HB 1243, HD 2

Measure Title:	**RELATING TO REPACKAGED DRUGS AND COMPOUND MEDICATIONS.**
Report Title:	**Workers' Compensation; Repackaged Drugs and Compound Medications**
Description:	**Establishes price caps for the Hawaii workers' compensation insurance system for drugs, including repackaged drugs and compound medications. Effective July 1, 2050. (HB1243 HD2)**
Companion:	
Package:	**None**
Current Referral:	**CPN, JDL**
Introducer(s):	**SOUKI**

NEIL ABERCROMBIE
GOVERNOR

SUNSHINE P.W. TOPPING
INTERIM DIRECTOR

BARBARA A. KRIEG
DEPUTY DIRECTOR

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

March 15, 2011

TESTIMONY TO THE
SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION

For Hearing on Thursday, March 17, 2011
10:00 AM, Conference Room 229

BY

SUNSHINE P.W. TOPPING
INTERIM DIRECTOR

Written Testimony Only

House Bill No. 1243, HD2
Relating to Repackaged Drugs and Compound Medications

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

The purpose of H.B. No. 1243, HD2 is to amend Section 386-21, Hawaii Revised Statutes, so as 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.

Thank you for the opportunity to testify on this measure.

HAWAII MEDICAL ASSOCIATION
1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814
Phone (808) 536-7702 Fax (808) 528-2376 www.hmaonline.net

Thursday, March 17, 2011 10:00 a.m. Conference Room 229

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

From: Hawaii Medical Association
Dr. Morris Mitsunaga, MD, President
Linda Rasmussen, MD, Legislative Co-Chair
Dr. Joseph Zobian, MD, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

Re: HB ~~1423~~ 1245 HD 2 RELATING TO REPACKAGED DRUGS AND COMPOUND MEDICATIONS.

In Opposition.

Chairs & Committee Members:

Hawaii Medical Association opposes HB 1423.

First, we challenge the basic premise of this legislation, which is that costs are in some way "out of control"; therefore it is justified to functionally strip doctors of their historic rights to dispense medications to their patients. Workers comp premiums have been falling in our state for the last five years thanks, in part, to the efficient delivery and cost control efforts of the very doctors this bill will injure most (i.e. Hawaii's Orthopedist and Occupational Medicine Doctors).

Next, the doctors of this state; and especially those who are still willing to care for injured workers; take offense at HEMIC's derogatory and accusatory remarks inferring that the long standing practice of physician dispensing is akin to tax evasion and a "loophole" that must be "nipped in the bud" because it is costing them and other payers too much. Actually HEMIC has done so well lately they have accumulate over ¼ of a billion dollars in investment assets and enjoys an enviable loss ration of less then 40 cents paid out in benefits out of every employer premium dollar that passes thru its hands. So where's the fire?

Finally, the real problems of our state's Workers Comp System (i.e. doctors boycotting the System by refusing to see industrial claims) will be exacerbated and made worse by this act. The entire HPH Healthcare System (Straub, Pali Momi, Kapiolani and Wilcox Hospitals) has already opted out--along with the entire psychiatric community and most of the eye specialists. Over the last two decades the number of orthopedist in Hawaii have dwindled from 73 to 23 and if this bill goes through, Oahu's two largest remaining orthopedic groups (Orthopedic Associates and The Bone and Joint Group—11 surgeons) may be unable to continue to care for WC patients because of the lost revenue offset that dispensing provides for these time-intensive, litigious cases. Thank you for the opportunity to testify.

HAWAII INJURED WORKERS ALLIANCE
715 SOUTH KING STREET SUITE #410
HONOLULU, HAWAII 96813

Senate Committee on Commerce and Consumer Protection
House Bill 1243 HD 2
March 17, 2011

Chairperson Roz Baker and fellow committee members. I have come to testify against House Bill 1243. House Bill 1243 has been the brain child of the insurance company HEMIC. HEMIC created this bill in order eliminate or minimized Doctors from dispensing drugs.

Their claim is they want doctor to continue to dispense medicine is not true. They are trying to eliminate doctors from dispensing drugs by economically forcing them out of this portion of the workers compensation business .

