients was 2.5 to 3 times higher than the Medicare practice expense rate.

The reduction in the numbers of physicians was accompanied by a decline in qualifications of physicians who elected to participate in the workers' compensation system. In Texas and West Virginia approximately one-half of neurologists who declined to accept workers' compensation patients were Board Certified and attended medical school in the United States. By comparison, only one-third of physicians who continued to participate in the system were Board Certified and US educated.

In order to cover the costs of providing care to workers' compensation patients, physicians who continue to participate in the system have expanded their practices and now provide medication and medical supplies to workers' compensation patients, in part because physician dispensing facilities high quality patient care, but also because dispensing from these items permit their continued participation in the workers' compensation program to remain financially viable. Significant cuts in these supplemental reimbursement sources will force many physicians to re-evaluate whether they can continue to provide care to injured worker eligible for workers' compensation benefits.

Claiming that physician offices must compete with retail pharmacies in the provision of medications and supplies disregards the significant advantages that many pharmacies, especially those run by pharmacy benefit managers and insurance carriers, have over physicians who do not have the option of buying in bulk and thereby dramatically lower medication costs.

2. This bill is likely to reduce injured workers' access to quality medical care.

In addition to providing dispensing physicians with needed supplemental practice income, physician dispensing of medications significantly improves patient care. Treatment outcomes can be negatively affected if patients do not start or maintain their medication therapy as instructed by their physicians. Point-of-care dispensing guarantees that injured workers receive medication and begin therapy immediately.

In contrast, 30-35% of all prescriptions that are sent to pharmacies are never filled. For workers' compensation patients, those numbers are even higher. Workers' compensation patients are not legally required to pay any of the costs for treating an on-the-job injury. However, the do not have an insurance card that provides the pharmacy with the information that it needs to bill a workers' compensation prescription. When a workers' compensation patient received a prescription from this physician he or she has two options: The first is to pay for his or her medications out of pocket and then attempt to obtain reimbursement from the carrier. Obviously, this can require the patient to undertake a substantial expense and be without the use of his or her money for weeks or months while awaiting reimbursement from the carrier.

The second is to wait for the pharmacy to receive approval for the claim from the carrier and return to the pharmacy several hours – or even days – later to pick up the medication. This can impose a substantial hardship on a workers' compensation patient who may have impaired mobility, significant paint, and challenges finding transportation for multiple trips to the pharmacy.

The end result of having to go to a pharmacy for medication is often poor compliance with treatment regimens and, therefore, reduced quality of care.

3. This bill is likely to increase the overall costs of caring for injured workers.

The need to pay out of pocket for medication or make repeated trips to the pharmacy to obtain it often results in diminished therapy compliance and, ultimately, delay healing, increased complications, increased transportation costs, and additional time lost from work.

Moreover, workers who have difficulty obtaining needed care are likely to file a claim against their employers with the Department of Labor and Industrial Relations. Litigating these claims increase carriers' expenses and, ultimately employers' premium expenses. The cost of litigated workers' compensation claims is typically 300 to 500% higher than non-litigated claims. Physicians share in the increased costs that accompany litigation. After a workers' compensation patient hires a lawyer in order to pursue a claim against his or her employer and the employer's insurer, physicians also frequently find themselves at increased risk of liability.

The number one reason that injured workers obtain representation and litigate workers' compensation claims is the anger and frustration that can result when the injured worker has difficulty obtaining access to benefits, such as needed medication. Physician dispensing helps avoid this outcome.

4. This bill fails to recognize the value provided to patients whose medications are dispensed by their treating physicians.

The Hawaii workers' compensation statues ensure that an injured worker has free choice of health care providers, including sources of medication. SB 1414's attempt to cap the fees that physicians may recover for dispensing medications is an attempt to circumvent that right, which fails to recognize the many benefits of physician dispensing. In addition to enhancing physician convenience and compliance, physician dispensing improves patient safety.

Physicians who dispense medications prepared by repackagers provide their patient with bar-coded containers of medication that contain the most commonly prescribed quantities of medication. Such packaging guarantees accuracy, as is reflected in the fact the most hospitals now insist that medication doses be identified by bar coding.

The potential for fatal errors resulting from a pharmacy's dispensing the wrong drug or wrong dosage can be as high as 5%. Cross-contamination is nearly universally present in pharmacy dispensed prescriptions because pharmacies of use the same counting trays to count different types of drugs – thereby introducing the risk of potentially life threatening reaction in patients with drug allergies. These same risks would be introduced into physician dispensing if physicians' use of repackaged product was restricted.

Repackagers are held to higher standards under the rules and guidelines established by the Drug Enforcement Administration and the Food and Drug Administration in order to prevent such occurrences. Additionally, repackagers products are "serialized." Each bottle of medication has its own identification number for tracking purpose, facilitating electronic tracking of medication in the event of drug recalls.

Finally, repackagers make greater use of less expensive generic drugs. Among pharmacies run by pharmacy benefit managers ("PBMs"), average generic drug use is about 65%. Rebates which PBMs receive from drug manufacturers, but are infrequently shared with employers, create a disincentive to use generic products. On the other hand, 82% of the medications dispensed by physicians are generic products.

5. As written, the bill does not provide a workable formula for medication pricing.

Finally, the bill does not provide an effective medication pricing mechanism. The proposal state that"[r]epackaged or relabeled drug price shall be calculated by multiplying the number of units dispensed by the average wholesale price set by the original manufacturer of the underlying drug, plus forty per cent." An examination of the American Druggist Redbook will reveal that the same drug product, from the same drug manufacturer, typically has several different average wholesale prices that vary with the size of the product passage. Drug manufacturers, like repackagers, pass the cost of product packaging on to consumers. Packaging costs tend to be relatively constant, and do not vary significantly with the number of units of medications in a package. Accordingly, the average wholesale price of a 100-unit container of a medication is likely to be substantially greater than the average wholesale price of a 5000-unit container, because, in the case of the smaller container, essentially the same packaging costs must be spread over a smaller number of units of medication.

Even if the same medication is dispensed by two retail pharmacies, the average wholesale price upon which the pharmacies' charges are based, and therefore, the amount ultimately billed to a workers' compensation insurance carrier, can vary significantly based on the size of the package of medication maintained in stock by the pharmacy. The size of medication container stocked by a pharmacy, in turn, depends on such factors as the pharmacy's total prescription volume and the relative number of physicians in the pharmacy's service area who frequently prescribe the specific medication. Accordingly, a low volume store is likely to keep only small packages of a medication in stock when it is regularly prescribed by only a few of the physicians with which the pharmacy customarily does business. Maintaining larger stock packages heightens the risk that the medication will expire, and the pharmacy will be required to dispose of it, before it is dispensed.

High volume pharmacies, on the other hand, typically maintain larger containers in their stock in order to maximize discounts that manufacturers provide to high volume purchasers because their larger customer base reduces the risk that the product will expire before it is used. Therefore, the bill's requirement that "[r]epackaged or relabeled drug prices shall not exceed the amount payable had the drug not been repackaged or relabeled" is meaningless because it is not possible to identify that amount from a practical standpoint.

Thank you for your attention to this matter.

Respectfully submitted,

INDUSTRIAL PHARMACY
MANAGEMENT, LL

Glenn Drobot
General Manager

WORKERS' COMPENSATION MEDICAL FEE SCHEDULES

NEW FINDINGS & IMPLICATIONS FOR CALIFORNIA

STEVEN E. LEVINE, M.D., PH.D., F.A.A.N.
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WORKERS' COMPENSATION MEDICAL FEE SCHEDULES: NEW FINDINGS & IMPLICATIONS FOR CALIFORNIA

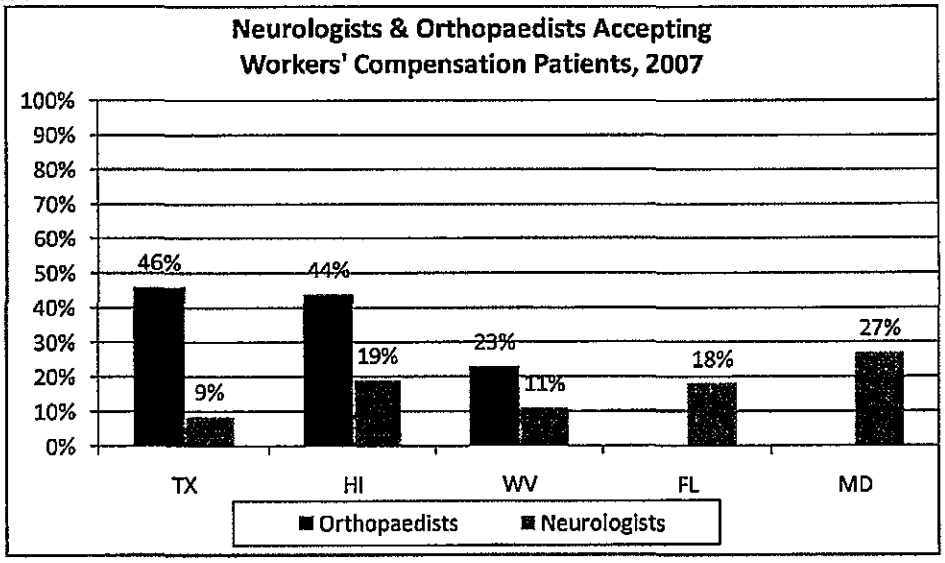
EXECUTIVE SUMMARY

We recently completed a comprehensive multi-state study of the impact of medical fee schedules on provider participation rates in workers' compensation systems. Specifically, the goal of the study was to determine whether the adoption of a workers' compensation medical fee schedule based on a low-multiple of the Medicare Resource-based Relative Value Scale (RBRVS) affected physicians' willingness to continue to treat workers' compensation patients.

For the purposes of this study, "low-multiple" was defined as a workers' compensation fee schedule that was at or below 125% of the Medicare RBRVS fee scale values. Five states in the country met the definition for neurologists — Florida, Hawaii, Maryland, Texas and West Virginia. Three states met the definition for orthopaedists — Texas, West Virginia and Hawaii. On January 1, 2007, Hawaii raised fees for specialists, and the present survey may overestimate specialist participation for that state. Nearly 1,400 neurologist and orthopaedist offices in these states, together with California, were included in a comprehensive telephonic survey to determine whether these doctors were accepting new workers' compensation patients. Responses were categorized as either: 1) Accepting workers' compensation patients without significant limitations, or; 2) Not accepting workers' compensation patients.

Every state that adopted a low-multiple RBRVS fee schedule demonstrated a markedly low rate of neurologist and orthopaedic participation in workers' compensation. In West Virginia, one of the states that has utilized a low-multiple RBRVS fee schedule the longest, less than a quarter of all orthopaedists and only 11% of all neurologists still accept workers' compensation patients.

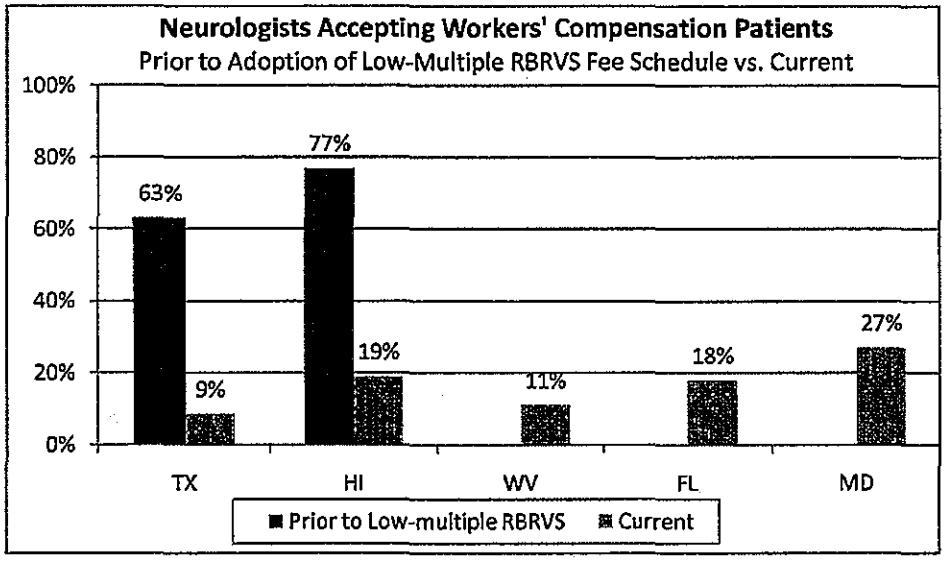
Figure 1



In the two states where pre-RBRVS and post-RBRVS data are available, there was a dramatic decline in participation with the adoption of a low-multiple RBRVS fee schedule. Neurologist

participation levels continued to decline in Hawaii more than a decade after it first adopted its low-multiple fee schedule. In Florida, where fees were raised three years ago to a low-multiple RBRVS level, participation among neurologists nevertheless continued to decline. Two states, Texas and West Virginia, now have neurologist participation rates of approximately ten percent. In contrast, participation in Texas was documented to be 63% a year before the adoption of a low-multiple (125%) RBRVS fee scale in 2003.

Figure 2



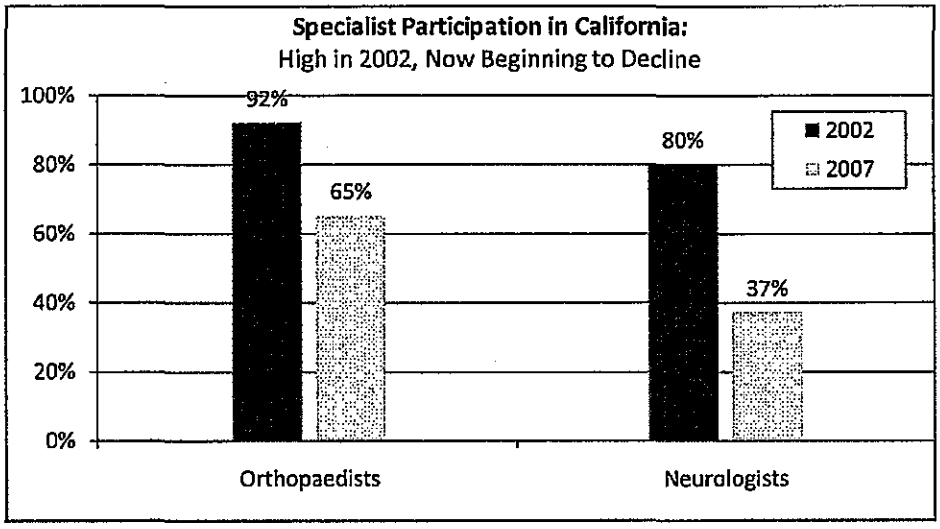
The results demonstrate that specialist workers' compensation participation after the adoption of a low-multiple RBRVS fee schedule was strikingly less than for lower-paying alternatives such as Medicare and Medicaid. This appears largely due to additional administrative and regulatory burdens associated with workers' compensation that are not sufficiently compensated by low-RBRVS fee schedules. An analysis of physician offices in the Los Angeles metropolitan area showed that the hourly practice expense for offices accepting workers' compensation patients was 2.5 to 3 times higher than the Medicare practice expense rate.