By changing the state's reimbursement formula it will be unaffordable for doctors to dispense drugs. This will also cause many doctors to withdraw from practicing workers' compensation. We are at a point that Hawaii is short 600 doctors, but in the workers' comp field this has exacerbate. On the island of Hawaii we have less than a handful of doctors providing workers' comp service. With fewer doctors you have fewer choices, less competition and service will go downhill. I believe that HEMIC knows this and would like this to happen so they could control the market.

The cost of drugs is also not on a level playing field. HEMIC utilize PBMs (pharmacy program), such as CompToday, which receives rebates on drugs from drug manufacturers. This gives them a great advantage compared to the Doctors who dispense drugs from their office who don't get to enjoy these "rebates".

HEMIC employees have said that doctors that do Workers' Comp in Hawaii and dispense drugs have been gouging the system. I have asked them for proof by documentation, it's been four weeks and nothing has come forward. It seems that HEMIC wants to yell fire when there is NO fire. If you pass this bill you will see price gouging from HEMIC.

When a workers' comp doctor dispenses drugs from his or her office, the injured worker has a 100 percent **guarantee** of receiving all drugs needed to recover from his or her injury. When an injured worker has to have their prescription filled at a pharmacy the guarantee drops to down to 70 percent of the injured workers' getting their drugs. This survey was commissioned by the National Community Pharmacists Association. By having doctors dispense drugs from their office there is a greater and earlier rate of recovery of injured workers because the injured worker is taking their drugs from the first day. This is not guaranteed when they have to go to a pharmacy or to the insurance company's participating pharmacy program.

What does this mean? It means that injured workers will recover faster and the cost of treating and injured worker will be reduced.

HEMIC seems hell bent on controlling workers' comp market. Here is a company that was established by the legislature to HELP and now it seems to have turn into the 800 pound TOAD. HEMIC has assets of at least 2 BILLION dollars but at the same time it has at least one vendor they have not paid in over 180 days, with a billing amount to over 130,000 dollars.

In the last few weeks, the Director of Labor, Dwight Takamine has received more information regarding House Bill 1243 and is now no longer testifying in support of this bill.

I recommend that House Bill 1243 be held.

I also suggest that we have and AUDIT of HEMIC which has not had one since its inception. This will insure that the 800 pound TOAD has been in compliance with all State of Hawaii laws.

Mahalo,

George M. Waialeale
Executive Director
Hawaii Injured Workers' Alliance

AHCS
Automated HealthCare Solutions
2901 SW 149th Avenue, Suite 400
Miramar, Florida 33027

March 15, 2011

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

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

Re: HB 1243 – Relating to Drug Repackaging and Compound Medication

Dear Chairwoman Baker, Vice Chairman Taniguchi and Distinguished Committee Members:

My name is Sean Duffy and I am the Chief Operating Officer of Automated HealthCare Solutions ('AHCS"), a national healthcare IT company providing technology solutions to physicians focused on patient care and access to care. One such solution we provide enables physicians to dispense medications to Hawaii's injured workers from their clinics at no cost to the injured worker.

I am here today on behalf of AHCS and its Co-CEOs, Dr. Gerald Glass, M.D. and Dr. Paul Zimmerman, M.D., to testify in strong opposition to HB 1243.

Automated HealthCare Solutions opposes HB 1243 as we believe it will discourage physicians from dispensing medications to injured workers and further exacerbate the access to care problem encountered by Hawaii's injured workers.

Proponents of the bill before you point to circumstantial evidence that suggests a cost savings in pharmacy-dispensed medications. These views are both prejudiced and myopic as it relates to cost savings for the Hawaii work comp system as a whole and the unintended consequences any fee schedule change will have on access to care for Hawaii's injured workers.

Geico, in its' testimony, points to one instance whereby a physician-dispensed medication was more costly than a similar pharmacy-dispensed medication. Geico's "cherry picked" claim is inconclusive as the AWP of any particular medication is tied to its' national drug code ("NDC"), which varies widely across manufacturers. The same flaw is inherent in the Hawaii Insurers Council's testimony.

I would like to point to an empirical study recently published by the Workers' Compensation Research Institute that demonstrates how physician-dispensed medications save the workers' compensation system as measured on a per-claim and per-script basis.

The Workers' Compensation Research Institute's (WCRI) latest report published in March of 2010 (see attached **EXHIBIT I:** "WCRI Report", p. 28) sought to compare costs between pharmacy-dispensed and physician-dispensed medications across 16 sample states. Indeed, the report concluded that physician-dispensed medications were incrementally more on a per-pill basis than pharmacy-dispensed medications, at a rate of $1.29 to $1.16.

However, on a per-script and per-claim basis, **physician-dispensing has proven to be more cost-effective**:

i. The average cost for a pharmacy-dispensed script was $51 as compared to $37 for a physician-dispensed script
ii. The average cost for a pharmacy-dispensed claim was $400 as compared to $128 for a physician-dispensed claim

Physicians do not enjoy the huge rebates offered from manufacturers and distributors of drugs that pharmacy chains do, nor do they have the resources to count pills nor the ability to assume the huge liability of cross-contamination and wrong-fills. Thus, for safety reasons, physicians must purchase medications in treatment dosages. There is obviously a cost associated with packaging medications in treatment dosages with trackable bar-coding. This explains the incremental cost on the per-pill level. However, as the study proves, dispensing physicians dispense fewer pills so that there is an overall cost savings to the system.

Workers' compensation patients often encounter difficulties when attempting to fill their prescriptions at the pharmacy. A recent study by the National Council on patient Information and Education found that one-third of all patients never fill their prescriptions (See attached EXHIBIT II: "NCPIE", p. 7). The figures for workers' compensation patients are higher as they invariably do not possess an insurance card. Thus, there is **enormous savings on the indemnity portion of the claim due to injured workers' actually being able to receive their medications** and follow their treatment protocol. As you know, the indemnity portion of any work comp claim is approximately 50% of the total claim, while the prescription medication portion is merely 5%.

I would also like to point to two more studies that demonstrate that any altering of Hawaii fee schedules as it relates to workers' compensation would drive specialists out of workers' compensation and severely choke off injured workers' access to care.

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 workers' compensation medical fee schedule should be adjusted". "The Bureau found 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 in the medical fee schedule level of reimbursement". The chart (see attached **EXHIBIT II:** "UCLA Study ", p. 14) concludes that **77% of Hawaii neurologists, neurosurgeons, orthopedists &**

physical med/rehab physicians accepted work comp before the straight 110% Medicare Fee Schedule while only 23% did after implementation of the new fee schedule.

A follow-up study was conducted by the California Association of Neurologists by interviewing all Hawaii neurologists in private practice to see if participation levels were improving as physicians adjusted their practices to the reality of the 110% fee schedule..."[p]erhaps the most troubling finding with regard to Hawaii is that it appears that the decline in physicians accepting workers' compensation caused by low-multiple fee schedules is extremely long-lasting...physician 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."

Current research has suggested that participation in Hawaii has dipped even more, with only 19% of neurologists and 44% of orthopedists indicating that they still accept workers' compensation patients.

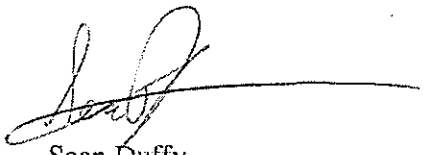
Physician dispensing has allowed specialists to gradually come back into workers' compensation by allowing them to subsidize the enormous overhead and reduced fee schedule associated with treating an injured worker.

Due to the high cost of purchasing medications in prescription doses, a new fee schedule based on original manufacturer's AWPs will make it too costly for physicians to dispense, thus eliminating it as an option to injured workers.

Any hypothetical cost savings to insurance companies will come at the real cost of impeding access to care for injured workers in Hawaii.

Please interdict the proposed regulations and call on your fellow commissioners to vote against their promulgation.

Sincerely,



Sean Duffy
Chief Operating Officer
Automated HealthCare Solutions

PRESCRIPTION BENCHMARKS FOR FLORIDA

Dongchun Wang
Richard A. Victor

With the Assistance of
Pinghui Li

WC-10-06
March 2010

Start Exhibit I

WORKERS COMPENSATION RESEARCH INSTITUTE
CAMBRIDGE, MASSACHUSETTS

Print Options

Click on a button to open a print dialog box set to print the indicated section of the study.

Entire Document – includes State Report & Technical Appendix

Slide Presentation

Reference Tables

Technical Appendix

Note to Reader: While we do our best to ensure that the product is fully functional for all users, there may be rare cases where user computer settings reduce the functionality. We would appreciate these instances being brought to our attention.