The telephonic surveys also revealed significant differences in the qualifications of neurologists who continued to treat workers' compensation patients after the adoption of a low-multiple RBRVS fee schedule. In both Texas and West Virginia, 50-55% of the neurologists who do not accept workers' compensation patients attended a U.S. medical school and are board-certified. By comparison, only 33% of those neurologists who continue to accept injured workers have these qualifications.

The dramatic departure of physicians from workers' compensation systems in states with low-multiple RBRVS fee scales appears to have been precipitated in all cases by decreases in reimbursement for specialist procedures, regardless of changes in other fees. For example, in Texas, the RBRVS conversion, which dramatically lowered specialty fees, also raised office visit fees 36%. It is worth noting that of the three most recent major workers' compensation fee schedule changes (in Hawaii, Tennessee and Illinois), each of the states elected to adopt fee schedules with higher relative fees for specialty providers in order to maintain or restore provider access.

The present survey also indicates that in California, specialist participation has already begun to decline. While 92% of orthopaedists and 80% of neurologists reported accepting workers' compensation patients in California in 2002, only 65% of orthopaedists and 37% of neurologists continue to do so in 2007.

Figure 3



Our findings suggest the need for an alternative to an unmodified low-multiple RBRVS fee schedule if medical access is to be maintained in California after the upcoming fee scale conversion to the RBRVS systems. Alternatives include 1) preserving existing specialist fees allowing gradual decreases due to inflation, while access is monitored; 2) using an RBRVS base, but with higher fees for specialty codes reflecting other fee data, as was done recently in Hawaii; and 3) using multiple RBRVS conversion factors, higher for specialty areas, as has been done in Tennessee, Oregon and many other states. Regardless of the particular approach, some modification of the RBRVS coupled with access monitoring would appear prudent. Such approaches would potentially allow implementation of a low-cost RBRVS-based fee scale for California, while reducing the likelihood of substantial declines in medical access.

PHYSICIAN WORKERS' COMPENSATION PARTICIPATION IN LOW-MULTIPLE RBRVS STATES

The initial phase of the research study was designed to determine whether the adoption of a workers' compensation medical fee scale that was based on a low-multiple of the Medicare resource-based relative value scale (RBRVS) schedule affected physicians' willingness to participate in that state's workers' compensation system and thereby impacted injured workers' access to care. For the purposes of this study, "low-multiple" was defined as anything at or below 125% of the Medicare RBRVS fee scale values.

According to data from the Workers' Compensation Research Institute in Cambridge, MA, five states in the country met the definition for neurologists: Texas, Florida, Maryland, West Virginia and Hawaii. Three states met the definition for orthopaedists: Texas, West Virginia and Hawaii. As the following table illustrates, these states could also provide insight into both the immediate and longer-term impacts of low-multiple RBRVS fee schedules, as two of the jurisdictions to be studied have had their RBRVS-based fee schedules in place for over a decade while three have only recently converted to this methodology.

Table 1: States with low-multiple RBRVS-based Workers' Compensation fee schedules

JURISDICTION	YEAR ADOPTED RBRVS-BASED FEE SCALE	CURRENT OVERALL % OF MEDICARE RBRVS	MET LOW-MULTIPLE RBRVS DEFINITION FOR
West Virginia	1994	113%	Neurologists & Orthopaedists
Hawaii	1995	110%	Neurologists & Orthopaedists
Texas	2003	125%	Neurologists & Orthopaedists
Maryland	2004	109%	Neurologists only
Florida	2005	110%	Neurologists only

Once the jurisdictions were selected, neurologists and orthopaedists practicing in those states were targeted as potential survey participants. All private practice neurologists were identified in Texas, West Virginia and Hawaii utilizing databases maintained by each state's Board of Medical Examiners. In Maryland, Florida and California, where such databases were not publically available, searches were performed using the American Academy of Neurology 2006-07 membership directory in an attempt to identify active neurologists in private practice within each respective state.

All private practice orthopaedist offices identified in Hawaii and West Virginia using the American Academy of Orthopaedic Surgeons (AAOS) 2006-07 membership directory and 411.com were contacted in addition to a random sample of 502 orthopaedist offices identified in Texas and California using the Texas Board of Medical Examiners database and the AAOS membership directory respectively. The Online telephone directory services 411.com and Yellow.com were then used to obtain current telephone numbers for all the physician offices identified.

The conclusions and opinions expressed in this study are solely those of the authors and do not represent the views of the David Geffen School of Medicine at UCLA.

This study was funded in part by a contribution from the California Society of Industrial Medicine and Surgery, Inc.

This process produced a data set of 1,398 physician offices (790 neurologist offices across six states and 608 orthopaedist offices in four states) to be surveyed. All 1,398 physician offices were contacted telephonically and asked whether the doctor was accepting new workers' compensation patients. Responses were categorized as either:

- Accepting workers' compensation patients without significant limitations, or;
- Not accepting workers' compensation patients

In most states, a third category of physicians was identified – those accepting workers' compensation patients ***with significant limitations.*** These physicians were only accepting injured workers from a single employer; only accepting from out of state insurance carriers; or accepting workers' compensation patients only on a limited, case-by-case basis after review of all files.

CASE STUDIES – PHYSICIAN PARTICIPATION IN TX, HI, WV, FL & MD

TEXAS

The Texas Workers' Compensation Commission adopted §134.202, the Medical Fee Guideline (MFG) in April 2002, with the new fee schedule officially going into effect on August 1, 2003. It was part of HB2600, a comprehensive package of workers' compensation reforms intended to control rising medical costs while also attempting to minimize the expense of administering the state workers' compensation fee schedule. Whereas the previous workers' compensation fee schedule was based on provider charge data, the new Texas MFG adopted a simple 125% of Medicare RBRVS fees across all procedure groups.

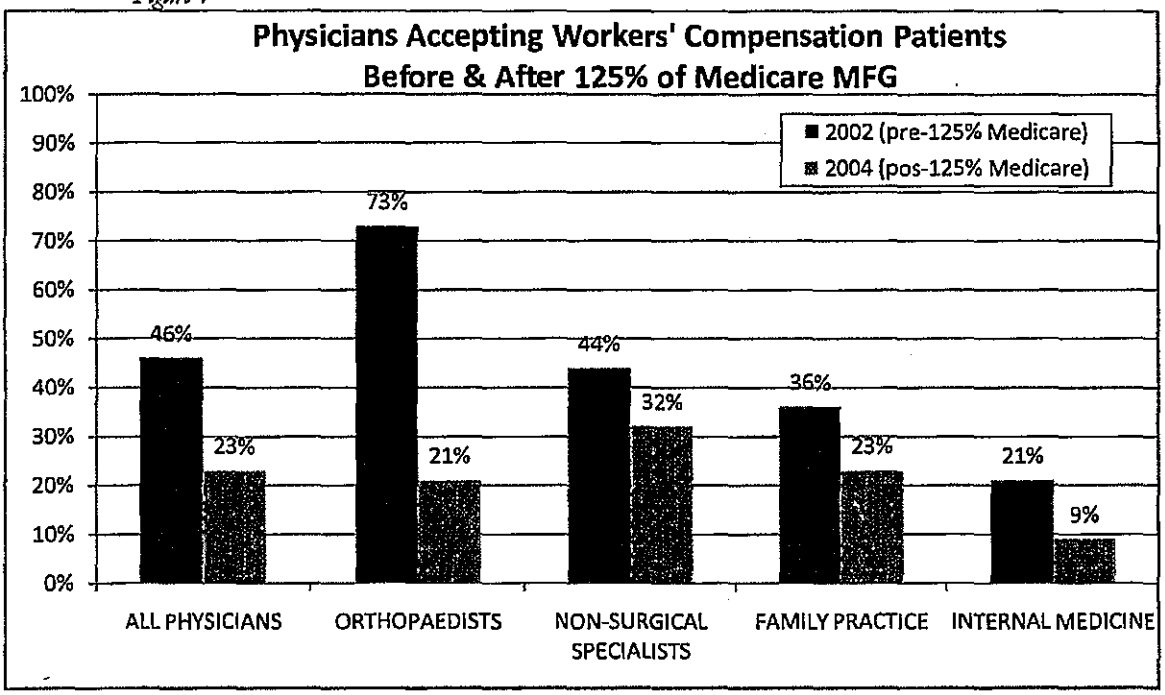
Interestingly, according to the preamble to §134.202, which officially implemented the 125% of Medicare MFG in 2002, the Workers' Compensation Commission received numerous comments expressing concern over whether the new MFG would negatively impact injured workers' access to quality healthcare in Texas.[1] According to the preamble,

> *"Commenters stated the proposed reduction in reimbursement will greatly affect the residents of Texas and impact injured employee by inhibiting care; it will be cost prohibitive to provide quality care, resulting in a lower standard of care. Commenters stated reducing reimbursement to curb costs would directly affect and jeopardize patient access to quality medical care by decreasing medical treatment options and driving ethical quality healthcare providers out of the workers' compensation system. Commenters stated healthcare providers would begin seeing more patients per hour, reducing quality of care. Commenter stated it is already difficult for injured employees to access health care. Commenters stated it would be an injustice for injured employees who will suffer emotional distress due to harassment and delays. Commenter stated the percentage of injured employees who transition from the acute to the chronic stage may increase. Commenters stated injured employees would resort to expensive care in emergency rooms or to poor health care in workers' compensation clinics or end up in the Medicaid system. Commenter stated a loss of access to quality medical care for injured employees will have a negative impact on the Texas labor pool, Texas businesses, and our economy in general."*[2] *(Commission, 2002)*

In response to these concerns, the Workers Compensation Commission published comments prepared by the Texas Association of Business Chambers of Commerce (TABCC) which stated, "While there were expressions of concern about potential access problems, no actual access problems have been documented in any specialty. The current level of Medicare payment to physicians is sufficient to provide reasonable access to quality medical care to injured workers."

Perhaps in response to the lack of research concerning physician access issues in Texas, two separate studies have been conducted since the adoption of the 125% of Medicare MFG. The first is a survey study now conducted bi-annually by the Texas Medical Association[3]. The goal of the Medical Association's surveys is a broad analysis of access issues throughout Texas and only a small portion of their survey focuses on workers' compensation. However, their workers' compensation findings are not encouraging. As shown in the figure below, the percentage of physicians who accept workers' compensation patients has declined significantly across all specialties since the adoption of the 125% of Medicare MFG.

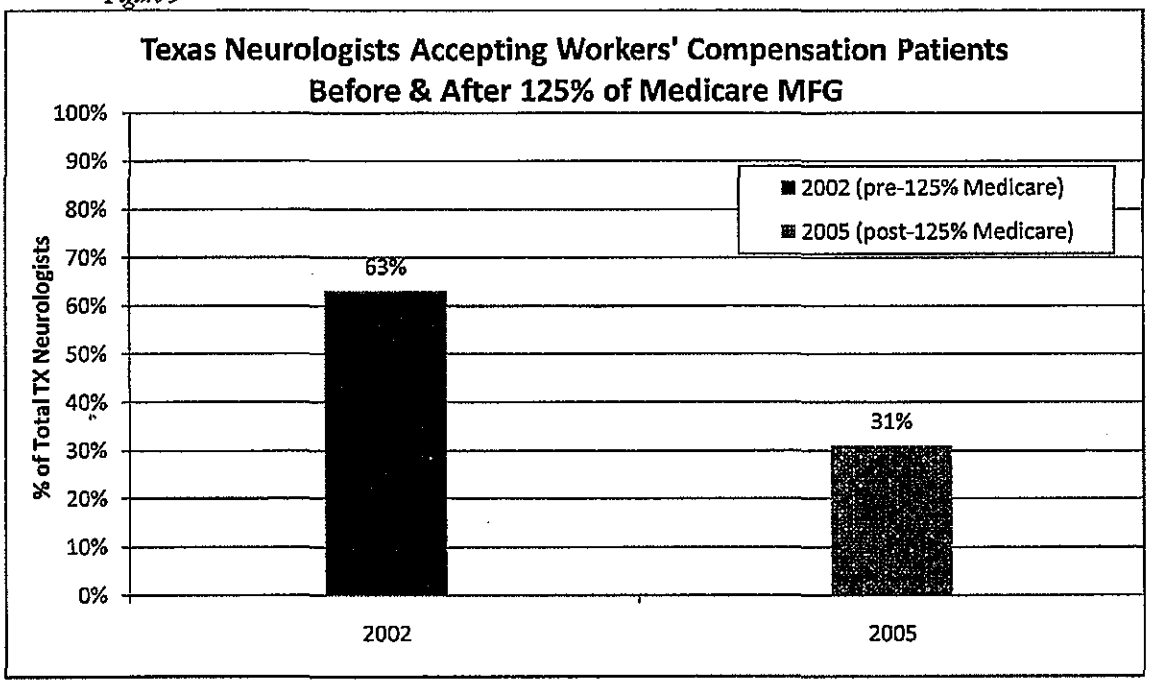
Figure 4



A second relevant study was conducted from December, 2004 to January 2005 by the Association of California Neurologists Workers' Compensation Committee (ACN).[4] The ACN study focused specifically on workers' compensation via a telephonic survey of all neurologists in Texas which specifically asked physicians if they accepted workers' compensation patients without significant limitations. If the provider's office responded that they were not accepting workers' compensation patients without significant restrictions as of the end of 2004, the survey staff then asked follow-up questions. The office was asked whether they had accepted workers' compensation patients without restrictions in 2002 (prior to the 125% of Medicare MFG) and what the most important factors were in their decision to no longer accept workers' compensation patients (reimbursement rates, administrative requirements, etc).

The ACN study of Texas neurologists yielded results that were strikingly similar to the findings of the subsequent Texas Medical Association study. As illustrated below, neurologist participation in the Texas workers' compensation system was cut in half, from 63% of all neurologists accepting injured workers in 2002 to only 31% by 2005.

Figure 5



It is worth noting that in addition to the changes to the medical fee schedule, the Texas Workers Compensation Commission introduced several administrative changes for providers as part of the HB2600 reform package. Perhaps the most important of these in terms of the potential impact on provider participation rates was a requirement that medical providers needed to apply to be on the state's "Approved Doctor List" (ADL) if they intended to treat workers' compensation patients. The primary administrative requirements for providers to be added to the Approved Doctor List were:

- The submission of a financial disclosure document that outlined the identity of any health care provider in which the doctor had a financial interest, an immediate family member of the doctor who had a financial interest, or the health care provider that employed the doctor who had a financial interest.

- The completion of a mandatory ADL training course - Level 1 training was for providers who anticipated treating 18 or fewer workers' compensation patients per year and Level 2 was for those who anticipated treating more than 18 patients per year.

While it could be argued that these additional administrative requirements played a role in the decrease in physicians willing to treat workers' compensation patients in Texas, a closer look at the actual requirements as well as the results of the ACN interviews suggest they were likely not a major factor.