ISBN 978-1-935325-03-1 (online)

TABLE OF CONTENTS

Table R1A Frequency, Costs, Price, and Utilization of Prescription Drugs, by Dispensing Point

	CA[a]	FL	IA	IL	IN	LA	MA[b]	MD	MI	NC	NJ	NY[b,c]	PA	TN	TX[b]	WI	Median
Rx dispensed at physicians' offices (MDRx)																	
% of total Rx payment that were paid for MDRx	73%	39%	6%	17%	6%	15%	n/a	27%	16%	6%	8%	n/a	10%	10%	n/a	5%	10%
% of all Rx that were MDRx	60%	30%	9%	22%	14%	9%	n/a	24%	27%	9%	14%	n/a	15%	11%	n/a	7%	14%
% of claims with Rx that had MDRx	82%	51%	22%	46%	38%	23%	n/a	47%	56%	30%	42%	n/a	39%	37%	n/a	17%	39%
Average payment for MDRx per claim with MDRx	$469	$427	$110	$150	$65	$528	n/a	$255	$84	$119	$79	n/a	$128	$135	n/a	$109	$128
Average price per Rx for MDRx	$76	$77	$29	$37	$20	$94	n/a	$54	$24	$37	$32	n/a	$35	$39	n/a	$29	$37
Average price per pill for MDRx	$1.83	$1.82	$1.04	$1.25	$0.86	$1.77	n/a	$1.71	$1.04	$1.24	$1.30	n/a	$1.30	$1.29	n/a	$0.90	$1.29
Average number of pills per claim for MDRx, among claims with MDRx	297	242	105	135	77	272	n/a	183	93	85	65	n/a	94	103	n/a	115	105
Average number of MDRx per claim with MDRx	6.7	5.5	3.8	4.1	3.2	5.6	n/a	4.7	3.6	3.2	2.5	n/a	3.7	3.4	n/a	3.8	3.8
Average number of pills per MDRx	44	44	28	33	24	48	n/a	39	26	27	26	n/a	25	30	n/a	30	30
Average number of visits to fill a MDRx, per claim with MDRx	3.7	2.8	2.5	2.3	2.1	3.0	n/a	2.6	2.0	2.0	1.7	n/a	2.4	2.3	n/a	2.4	2.4
Average number of MDRx per visit with MDRx	1.7	1.9	1.6	1.7	1.5	1.8	n/a	1.8	1.7	1.6	1.5	n/a	1.4	1.5	n/a	1.7	1.7
Rx dispensed at pharmacies (PDRx)																	
% of total Rx payment that were paid for PDRx	26%	60%	93%	82%	93%	85%	100%	73%	84%	93%	91%	100%	89%	90%	100%	94%	91%
% of all Rx that were PDRx	39%	69%	91%	78%	86%	91%	100%	76%	73%	91%	86%	100%	85%	89%	100%	93%	87%
% of claims with Rx that had PDRx	46%	77%	89%	74%	84%	90%	100%	72%	74%	87%	75%	100%	79%	91%	100%	92%	85%
Average payment for PDRx per claim with PDRx	$332	$435	$340	$398	$385	$676	$289	$445	$328	$503	$403	$555	$500	$381	$532	$292	$400
Average price per Rx for PDRx	$47	$53	$43	$52	$47	$57	$44	$57	$47	$56	$61	$76	$61	$46	$49	$44	$51
Average price per pill for PDRx	$0.87	$1.17	$1.00	$1.12	$1.06	$1.42	$0.87	$1.19	$0.98	$1.17	$1.33	$1.31	$1.22	$1.14	$1.17	$0.98	$1.16
Average number of pills per claim for PDRx, among claims with PDRx	316	328	320	323	324	511	280	344	306	388	276	371	361	315	448	280	324
Average number of PDRx per claim with PDRx	7.0	8.2	7.9	7.6	8.1	12.3	6.6	7.8	7.0	9.0	6.6	7.3	8.3	8.4	10.5	6.6	7.8
Average number of pills per PDRx	45	40	40	42	40	42	42	44	44	43	41	51	44	38	43	42	42
Average number of visits to fill a PDRx, per claim with PDRx	4.3	5.1	5.1	4.9	5.5	7.4	4.6	5.1	4.4	5.9	4.3	4.7	5.4	5.3	5.4	4.4	5.1
Average number of PDRx per visit with PDRx	1.7	1.7	1.6	1.6	1.5	1.7	1.5	1.6	1.6	1.6	1.6	1.6	1.5	1.6	1.9	1.5	1.6

Note: The underlying data include claims with > 7 days of lost time that had injuries arising from October 2005 to September 2006 and prescriptions filled through March 2007. See the Data and Methods and the *Technical Appendix* for more details.