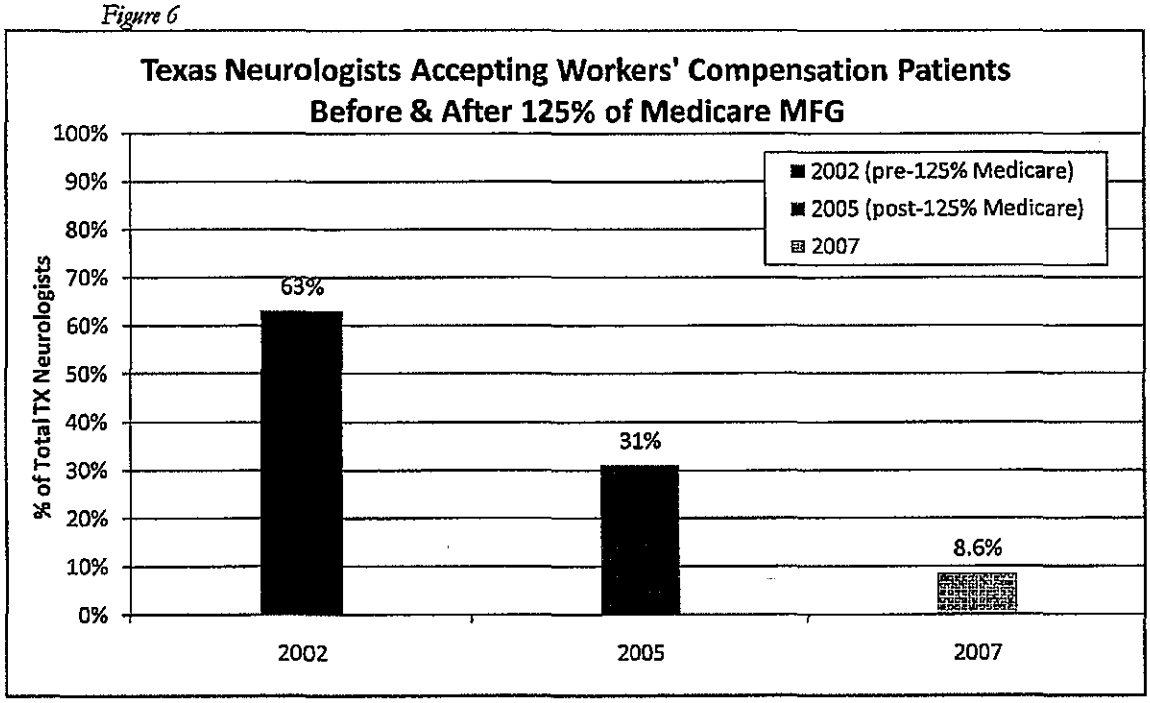
The financial disclosure statement was a straightforward two-page form that would have required less than an hour to complete. The ADL training sessions were very carefully structured to mirror the form and function of the Continuing Medical Education (CME) courses that physicians were routinely required to complete. The training courses were in fact administered jointly by the Workers' Compensation Commission and the Texas Medical Association and were offered as either one-day workshops at locations across the state or as an online training course that could be completed at the

provider's leisure. Considering the numerous financial disclosure forms and continuing education requirements with which all physicians must routinely comply, it seems unlikely that the Texas administrative requirements would have represented a significant impediment to physicians who wished to participate in the workers' compensation system.

Perhaps most telling regarding physician participation is that the ACN study specifically asked those Texas neurologists who had stopped accepting workers' compensation patients between 2002 and 2004/5 why they had done so. Sixty-three percent of those Texas neurologists who stopped seeing workers' compensation patients reported doing so either solely or primarily due to the introduction of the 125% of Medicare MFG[5].

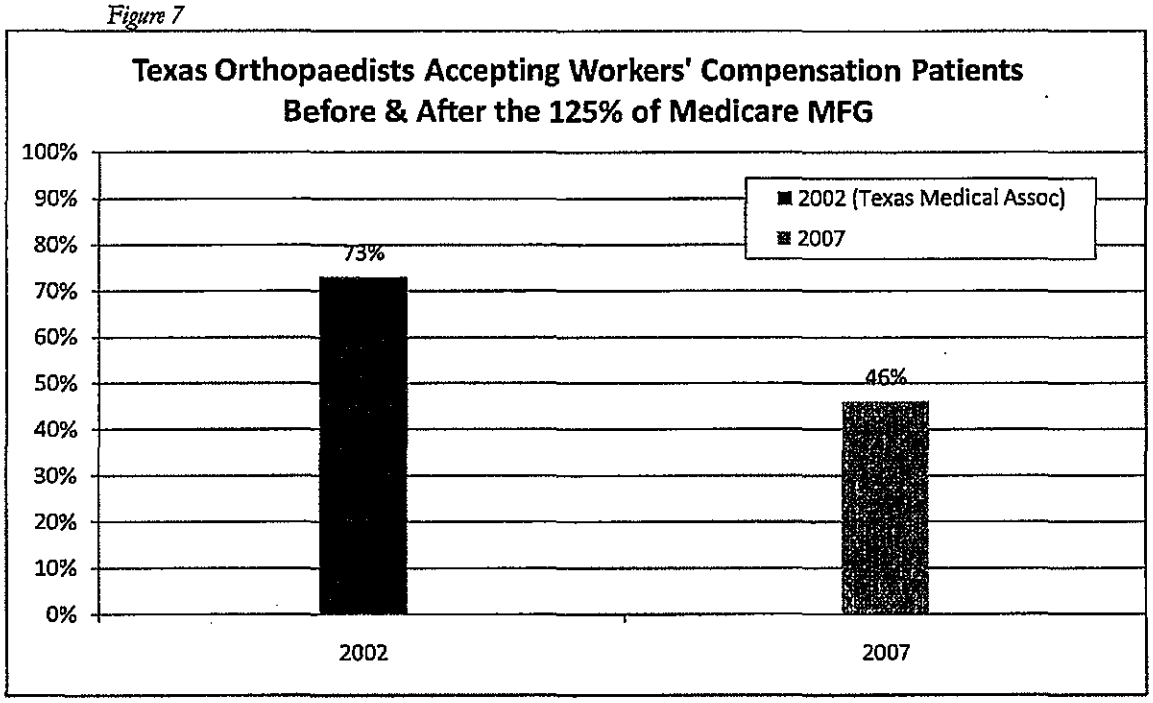
Supporting the notion that it is the fees, not any new administrative requirements that are driving neurologists out of the workers' compensation system, the present survey results suggest that neurologist participation in Texas has continued to decline sharply despite the fact that the Texas Legislature effectively relaxed the ADL administrative/training requirements for providers as part of House Bill 7 in September, 2005. Using telephonic survey methods identical to the 2005 ACN study, we found that less than 9% of all neurologists still accept Texas workers' compensation patients as of 2007.

Figure 6



The latest survey results also show a similar, though not quite as dramatic, continued decline in orthopaedist participation in the Texas Workers' Compensation system.

Figure 7



These trends are even more concerning when placed into their geographic context. According to the most recent survey data, there are now entire regions of Texas without close proximity to a neurologist willing to accept workers' compensation patients. As shown in the maps below, while there was good rural access to neurologists across the state in 2002, by 2007 most of the remaining neurologists willing to accept workers' compensation patients are limited to the major metropolitan areas of Dallas/Fort Worth, Houston and San Antonio. Over a span of only 5 years, access to neurologists for the vast majority of injured workers in Texas has evaporated.

Figure 8: Texas Neurologists Accepting Workers' Compensation Patients, 2002

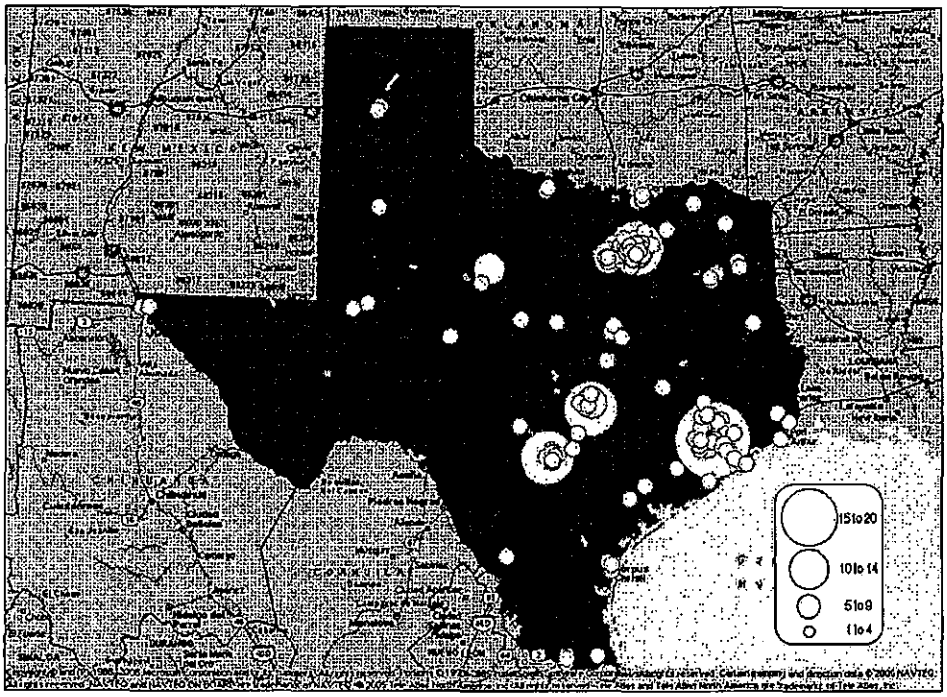
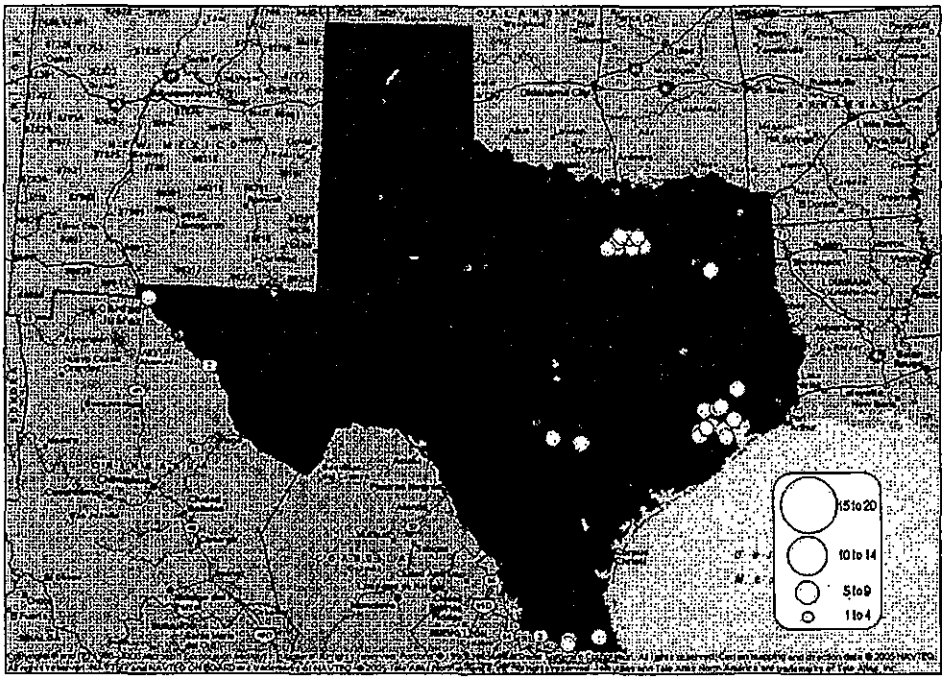


Figure 9: Texas Neurologists Accepting Workers' Compensation Patients, 2007



HAWAII

While Texas provides evidence of a disturbing trend with regard to physician participation in the years immediately following the adoption of a Medicare-based RBRVS workers' compensation fee schedule, Hawaii offers an opportunity to study the longer term effects of such fee schedules.

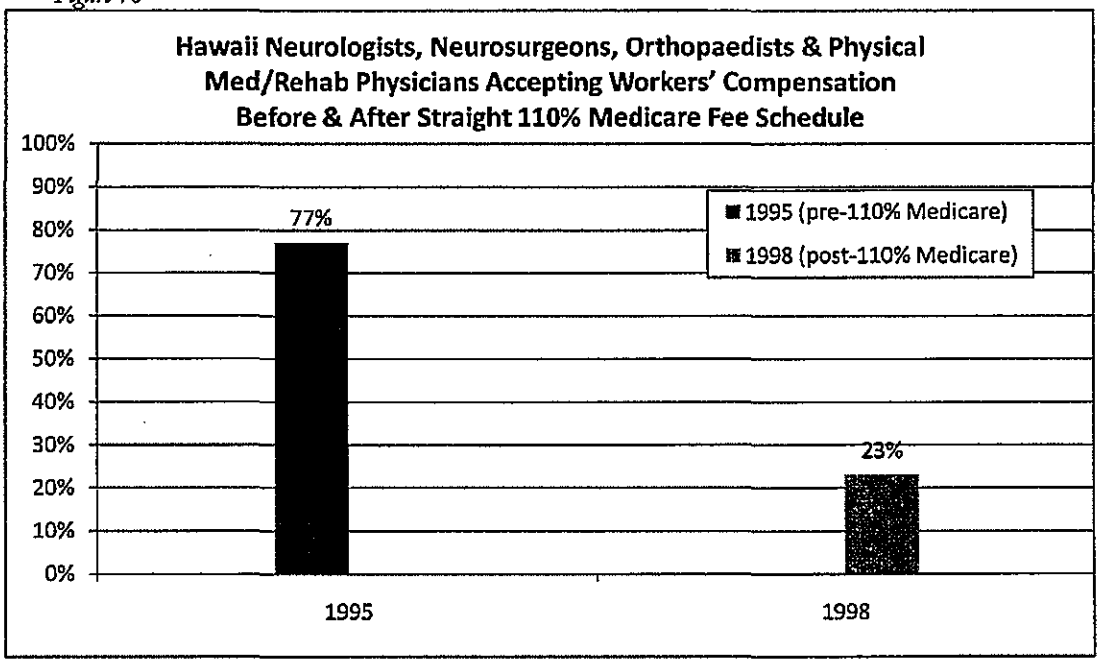
Hawaii adopted its first medical fee schedule more than 40 years ago. The state's Disability Compensation Division is responsible for developing the medical fee schedule with input from the state medical association and public comment. The fee schedule was originally based on relative values supplied by the Hawaii Medical Association, but in 1995 the system converted to a flat 110% of the state's Medicare RBRVS values.

In 1998, in response to growing concerns about injured workers' access to medical care, Hawaii's state legislature commissioned a study by the Legislative Reference Bureau to determine, "if the 110% ceiling on the workers' compensation medical fee schedule should be adjusted, whether the workers' compensation fee schedule has had a negative impact on the access to specialty care or diminished the quality of care, and what the conditions are for adjusting the fee schedule."[6] Completed in December of 1998, the study did find evidence that the fee schedule was having a negative impact on injured workers' access to medical care, particularly specialty care. According to the report,

> *'The Bureau identified a significant trend in health care providers that is shifting away from accepting all patients with workers' compensation injuries and moving towards policies that limit or totally reject prospective patients with work-related injuries covered under the workers' compensation law. The most common reason given for this trend is the change to the medical fee schedule level of reimbursement."*[7]

The chart below summarizes the Reference Bureau's finding with regard to the significant decline in the percentage of Neurologists, Neurosurgeons, Orthopaedists and Physical Medicine/Rehab Physicians accepting workers' compensation patients within just three years of the adoption of the 110% of Medicare fee schedule.

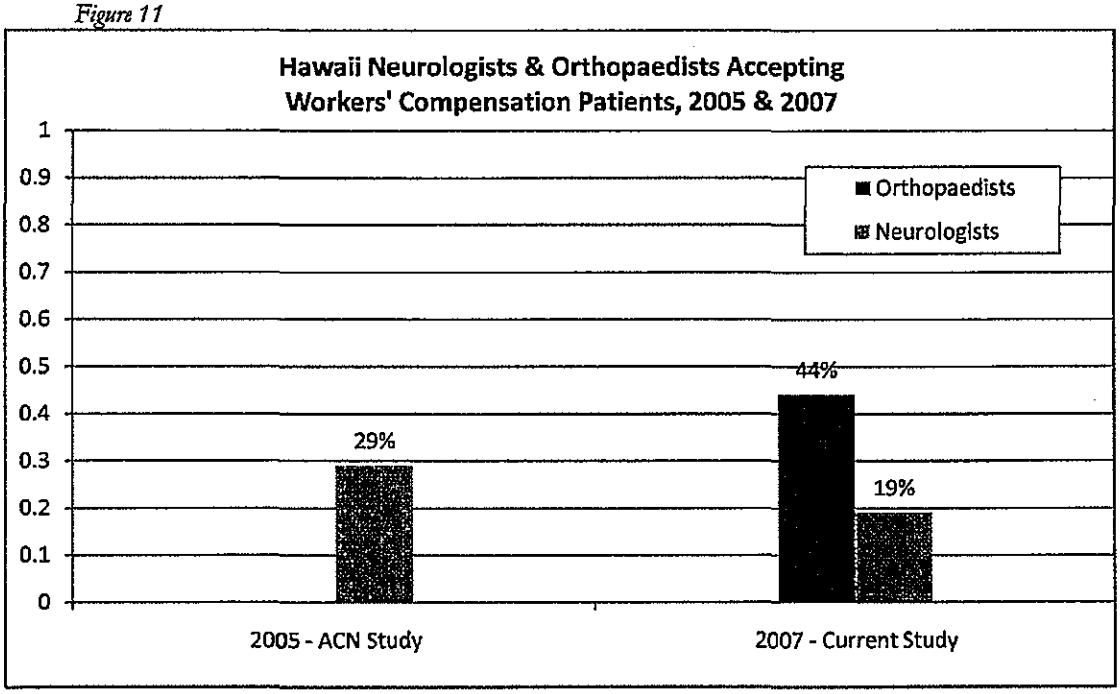
Figure 10



Perhaps the most troubling finding with regard to Hawaii is that it appears that the decline in physicians accepting workers' compensation caused by low-multiple RBRVS fee schedules is extremely long-lasting. As follow-up to their Texas study the Association of California Neurologists (ACN) interviewed all Hawaii neurologists in private practice in 2005 to assess whether workers' compensation participation levels were improving as physicians adjusted their practices to the reality of the 110% fee schedule. As the chart below illustrates, physician workers' compensation participation levels remained largely unchanged even ten years after the original fee schedule was adopted, with less than 30% of all neurologists accepting workers' compensation patients in Hawaii in 2005.

The results of the current research, in which all private practice neurologist and orthopaedist offices that could be identified in the state of Hawaii were interviewed telephonically, suggests that participation levels have dipped even further in 2007, with only 19% of neurologists and 44% of orthopaedists indicating that they still accept workers' compensation patients.

Figure 11



This decline continues in spite of a recent increase in Hawaii's workers' compensation neurological procedure fees (announced in September 2006, effective 1/1/2007). The orthopaedist portion of the study was conducted in June 2007, nearly six months after specialist fees were raised, and may significantly overstate orthopaedist participation that existed in 2006 under the 110% of Medicare regime.

Some of the arguments presented in the original Reference Bureau study[8] and even in the preamble to the Texas Medical Fee Guide[9], suggested that although specialists appeared to be leaving the workers' compensation system immediately after the adoption of the low-multiple RBRVS fee schedule, they would return once they had adapted their practices and/or treatment patterns to the reality of the new rates. This look at the long term impact of low-multiple RBRVS fee schedules would appear to refute that notion and instead suggests that once physicians choose to exit the workers' compensation system, they are unlikely to return while the fee schedule remains unchanged.

WEST VIRGINIA

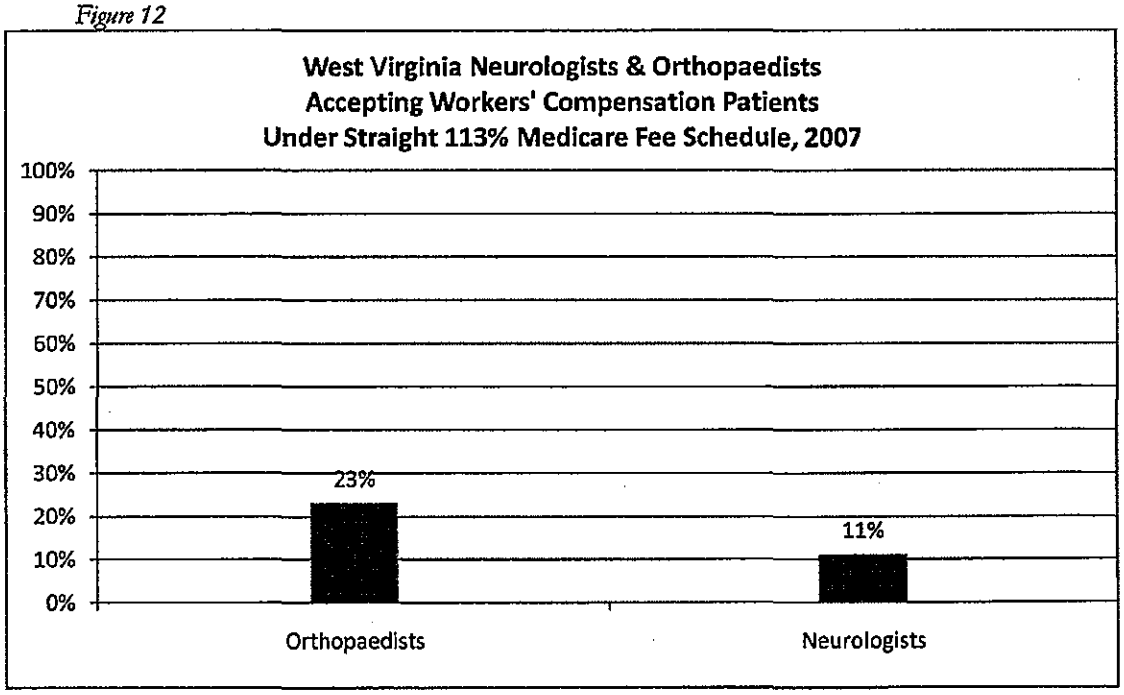
The state of West Virginia offers another potential look at the long term effect of low-multiple RBRVS fee schedules on physician's willingness to participate in the workers' compensation system. West Virginia implemented its first workers' compensation medical fee schedule in April 1988, but changed to a resource-based relative value scale in November 1994. The fee schedule is managed by the state's Workers' Compensation Division (WCD), which most recently moved to a straight 113% of Medicare effective 1/1/2006.

Until recently, West Virginia has also had the relatively unique distinction of being a monopolistic workers' compensation system – a state with only a single workers' compensation carrier, the West Virginia Workers' Compensation Fund. In effect, the Fund (a part of the state's Workers' Compensation Division) was the only source of workers' compensation insurance to employers in the state. This meant that medical providers had to deal with only a single payer when

submitting medical bills for treatment of injured workers, minimizing a significant portion of the administrative complexity usually attributed to the claims payment process in workers' compensation.

Nevertheless, even though the administrative burden was less, our most recent provider surveys found that similar to Hawaii, another state that has been using a low-multiple RBRVS fee scale for more than ten years, less than twenty-five percent of the private practice orthopaedist offices in West Virginia still accept workers' compensation patients. Perhaps even more striking, the number of neurologists still willing to treat workers' compensation patients in West Virginia as of 2007 has declined to only 11%.

Figure 12

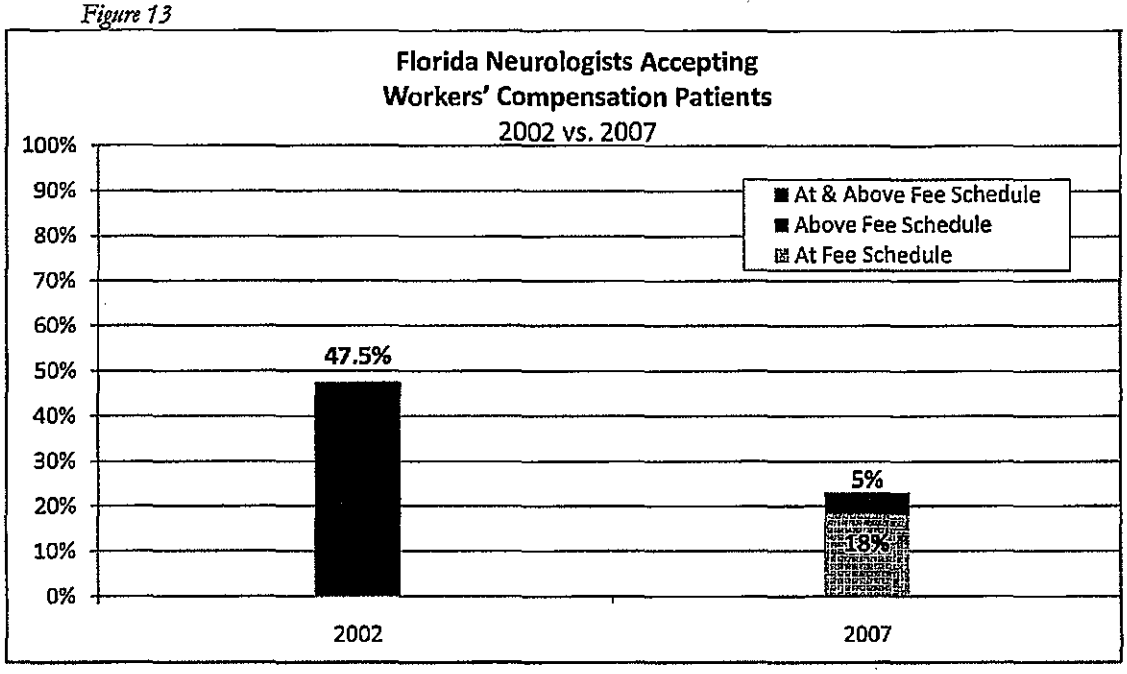


FLORIDA

Florida provides a slightly different example of a state that recently turned to a low-multiple RBRVS fee schedule in an attempt to actually improve its' provider reimbursements. Florida had been using a resource-based relative value scale managed by the Department of Insurance to set maximum medical reimbursement levels in workers' compensation since 1993. This fee schedule system actually yielded some of the lowest unit cost reimbursement rates to providers treating workers' compensation patients in the country – estimated at only 83% of the Medicare RBRVS rates. However, Florida's workers' compensation costs continued to rise and as a result, in 2003 the governor appointed a commission to review the entire system and make recommendations designed to address the major cost drivers. With regard to medical reimbursement levels, the governor's commission recommended increasing fees to a straight 150% of Medicare values in order to improve and maintain injured workers' access to care. However, the bill ultimately passed by the Florida legislature in May of 2003 opted instead to set surgical procedures at 140% of Medicare and all other procedures at 110% of Medicare.

A telephonic survey of neurologists practicing in the state of Florida in 2002 conducted by the HJH Group in Tampa, FL determined that 47.5% of all neurologists were accepting workers' compensation patients under the previous fee schedule.[10] Interviews conducted in March of 2007 found that neurologist participation in the workers' compensation system had fallen to just 23% after the adoption of the 110% Medicare RBRVS schedule. In fact, 5% of the neurologists surveyed in 2007 disclosed that they only accepted workers' compensation patients if the payer agreed to reimburse them at rates above the official fee schedule. This means that the number of neurologists actually willing to treat Florida injured workers' at the rates specified by the fee schedule has fallen to only 18%.

Figure 13

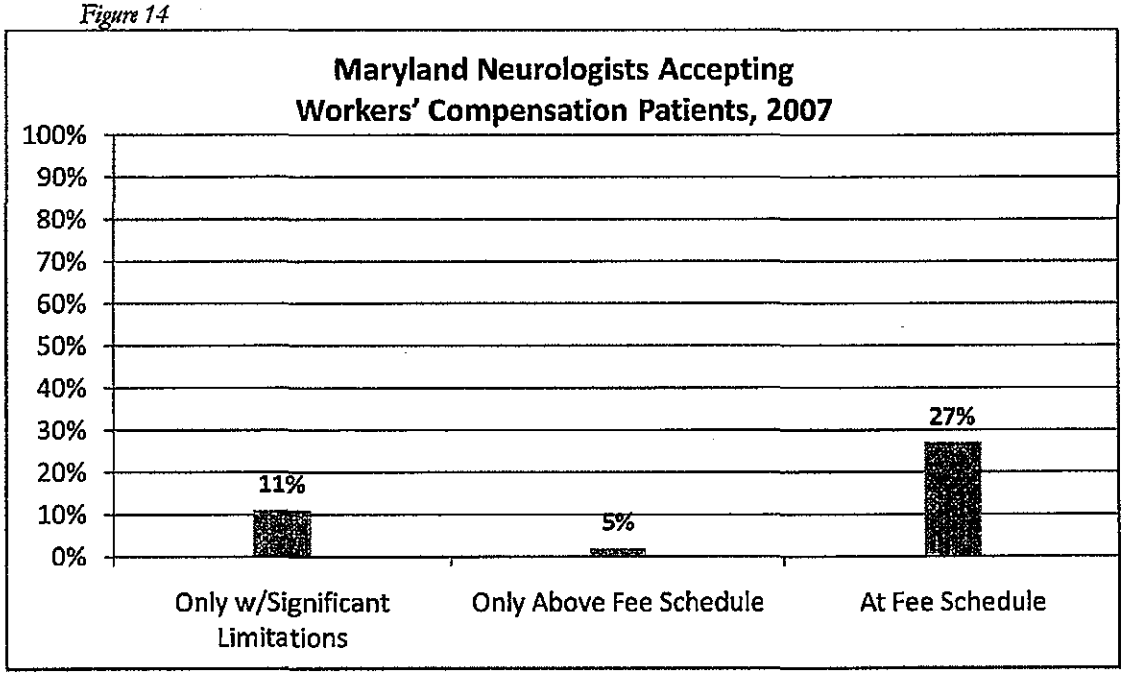


MARYLAND

Maryland represents the final state that has adopted a low-multiple RBRVS fee scale for workers' compensation. Maryland actually based its first workers' compensation medical fee schedule on the California Relative Value Study (CRVS), with a fee schedule committee responsible for updating the relative values and conversion factors bi-annually. In 2004, Maryland replaced the CRVS-based fee schedule with one set at 109% of the Medicare RBRVS values. Effective February 2006, Maryland has increased the reimbursement rate for Orthopedic and Neurosurgical procedures to 144% of Medicare, while all other procedures remain at 109% of Medicare.