[a] Data for California include claims from the period prior to the implementation of major statutory changes affecting pharmacy reimbursements. In 2007, a new California law equalized prices for pharmacies and physicians.

[b] In Massachusetts, New York, and Texas, physician dispensing is not allowed.

[c] Data for New York include claims from the period prior to the implementation of major statutory changes affecting pharmacy reimbursements.

Key: n/a = not applicable; Rx = prescriptions.

EDUCATE *before* YOU MEDICATE

The NCPIE Coalition–working together to promote safe medicine use

Start Exhibit II

Enhancing Prescription Medicine Adherence: A National Action Plan

National Council on Patient Information and Education

August 2007

Introduction

There is much to celebrate about the improved health status of many Americans. Smoking rates have dropped significantly, infant mortality has declined and there have been major advancements in treatments for serious diseases that once devastated the lives of millions. This includes more than 300 new drugs, biologics and vaccines approved by the U.S. Food and Drug Administration (FDA) since 1993 to prevent and treat over 150 medical conditions.[1]

While we recognize such progress, now is the time to be even more mindful of the public health problems we have yet to solve. One of these persistent challenges is improving patient "compliance" (or "adherence") – defined as the extent to which patients take medications as prescribed by their health care providers.[2] At the same time that medical science has made possible new therapies for treating AIDS, cancer, and other once fatal diseases, poor adherence with medication regimens has reached crisis proportions in the United States and around the world. According to the World Health Organization (WHO), only about 50 percent of patients typically take their medicines as prescribed.[3] For this reason, WHO calls poor adherence rates "a worldwide problem of striking magnitude"[3] and has published an evidence-based guide for health care providers, health care managers, and policymakers to improve strategies of medication adherence.[2]

Looking specifically at lack of medication adherence in the U.S., a recent survey reported that nearly three out of every four American consumers report not always taking their prescription medicine as directed.[4] Commissioned by the National Community Pharmacists Association (NCPA), this survey also found a major disconnect between consumers' beliefs and their behaviors when it comes to taking medicines correctly. Some of the findings of the survey include:

- Almost half of those polled (49 percent) said they had forgotten to take a prescribed medicine;
- Nearly one-third (31 percent) had not filled a prescription they were given;
- Nearly three out of 10 (29 percent) had stopped taking a medicine before the supply ran out; and
- Almost one-quarter (24 percent) had taken less than the recommended dosage.

While disturbing, these statistics only begin to demonstrate the magnitude and scope of poor adherence in the U.S. Lack of adherence affects Americans of all ages and both genders, but is of particular concern among those aged 65 and over who, because they have more long-term, chronic illnesses, now buy 30 percent of all prescription medicines[5] and often combine multiple medications over the course of a day. Regardless of age and sex, poor medication adherence is also just as likely to involve higher-income, well-educated people as those at lower socioeconomic levels.[2] As a result, poor medication adherence has been estimated to cost approximately $177 billion annually in total direct and indirect health care costs.[6]

Adherence rates are typically higher in patients with acute conditions, as compared to those with chronic conditions, with adherence dropping most dramatically after the first six months of therapy.[2] The problem is especially grave for such patients with chronic conditions requiring long-term or lifelong therapy, because poor medication adherence leads to unnecessary disease progression, disease complications, reduced functional abilities, a lower quality of life, and premature death.[3] Lack of adherence also increases the risk of developing a resistance to needed therapies (e.g., with antibiotic therapy), more intense relapses, and withdrawal (e.g., with thyroid hormone replacement therapy)

WORKERS' COMPENSATION MEDICAL FEE SCHEDULES

NEW FINDINGS & IMPLICATIONS FOR CALIFORNIA

Start Exhibit III

STEVEN E. LEVINE, M.D., PH.D., F.A.A.N.
CLINICAL PROFESSOR OF NEUROLOGY
DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA

RONALD N. KENT, M.D., PH.D.
CLINICAL PROFESSOR OF NEUROLOGY
DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA

Table of Contents

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.