While no historical data is available for Maryland providers, the 2007 survey data suggests a similar pattern to the other states studied. Twenty-seven percent of neurologists are willing to treat workers' compensation patients at the low-multiple RBRVS rates. Another 5% will accept injured workers only for fees above the official state fee schedule.

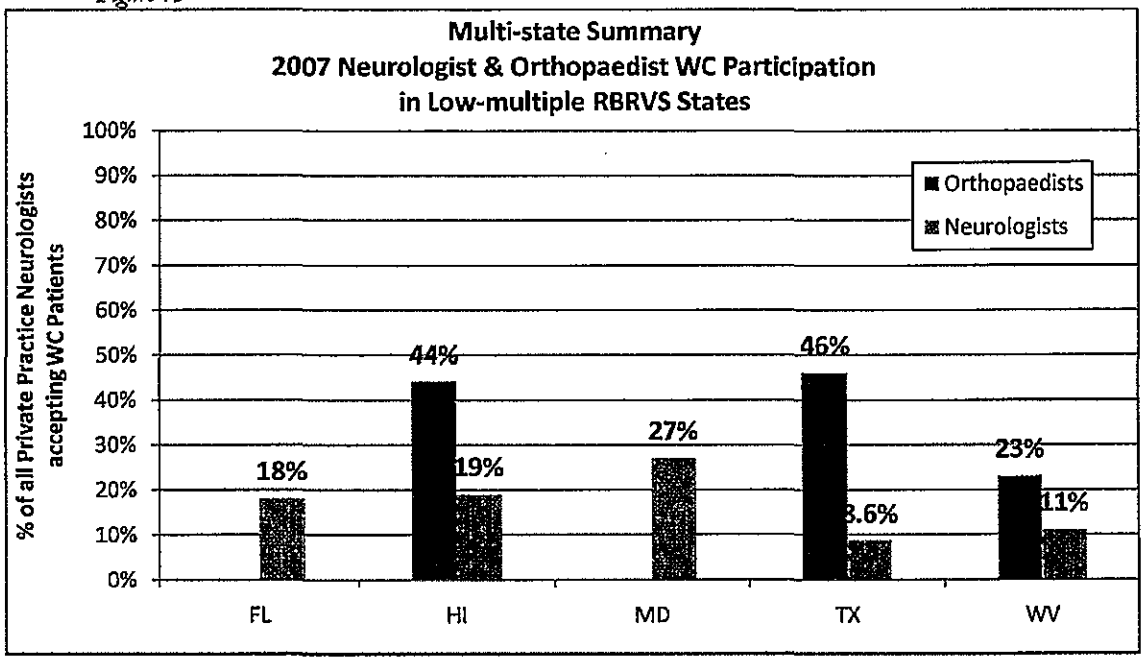
Figure 14


Maryland Neurologists Accepting
Workers' Compensation Patients, 2007
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
11%
5%
27%
Only w/Significant Limitations
Only Above Fee Schedule
At Fee Schedule

SUMMARY – ALL LOW-MULTIPLE RBRVS STATES

When all five study states are taken into consideration, the prospects for maintaining substantial access for injured workers under a low-multiple RBRVS fee scale are not promising. The chart below illustrates the current neurologist and orthopaedist participation levels in all states that have adopted a low-multiple RBRVS-based fee schedule. In every one of the low-multiple states, less than half of the private practice orthopaedist offices and fewer than a third of the neurologist offices are willing to treat workers' compensation patients at the mandated fee schedule amount. Conversely, over half of orthopaedists and over 70% of neurologists are unwilling to accept workers' compensation in these states.

Figure 15



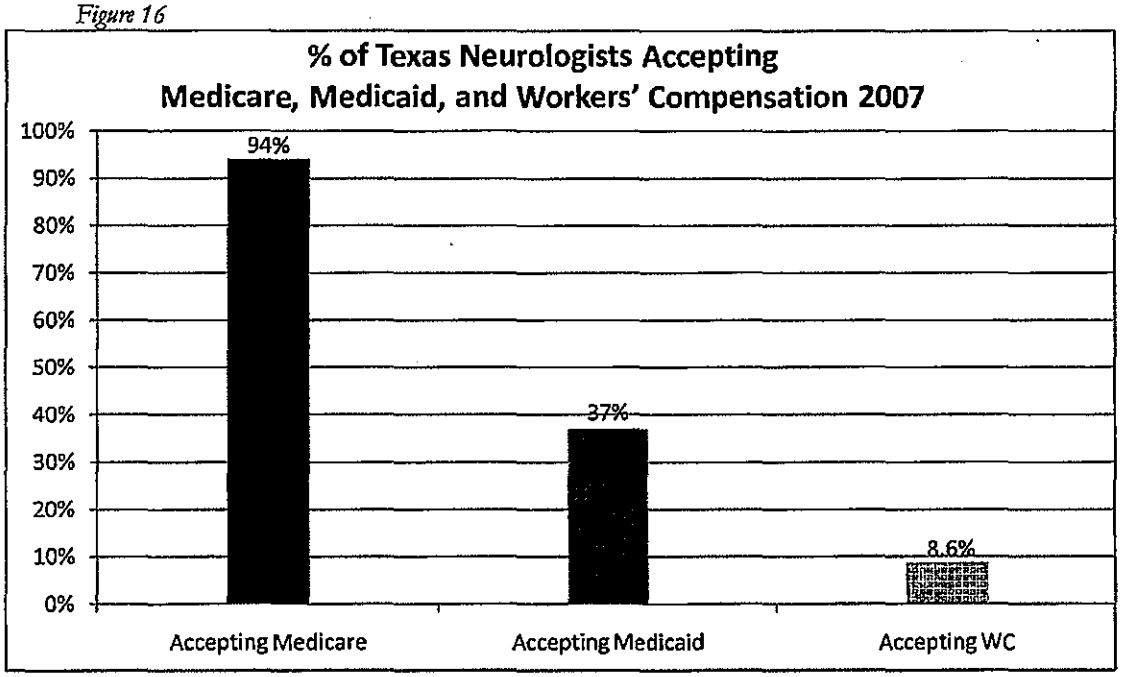
As seen in Texas and Florida, physician participation declines significantly within the first 2-3 years after a low-multiple fee schedule has been put in place. As Hawaii and West Virginia demonstrate, physician participation remains low even ten years after a low-multiple fee schedule has been in place. This suggests that once providers give up on the workers' compensation system, they are not motivated to find ways to adjust their practices or treatment patterns in an effort to rejoin the system. In fact, as Hawaii illustrates, participation continues to drop even once fees begin to rise again, as providers prove extremely reluctant to rejoin the workers' compensation system once they have found other sources of patients and revenues.

COMPARISON OF MEDICARE, MEDICAID & WORKERS' COMPENSATION

In an attempt to determine whether the barrier to physician participation in the workers' compensation systems of states with low-multiple RBRVS fee schedules was just the reimbursement levels, a secondary survey was conducted of the number of neurologists in the survey groups that accepted Medicare and Medicaid patients. The unit cost reimbursement rates for Medicare and Medicaid patients was lower than for workers' compensation patients and yet, as the charts below illustrate, participation in both the Medicare and Medicaid systems was strikingly higher than in the workers' compensation system.

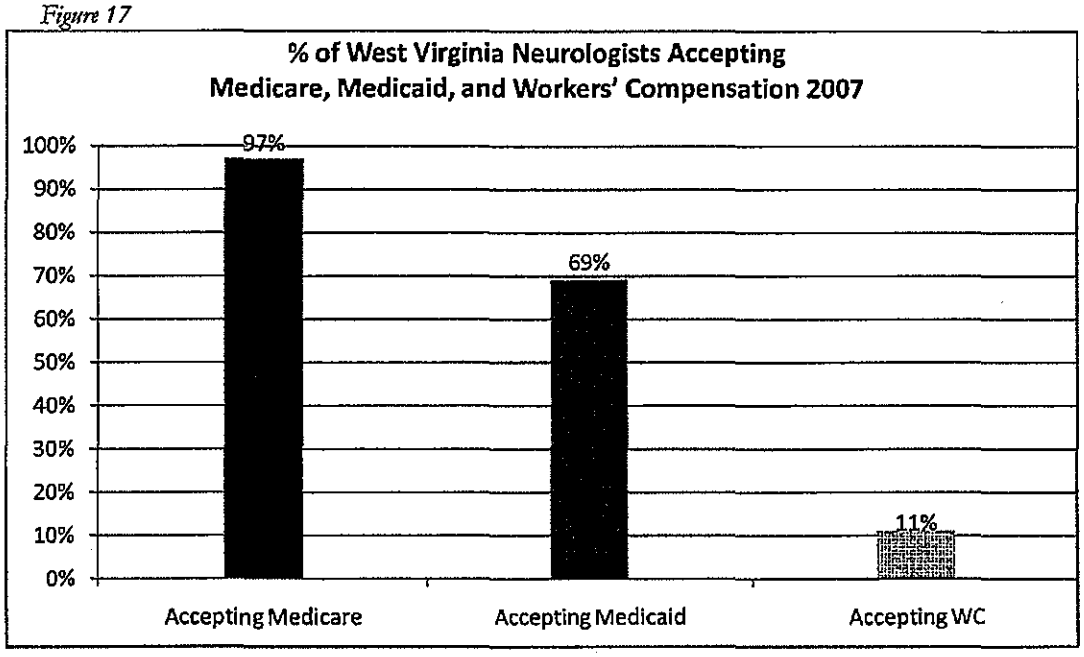
For example, in Texas the neurologist participation rate in Medicare was more than ten times higher than the workers' compensation rate, with 94% of all Texas neurologists accepting Medicare patients. While significantly fewer neurologists accepted Medicaid patients, participation levels were still four times the workers' compensation rate despite Medicaid fees that were only 52% of Medicare fees and 42% of workers' compensation fees.

Figure 16



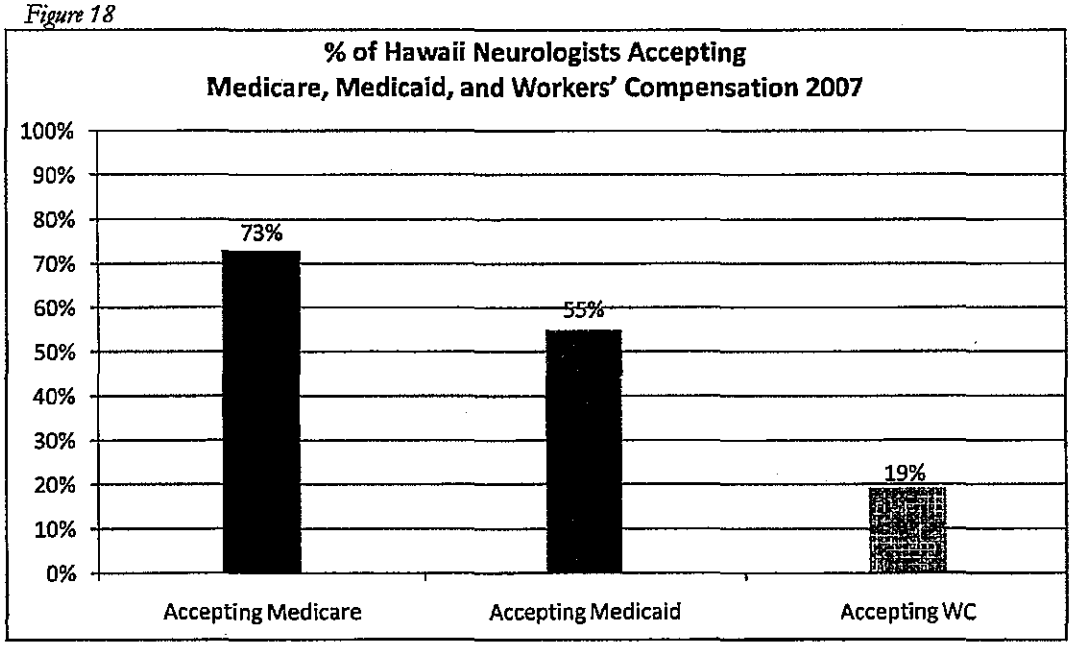
Similarly, in West Virginia, nearly all neurologists surveyed (97%) accepted Medicare patients and more than two-thirds (69%) accepted Medicaid. And yet only 11% reported they were willing to accept workers' compensation patients with higher unit cost reimbursement levels.

Figure 17



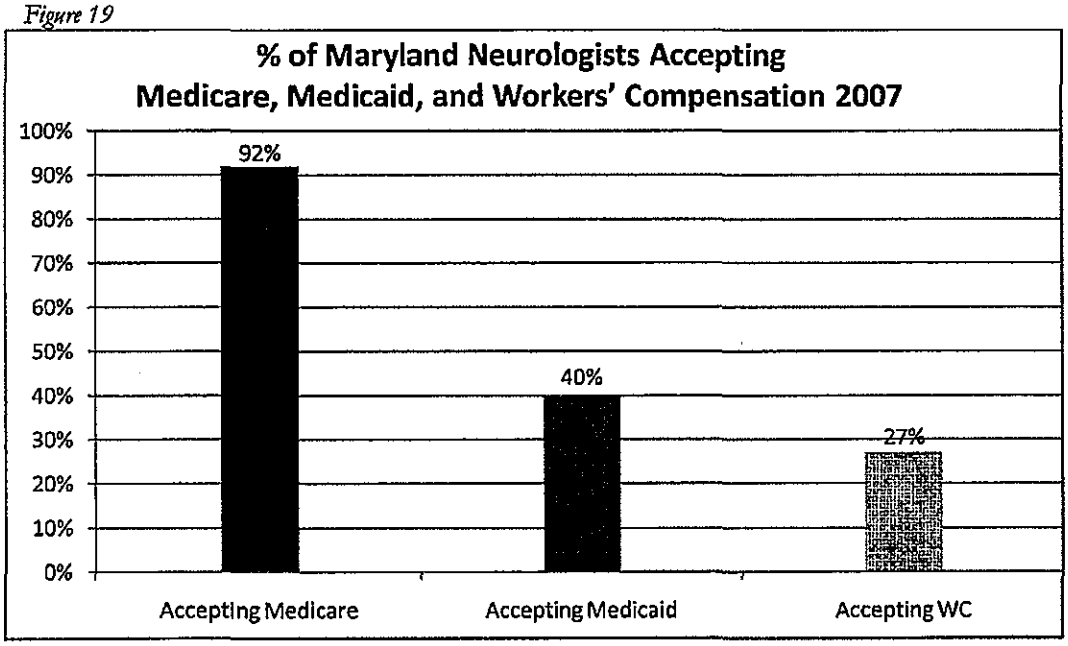
The same pattern was found in Hawaii. Although overall participation levels in Medicare and Medicaid were not as high as in West Virginia, they were still 3-4 times higher than the workers' compensation participation levels in the state.

Figure 18



Results from the Maryland surveys complete the picture. In every state with a low-multiple RBRVS fee schedule for workers' compensation, neurologists were much more likely to accept Medicare or Medicaid patients than injured workers covered by higher workers' compensation rates.

Figure 19



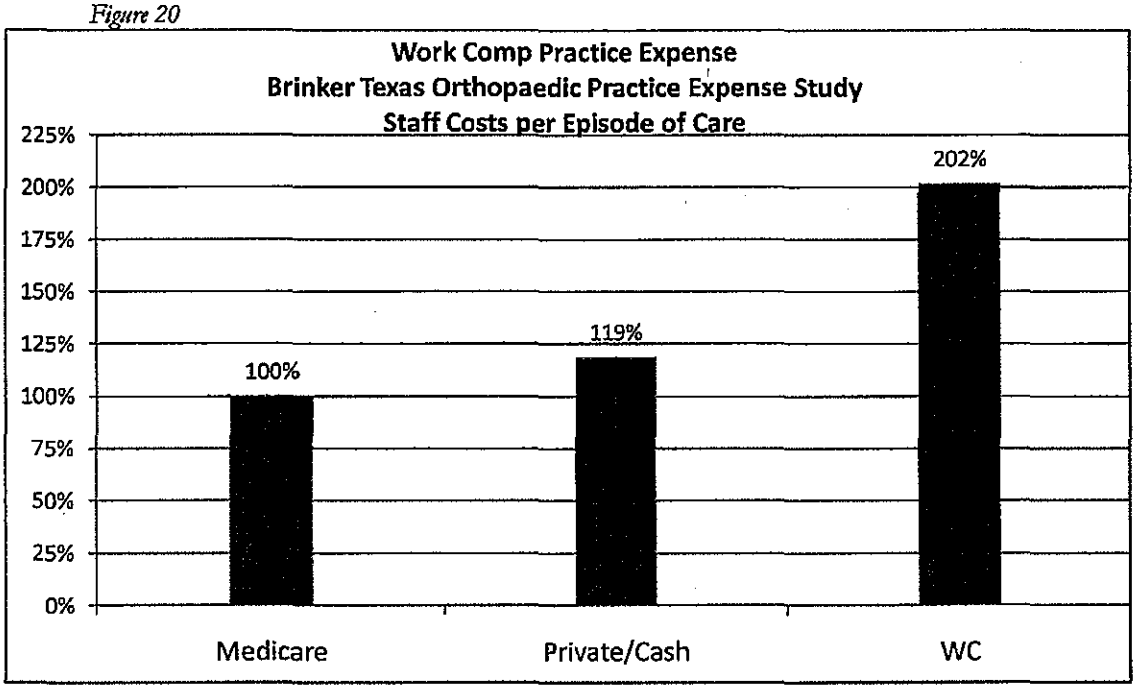
Since the procedure-level reimbursement rates for workers' compensation patients were higher than the rates for either Medicare or Medicaid in each of the study states, it is clear that fees alone are not the determining factor in a physician's willingness to participate in that state's workers' compensation system.

On the basis of comments from physicians and office staff during the survey process, it appears that additional administrative burdens or "hidden costs" which are not sufficiently offset by low-multiple RBRVS fee schedules are embedded in the workers' compensation system. It seems that the combination of these additional workers' compensation-specific administrative burdens, coupled with what are perceived as an insufficient increment in fees to pay for the added overhead drives the significant differences between physicians' willingness to accept Medicare, Medicare and workers' compensation patients.

COMPARISON OF PHYSICIAN PRACTICE EXPENSE

The evaluation of incremental expenses associated with operating a medical practice that accepts workers' compensation patients has been the subject of previous research. A study of the effect of payer type on orthopaedic practice expense was completed in Texas in 2002.[11] The results, published in the American Journal of Bone and Joint Surgery (Brinker, 2002), demonstrated that the staff costs per episode of care for a single type of injury (knee pain) were twice as high for workers' compensation patients compared to Medicare patients.

Figure 20



The Brinker study, along with provider feedback from the telephonic surveys conducted in the low-multiple RBRVS states, suggested that the physician work component (typically the focus of RBRVS-driven fee scales) may not adequately reflect additional administrative burdens embedded in the workers' compensation system. These additional administrative requirements typically encountered in workers' compensation claims include:

- Obtaining PPO and/or MPN network certification,
- Interfacing with Nurse Case Managers,
- Seeking approval for treatment from Utilization Review,
- Transcribing dictated medical reports and,
- Reconciling medical invoices that have been reduced to state fee schedules

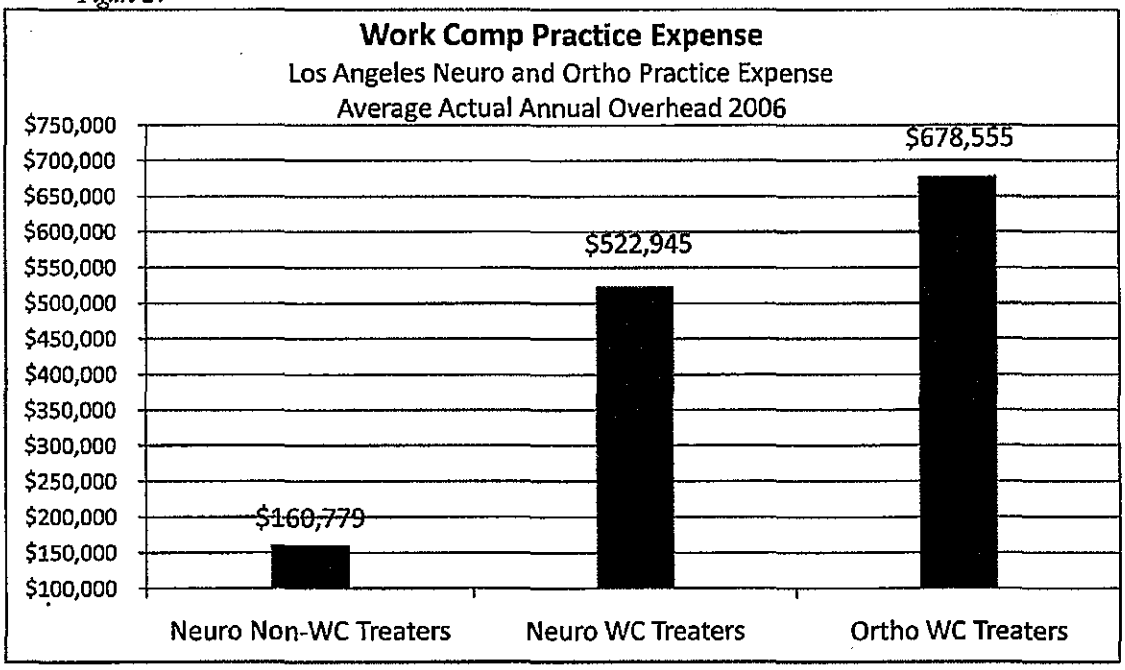
In addition to requiring some additional physician time for workers' compensation claims, these factors are much more likely to require additional staff resources that increase offices' overall practice expense.

With this in mind, a more detailed analysis of the practice expenses of neurologist and orthopaedist practices in the Los Angeles metropolitan area was conducted. Eleven neurologists and six orthopaedists in fifteen private practices agreed to confidentially share with the authors their practice expenses for the calendar year 2006. Practice expenses included all business expenditures but did not include physician income and retirement contributions. Data was self-reported by the physicians. Neurologists were classified as either accepting or not accepting workers' compensation patients without major limitation. All orthopaedists in the survey accepted workers' compensation patients. Several orthopaedists who do not accept workers' compensation patients agreed to participate, but were eliminated because they practiced with partners who did, and their practice expense data could not be segregated.

Practice expense per hour was calculated as annual overhead divided by 2,200 hours, per the U.S. Department of Health and Human Services Health Resources and Services Administration. Medicare 2007 practice expense data per hour was multiplied by the Los Angeles County GPCI practice expense factor of 1.156, yielding Medicare practice expense of $80.57 per hour for neurologists and $124.85 for orthopaedists.

The actual average practice overhead expenses for calendar year 2006 were calculated for each group (shown below). The average overhead practice expense for neurologists who did accept workers' compensation patients was more than 3 times the overhead expense of those neurologists who did not treat injured workers.

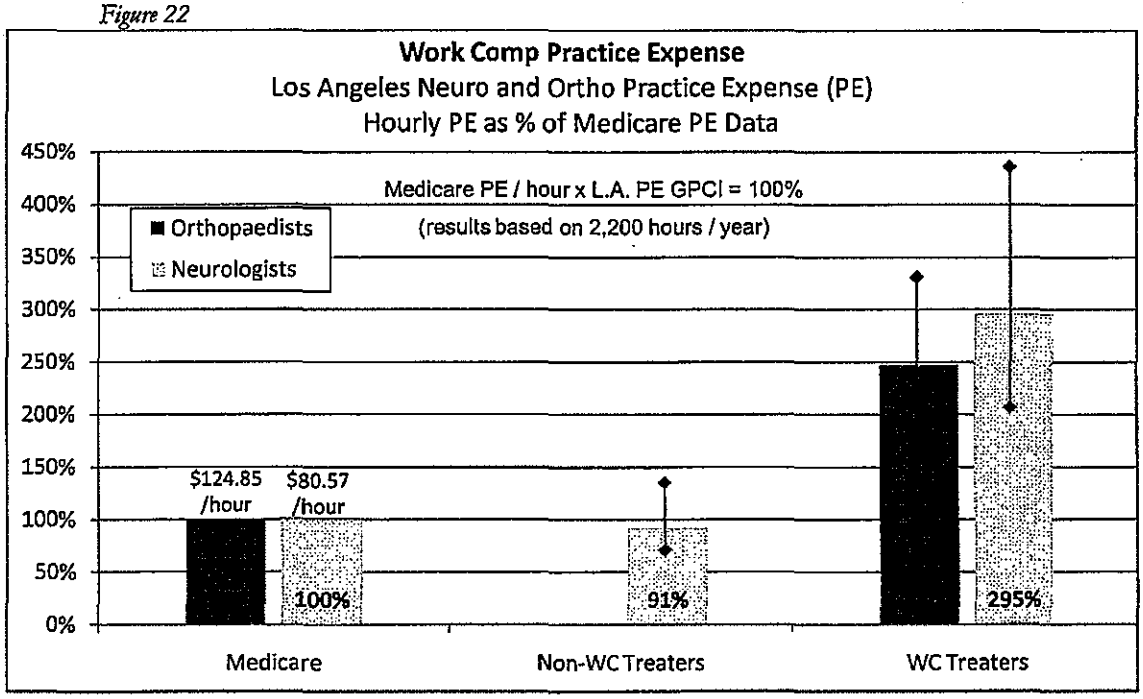
Figure 21



Data from the Medicare GPCI for Los Angeles County was then incorporated to provide a relative comparison of the hourly practice expense of three distinct groups of providers: 1) Medicare

providers; 2) neurologists/orthopaedists who treat workers' compensation patients and; 3) neurologists who do not treat workers' compensation patients.

Figure 22



The hourly practice expense for physicians who accepted workers' compensation patients was determined to be 2.5 to 3 times the hourly Medicare practice expense. This significant gap between the Medicare hourly cost and the practice expense of offices that treat workers' compensation patients helps explain why the Medicare participation rates were so much higher than workers' compensation acceptance rates across all study states despite the fact that procedure reimbursement rates were higher for workers' compensation. If practice expenses associated with treating workers' compensation patients are 247-295% of Medicare for neurologists and orthopaedists, fee scales set at 100-125% of Medicare fees simply do not provide enough financial incentive to maintain high physician participation levels.

Based on the actual 2006 practice expense data from the Los Angeles area offices, the ratio of practice expenses by specific category for those neurologists who treat workers' compensation patients was compared to those who do not. As the following table illustrates, practice expenses were found to be significantly higher for workers' compensation treaters across all categories – including both fixed and variable expenses.

Table 2

CATEGORY	WC TREATERS VS. NON-TREATERS PE RATIO
Rent	289%
Staff	392%
Office Expense	378%
Equipment	412%
Outside Services	326%
Health Plan	136%
Insurance	215%
Non-Income Taxes	453%

QUALIFICATIONS OF PHYSICIANS ACCEPTING WORKERS' COMPENSATION

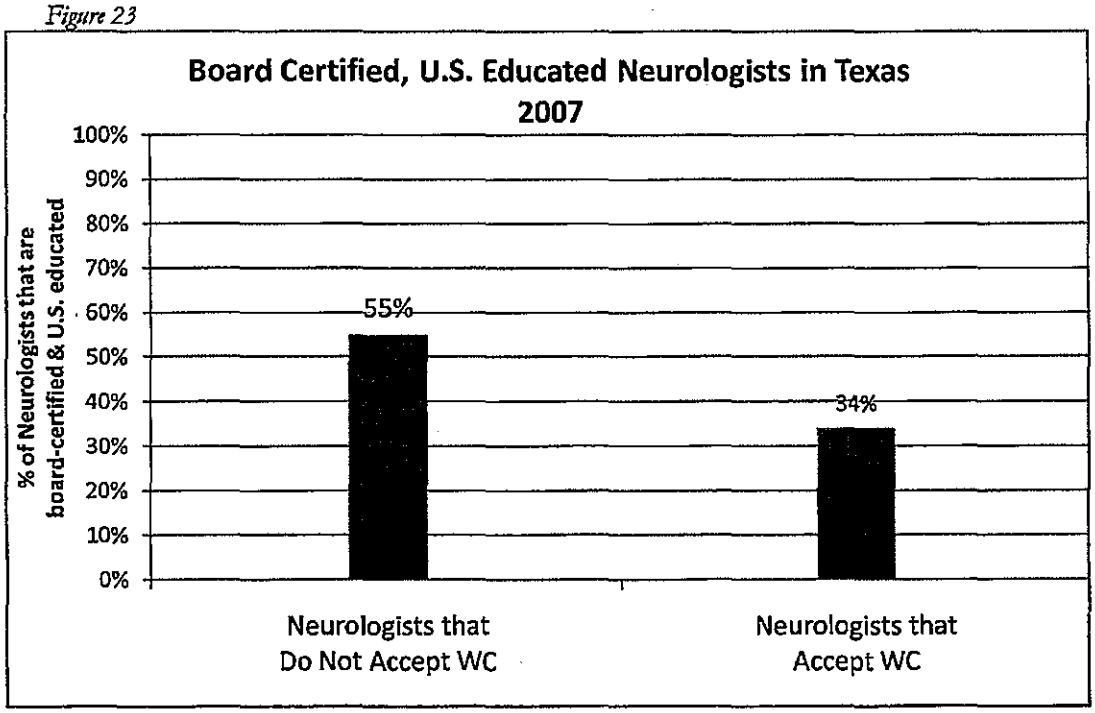
In states with low-multiple RBRVS workers' compensation fee schedules, the telephonic surveys also uncovered interesting differences in the qualifications of neurologists who continued to treat injured workers.