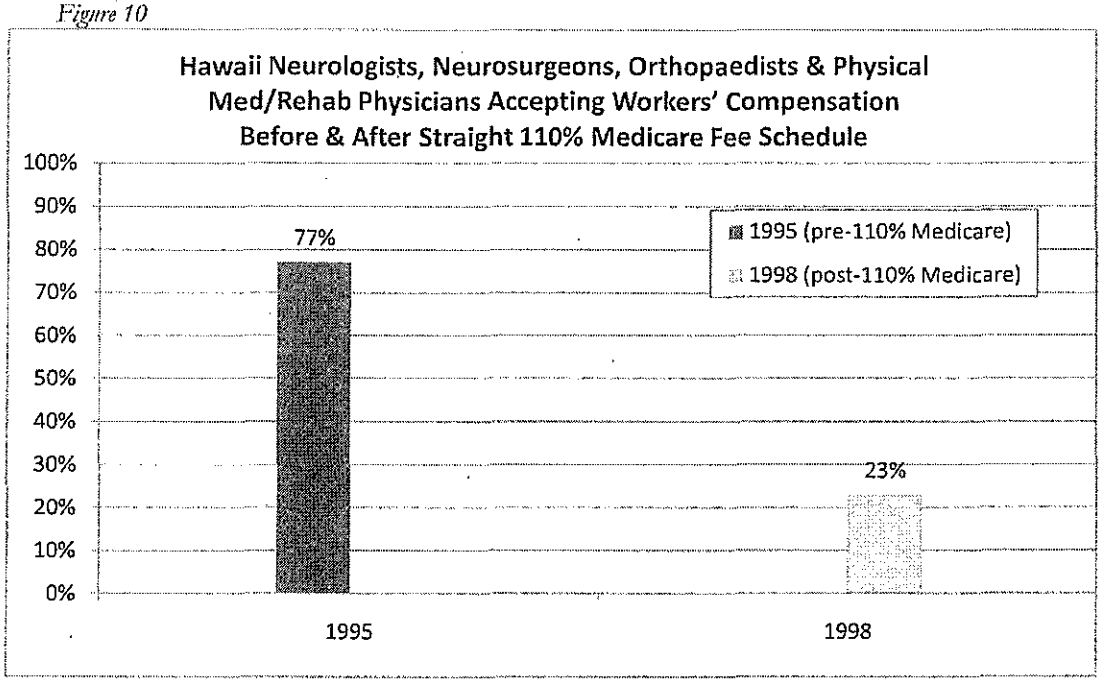
Hawaii adopted its first medical fee schedule more than 40 years ago. The state's Disability Compensation Division is responsible for developing the medical fee schedule with input from the state medical association and public comment. The fee schedule was originally based on relative values supplied 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.