Searches were performed using the Texas Medical Board website (http://reg.tsbme.state.tx.us/OnLineVerif/Phys_SearchVerif.asp), the West Virginia Board of Medicine website (http://www.wvdhhr.org/wvbom/licensesearch.asp), and the website of the American Board of Medical Specialties (http://www.abms.org/) to determine the educational and certification status of each survey respondent as listed on the websites. The educational status results for all physicians in the survey population were categorized as (1) graduated from a U.S. or Canadian Medical School (U.S.-educated) or not; and (2) and certified in adult neurology by the American Board of Psychiatry & Neurology or not.

The 2005 ACN study found that in Texas, neurologists who stopped treating injured workers in the period immediately following the implementation of the 125% of Medicare fee scale were nearly two times more likely to be board-certified graduates of U.S. medical schools than those physicians who continued to participate in the workers' compensation system.

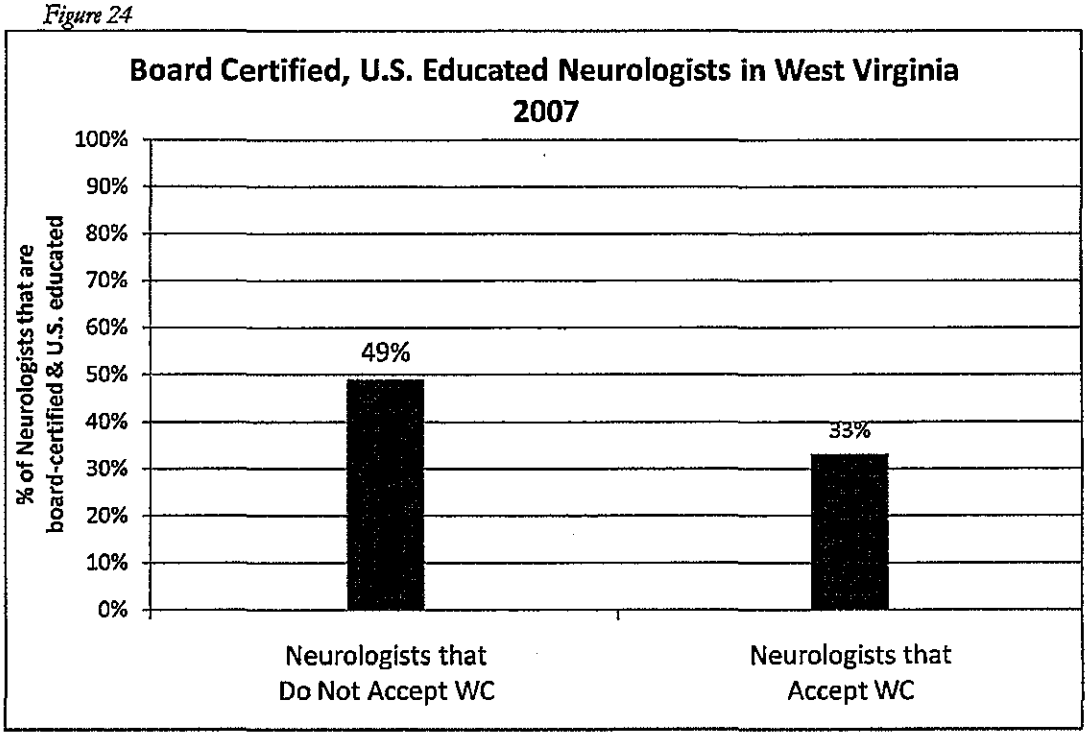
The current study found that among Texas neurologists who do not accept injured workers the proportion of those who are board-certified graduates of U.S. medical schools is far higher than among those who do accept injured workers.

Figure 23



This same trend was found in West Virginia where only one-third of all neurologists who still accept workers' compensation patients were board-certified and U.S. educated compared to nearly half of all neurologists who do not treat injured workers.

Figure 24

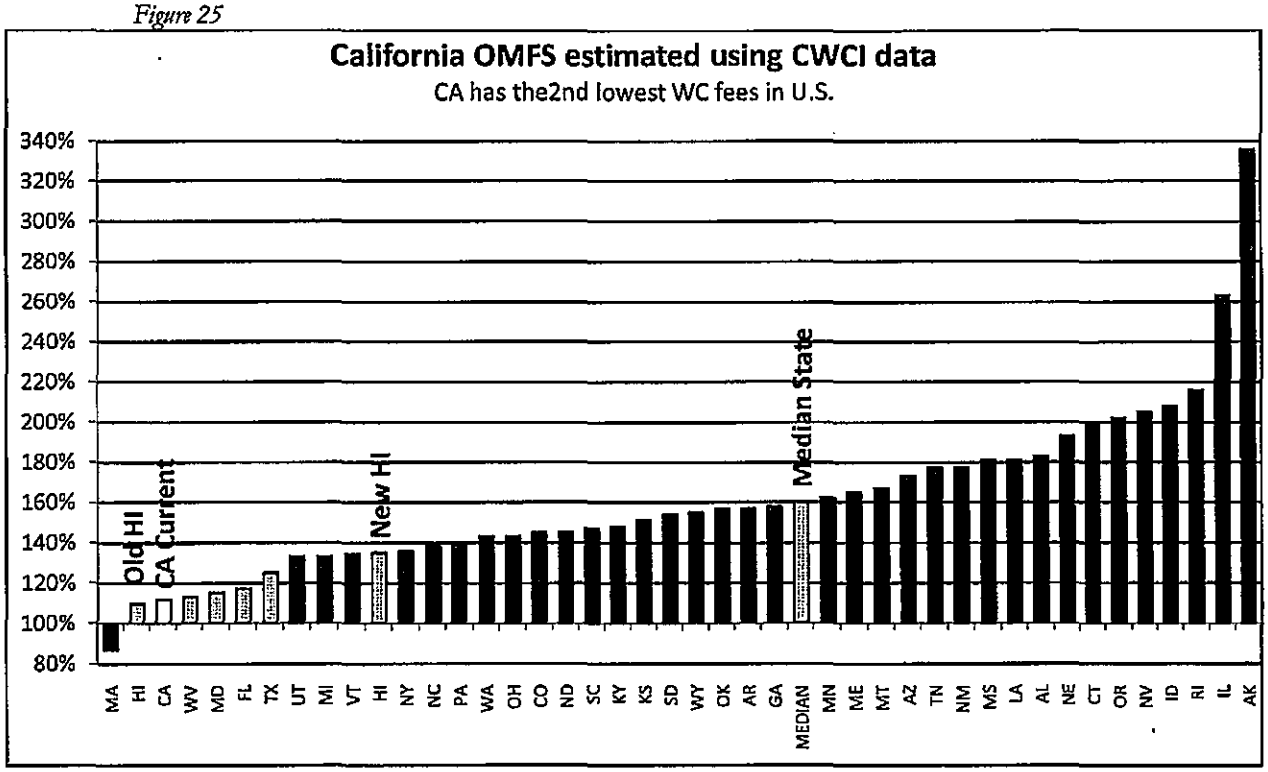

Board Certified, U.S. Educated Neurologists in West Virginia
2007
% of Neurologists that are board-certified & U.S. educated
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
49%
33%
Neurologists that Do Not Accept WC
Neurologists that Accept WC

CALIFORNIA UPDATE

California's current workers' compensation regulations provide for a charge-based Official Medical Fee Schedule (OMFS) that averages between 112% - 121% of the state Medicare rates. Under the current OMFS system, California medical fees are generally in a range very comparable to the study states of Hawaii, West Virginia, Texas and Florida.

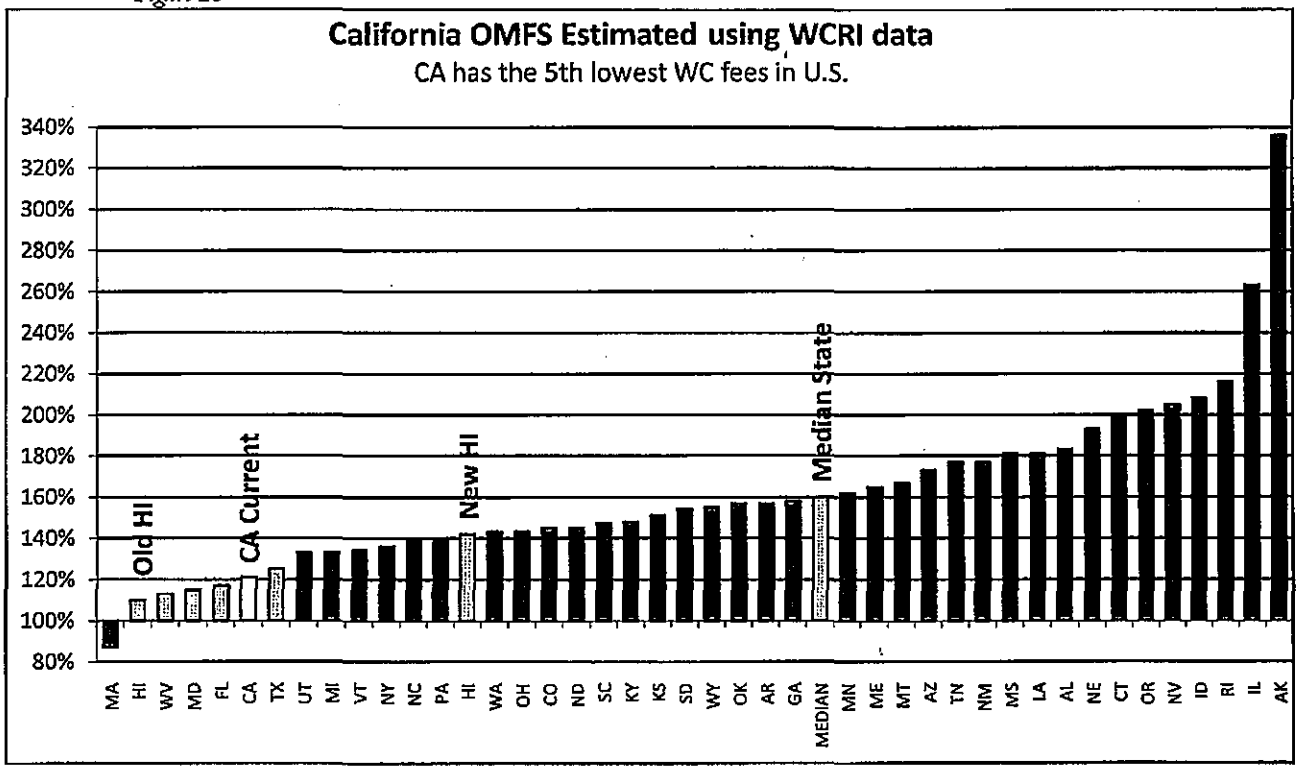
Historical procedure utilization data from CWCI would suggest that California (at 111.9% of Medicare) had the third lowest workers' compensation unit cost fees in the country, with only Massachusetts and Hawaii offering lower fees to workers' compensation providers. However, in 2006 as a result of continued concerns over injured worker access to specialty providers, the Hawaii state legislature increased their fee schedule to an average of approximately 135% of Medicare. Interestingly, rather than simply increase the Medicare multiple from 110% to a flat 135% across all procedure groups, Hawaii implemented a system which allocated higher fees to surgery and other specialty care in an effort to retain those providers engaged in the system and attract those who had deserted the system over the previous decade. As a result, California now has the second lowest workers' compensation fee schedule in the country according to the CWCI data.

Figure 25



Alternatively, if the historical distribution of medical charges from WCRI is used; California is currently the fifth lowest unit cost state in the nation at an average of 121% of Medicare.

Figure 26



Both CWCI and WCRI agree that the greatest medical cost drivers in California have been unregulated charges from outpatient surgery centers and over-utilization of specific procedure groups such as physical medicine, rather than high fee levels. Recent California reforms would appear to have successfully controlled both of these cost driver issues as billing for outpatient surgical centers is now capped at 120% of Medicare and the introduction of utilization review with hard limits on both physical therapy and chiropractic care has dramatically reduced over-utilization concerns.

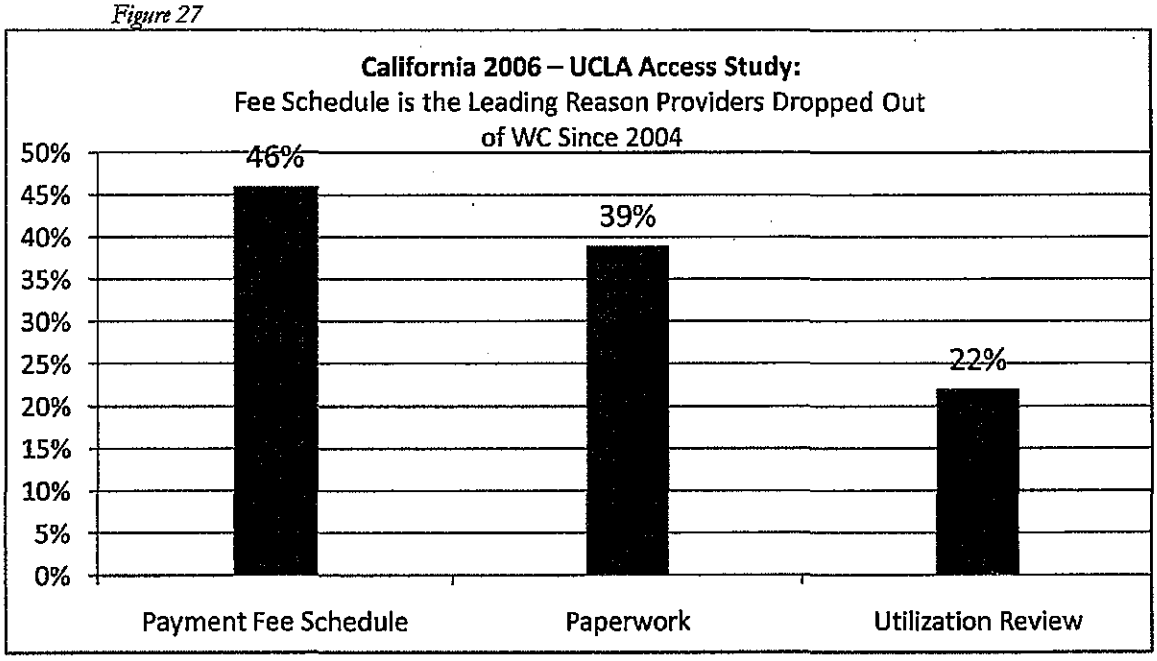
However, it must be noted that no data whatsoever is publicly available (from CWCI or WCRI) regarding code frequencies or even code group weightings in the post-reform era, during which a vigorous regime of pre-authorization/utilization review affecting expensive procedures has been applied. Given the likely shifts in code use since the reforms were implemented, it is difficult to accurately determine the current rank of California's fee schedule compared to other states and it is virtually impossible to precisely predict the impact of implementing an entirely new fee schedule methodology. Nonetheless, it is clear that California's fee schedule is among the lowest in the nation.

While the rates for the most common Evaluation and Management procedure codes were recently increased to approximately 100% of California Medicare values, major specialty care fees were cut 5% on January 1, 2004. This fee reduction coupled with the increase in the perceived administrative burdens of recent California reforms (utilization review, medical provider networks, etc.) and increase in practice expenses with inflation has apparently weakened the incentives for

physicians, particularly specialty physicians, to continue participating in the workers' compensation system.