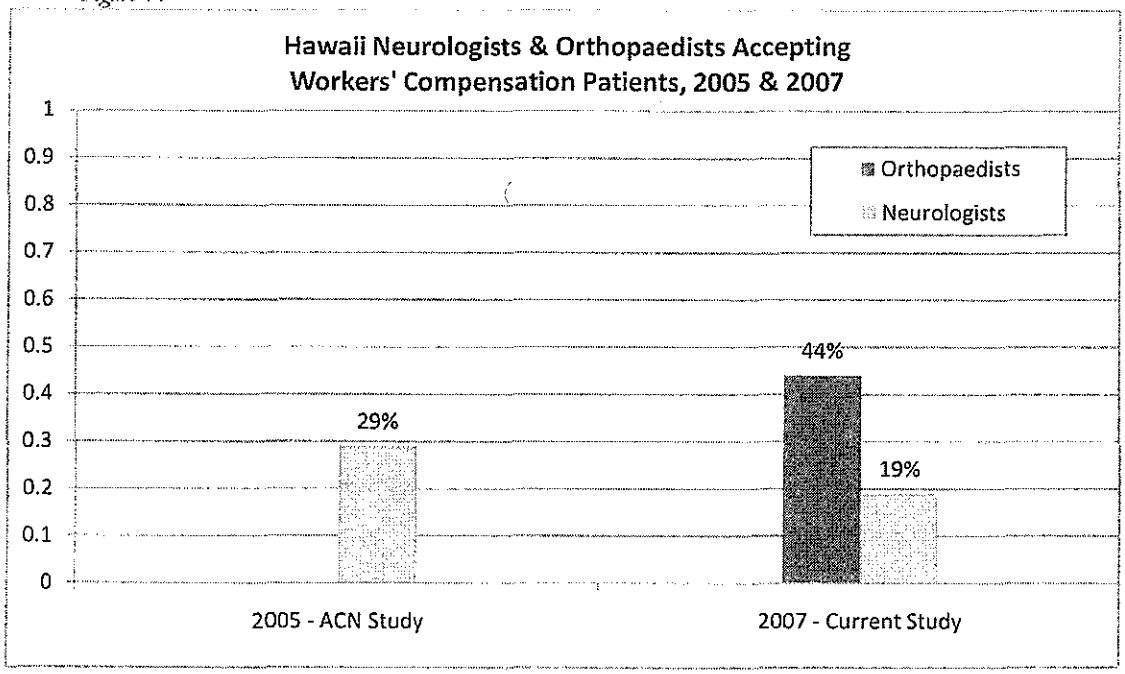
Figure 10



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

INDUSTRIAL
PHARMACY
MANAGEMENT

Industrial Pharmacy Management (IPM)

2875 S. King St.
Honolulu, HI 96826

~~**Senate Commerce and Consumer Protection Committee**~~

House Bill 1243 HD2

March 17, 2011
10:00 AM

My name is Michael Drobot and I am the President of IPM. IPM opposes HB 1243 HD2.

IPM, which has operated in Hawaii since 2004, assists over 3000 Medical Professionals across 24 states with medication management. IPM represents the largest and most notable roster of Hawaiian Medical Providers that treat injured workers in the State of Hawaii. HB 1243 aims to "...contain unreasonable increases of prescription drug costs in Hawaii's workers' compensation insurance system..." If there is indeed a problem with the overall cost of workers' compensation medications then it should be defined. I have reviewed all literature developed by the House and Senate and cannot see where or how this problem is quantified. Shouldn't a bill have back up on the problem it is trying to correct? Shouldn't it have the data formed before it is introduced? Once we know the total annual cost, and then the amount of additional cost which has occurred because of office dispensing, THEN we can see if this is truly something that needs to be addressed.

29 states across the country utilize a medication fee schedule that is based on 1.0 AWP. If a revision is required why not utilize this "reasonable" level? Locking the State medication fee schedule to the proposed Original Manufacturers AWP will add administrative complexity to all involved. This complexity will add more costs to the system. Is this the goal? Has this been reviewed / addressed?

IPM also believes that this bill was developed to restrict a small sect of local physicians that abuse the system by over prescribing and over billing. IPM believes that if passed this bill will inadvertently cripple those long standing and extremely reputable local providers like Orthopedic Associates that practice "self monitoring" quality care. These physicians focus on getting their patients back to work in a timely manner which saves the entire system money.

20377 SW Acacia Street • Newport Beach, CA 92660 • **tel** 800.803.7776 • **fax** 949.777.3166
www.ipmrx.com

IPM
INDUSTRIAL
PHARMACY
MANAGEMENT

There are apparently local primary providers in the State of Hawaii that over prescribe medications to their patients for financial reasons, often times forcing patients to walk out of their offices with 5+ bottles. The extreme volumes of medications are often times so high that the patient(s) 1) may be in danger of serious complications if all the medications are consumed, 2) may actually be delaying their recovery, and / or 3) are tempted to sell their medications on the street for large profits causing a further dilemma. Some of these local medical providers work with a management company that has only been in Hawaii for a matter of months and brings further abusive strategies for defrauding Hawaii Insurance Carriers and Employers like billing above the established state medication fee schedule. Meanwhile the majority of Hawaii providers treat injured workers with an aim toward self monitorization and quality care. The most qualified, reputable, and trusted providers in the state often times "under prescribe" in fear that they will disrupt the delicate workers' compensation system (data available upon request).

Proponents of this bill claim that the current fee schedule encourages abuse. The facts show differently, except for the outliers. If abuse exists, it only exists because of a small number of providers. Yet the bill aims to harm all providers including those that represent the Gold Standard of Care. If the goal is not to kill dispensing but rather to control those that may be abusing the system then why not focus on that Strategy? Allow IPM to share reform options that HAVE worked in similar situations with other states.