A provider access study conducted by UCLA in 2006 identified the top three reasons physicians have dropped out of the workers' compensation system as involving the existing payment fee schedule, additional paperwork required and the introduction of utilization review.[12]

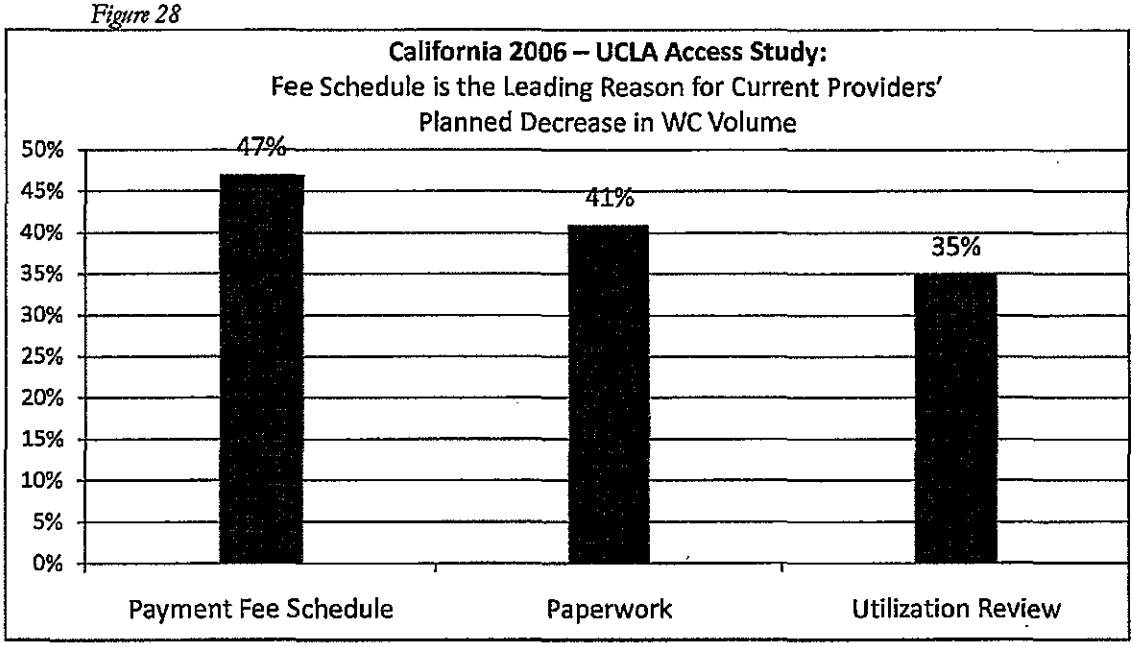
Figure 27



Providers noted that the combination of growing regulatory burdens and increased overhead required to service workers' compensation patients coupled with fees for procedures that are already considered low and will likely decrease prompted their decisions to exit the market.

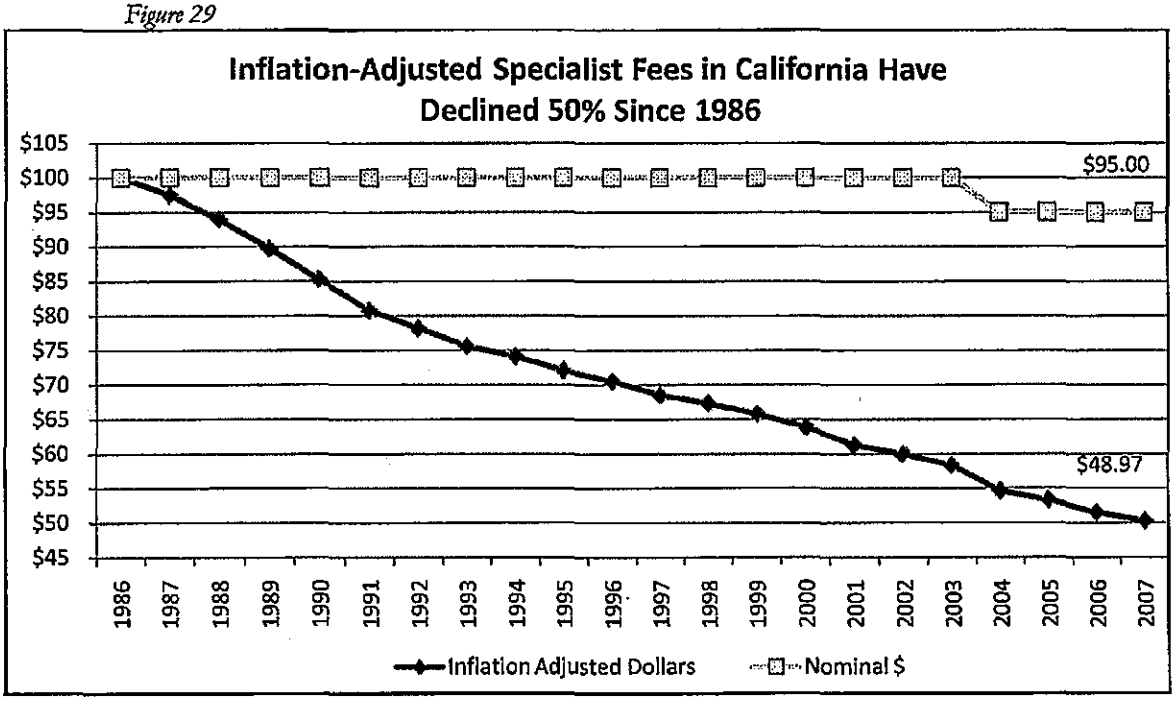
Similarly, those providers who were still accepting workers' compensation patients at the time of the survey cited the same three issues as the major reason they were planning to decrease the volume of workers' compensation patients they accepted going forward.

Figure 28



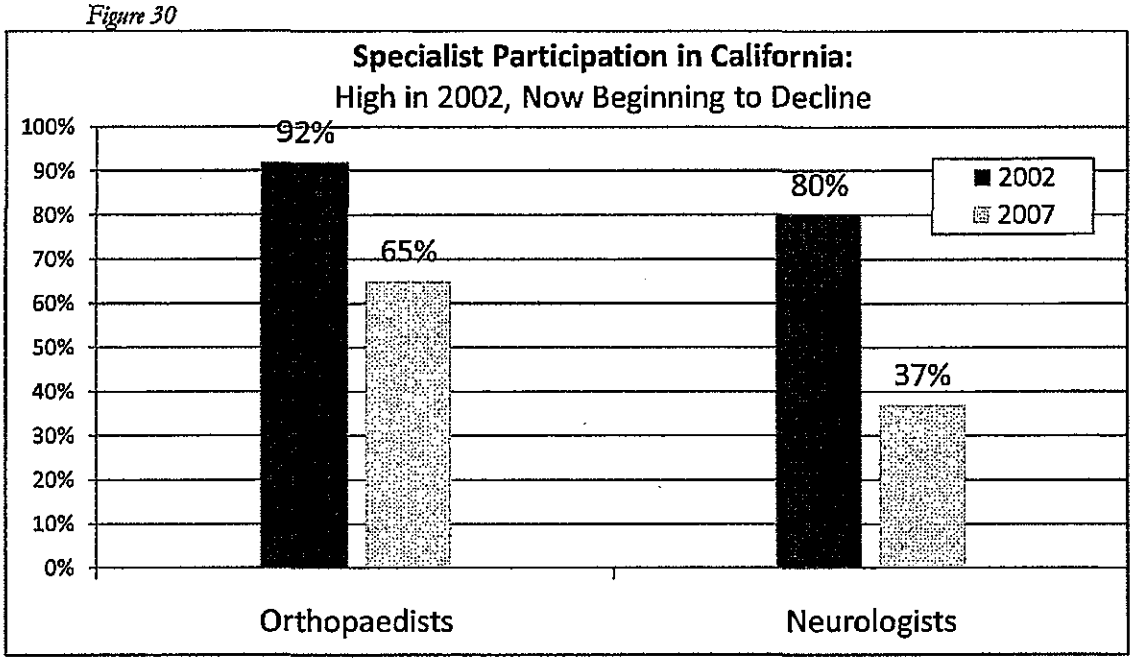
The issue of fees that are no longer sufficient to offset growing administrative and regulatory burdens is even clearer when workers' compensation specialist fees in California are adjusted for inflation. As the following chart illustrates, the California fee schedule for specialists has not changed between 1986 and 2003, but inflation adjusted fees have actually declined by 50%. At the same time, the number and complexity of the additional administrative burdens associated with treating workers' compensation patients has increased dramatically.

Figure 29



Interestingly, over that same time period specialist participation in the California workers' compensation system remained high. As recently as 2002, more than 80% of all neurologists and 92% of orthopaedists reported they still accepted workers' compensation patients without significant restrictions.[13] The current survey shows that participation has recently begun to change, with only 37% of neurologists and 65% of orthopaedists still accepting workers' compensation patients in 2007.

Figure 30



This change appears to be largely driven by changes (and proposed changes) in the fee structure coupled with the growing administrative burdens of reform. In 2002, the California fee schedule averaged 112% of Medicare, but specialty care was priced at 140-180% of Medicare while common Evaluation & Management (E&M) procedures were priced at 90% of Medicare. With the recent 5% cut in specialty fees and the threat of additional fee shifts away from specialty care towards primary care E&M visits, many specialists have already begun to exit the workers' compensation system.

A similar pattern emerged in Texas after the 2003 fee schedule reform. Even though E&M fees rose a full 36% in the conversion to RBRVS and the overall payment level only fell from 138% of Medicare to 125%, specialist participation in the workers' compensation system plummeted.

Although California workers' compensation patients still have reasonable access to specialists, participation has already begun to decline and the conversion to a low-multiple RBRVS schedule threatens to create the same result as Texas, where less than 10% of all neurologists and less than 50% of all orthopaedists still accept injured workers.

PCI Property Casualty Insurers Association of America
Shaping the Future of American Insurance
1415 L Street, Suite 670, Sacramento, CA 95814 Telephone 916-449-1370 Fascimile 916-449-1378 www.pciaa.net

To: The Honorable Rosalyn H. Baker, Chair
Senate Commerce and Consumer Protection Committee

From: Samuel Sorich, Vice President

Re: **SB 1414 – Relating to Repackaged Drugs and Compound Medications**
PCI Position: Support

Date: Friday, February 11, 2011
8:30 a.m.; Conference Room 229

Aloha Chair Baker and Committee Members,

The Property Casualty Insurers Association of America (PCI) supports SB 1414 which would restrict markups of repackaged prescription drugs and compound medications to what is currently authorized for retail pharmacies under state law.

Recent workers compensation cost data has shown an alarming increase in medical costs and much of this cost is driven by pharmacy costs, in particular the increasing use of repackaged and compound drugs. Often times these drugs are "created" or packaged for the sole purpose of moving the prescription off of the pharmacy fee schedule. This practice allows for higher markups. SB 1414 would close this loophole by restricting the markups for these types of drugs.

Compound medications are often paired with topical and transdermal creams that have not been approved by the FDA which poses a safety risk to injured workers. Since compound medications are a combination of other medications, these medications present unique billing issues and many insurers have seen instances where the bill for a compounded drugs is several times more expensive than the comparable oral, FDA-approved, commercially available oral dosage.

One company's experience in another state helps illustrate the problems posed by compound drugs. In 2008, the company's prescription cost related to compound medications was $128,484 or 9.6% of the total. By the end of 2009, that figure had ballooned to $2,005,794, which represents 44.1% of the total pharmaceutical expense.

In addition to the cost of compound drugs, the cost of repackaged drugs is emerging as a significant cost-driver for Hawaii's workers compensation system. A recent study by the National Council on Compensation Insurance Inc. reports that the process of repackaging drugs allows prices to be set at artificially high levels.

It should be stressed that SB 1414 would not abolish the use of compound or repackaged medications. Instead, the bill simply places some guidelines around their use. This is an important step not only for controlling an unnecessary cost to the workers' compensation system, but also to ensure that injured workers are protected and that compound and repackaged drugs do not generate inappropriate fees.

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Hawai'i's Employment Expert

February 10, 2011

The Honorable Rosalyn H. Baker, Chair
The Honorable Brian T. Taniguchi, Vice Chair
Committee on Commerce and Consumer Protection
State Capitol
415 South Beretania Street
Honolulu, HI 96813

Subject: S.B. No. 1414
Relating to Repackaged Drugs and Compound Medications
Friday, February 11, 8:30 a.m., Conference Room 229

Dear Senators Baker and Taniguchi:

My name is Kerry Kopp, and I am the Vice President of ALTRES, Inc. a 41-year old Hawaii company in the Human Resource and Employment industry. I am writing this testimony in SUPPORT of S.B. 1414, Relating to Repackaged Drugs and Compound Medications.

The current loophole in the statutes allows repackagers and compounders to raise the price of drugs above the current approved fee schedule of "wholesale price plus 40%" and creates unnecessary increased cost to our Worker's Compensation system. This inflated cost of identical drugs is of no benefit to the injured worker. Repackaging doesn't create a "better drug" or improved treatment; it merely leverages the ability to circumvent Hawaii's Medical Fee and Prescription Drug statutes.

We employ thousands of workers on all islands. Some of them have limited means of transportation and may rely on the convenience of having their medication dispensed during their physician visit. ALTRES supports a physician's ability to dispense medication. SB1414 will not change that. It will only curtail existing abuse by requiring adherence to the existing prescription drug fee schedule.

On a closing note, I am extremely concerned about the effect of higher than necessary Worker's Compensation costs to our local economy. From experience in the employment sector, I know higher Worker's Compensation costs means Hawaii employers will hire fewer workers. Now more than ever, Hawaii needs more jobs, not more costs to our Worker's Compensation program.

The drug repackaging and compound medication loophole has already been closed by the Federal Government's Medicare/Medicaid system and Group Health Insurers such as Kaiser, HMSA and UHA. Isn't it time to do the same for Hawaii's Worker's Compensation system?

I humbly urge your support in passing SB1414.

Sincerely,

Kerry Kopp
Vice President

KK:lo

February 10, 2011

To: Committee on Commerce and Consumer Protection

From: Patrick Adams, Rph

Re: SB 1414

In Opposition to SB 1414

I am concerned that the bill puts repackaging and compounding into the same context. Repackaging and Compour ding are separate issues and should be address in different bills.

Unlike Repackaging, compounding is the creation of a medication. A pharmacist may take many ingredients to compound a specific medication, at a specific dose, for a specific patient. This bill does not account for the labor or professional knowledge to produce these medications. This is not just an independent pharmacist issue but an issue that would affect hospitals with IV's and nuclear pharmacies with thei · expertise in the compounding of radioisotope imaging medications. The bill is much too far reaching and crosses over into many different pharmacy divisions resulting in reduced payments that will not pay for the producers of these medications.

Repacking is another issue entirely. I am not as familiar with these practices and con not testify to the impact of this bill on the industry. Stands because it opposes the bill as it only takes into account the ingredier t cost and would eliminate payment for newly created medications compounded by a pharmac st. Compounding is an expertise that takes knowledge, effort and time to produce. These services : hould be paid for.

Sincerely,

Patrick Adams, Rph