In summary, the current medication fee schedule combined with the small local medical community inherently has a "self-monitoring" system to limit/prevent abuse. The proposed fee schedule penalizes those medical providers that supply the best care, and have absolutely NOT abused the system; and adds significant administrative complexity to the workers' compensation system. It also seems "reasonable" to ask the State Legislature for cost data backing up the claims of this bill such as total annual costs of the problem.

(Data is available for all statements made above)

Sincerely,

Michael Drobot
President
Industrial Pharmacy Management
949.777.3198

QCP

QUALITY CARE PRODUCTS, LLC
6920 Hall St. Holland, OH 43528
Phone: 800-337-8603 Fax: 800-947-7921

March 15, 2011

Attn: Honorable Members of the Committee Commerce and Consumer Protection

Opposing: **HB1243 Relating to Repackaged Drugs and Compound Medications**

Dear Senator Rosalyn Baker, Chair and Senator Brian Taniguchi, Vice Chair and Committee members,

Supporters of HB1243 would like you to think that the need for Repackers to increase the AWP is not necessary. Here are just a few of the things we, as FDA and DEA-licensed Re-packagers do.

First and foremost, it's pretty obvious from data that we've seen that it makes sense to allow Occupational Health, and Board-Certified Anesthesiologists, Orthopedists, Neurologists, Psychiatrists, and PM&R Specialists to dispense directly to Patients at the Point-of-care because it increases compliance by 30%. (i.e., the percentage of prescriptions that actually are filled) This is especially important when a patient is first injured in order to get them to MMI (Maximum Medical Improvement) as quickly (and, may I add, as inexpensively) as possible. When patients have to go out-of –pocket, 30% of the scripts go unfilled, the road to recovery and MMI is inhibited, and costs rise, sometimes exponentially. That's why it's not always easy for Legislators to determine their least-expensive option. Most people can understand that it's much less expensive for a Physician to dispense the exact, re-packaged medication they need directly to a patient at the Point-of-Care than it is to have that patient go with an unfilled prescription, which may lead to a very expensive ER visit, or even admitted to the hospital at a cost of thousands of dollars per day.

The DEA has weighed in on the benefit of using Re-packagers, as well, in their battle against Diversion. There are only 400 DEA inspectors in the USA, and so they rely on us to perform due-diligence on anyone we sell to because they don't have the manpower to do so. The DEA tells us that we are "their first line of defense against diversion," and work with us to ensure that our due-diligence process is robust. Every month it seems that we turn down potential new clients because they don't meet our rigorous rules, as set forth by the DEA's mandate. Certainly Hawaii is better off than, say, FL, but this battle is a never-ending one, and the more people enlisted in the fight, the better.

Last, but not least, is our commitment to accuracy, which is also mandated by the FDA. Our Mission Statement begins with, "First Do No Harm," and we begin every meeting with the reading of that Statement. From FDA's mandate, we must and we do follow CGMP-Current Good Manufacturing Practices. That's the same guideline that the original pill's manufacturer adheres to. Our company employs 6-Sigma Quality processes, as well. Our process for filling each bottle involves over 40 inspections, from Receiving the drug properly, to creating the proper Label for the med, choosing the correct bulk-bottle to package it from in our Air-Controlled Clean Room by our gowned-packaging personnel, to our Quality Control Inspection, and even to our shipping department. The FDA inspects us often-usually bi-annually.

That Receiving Process begins with a Pedigree. I.e. we do NOT buy any products from any non-manufacturer, and so we first check for a Pedigree when we receive that product. If we aren't purchasing that medication directly from the manufacturer, we buy it only from an ADR-Authorized Distributor of Record. We track it by NDC # (National Drug Code #), by date, and by Lot #.

Did you know that Penicillin's and Cephalosporin's are NOT packaged in the same room, not even in the same building at the same address, as non beta-lactams? That's to prevent contamination so that no one who is allergic to those drugs are exposed to them. These medications are safer for patients than medications counted in a pill tray at a pharmacy.

There are many more reasons to buy from a Re-packager, than not to. Remember to look at the cost to MMI (Maximum Medical Improvement), and to include the cost of losing a life to a Diverter, rather than just singling out one part of the cost-factors as the "bad-egg" in Workers' Comp. By not allowing the acknowledgment of Repacker's AWPs, you are preventing "good practice" to take place.

Please vote NO on HB1243.

Sincerely,

Michael W. Holmes, CEO

QCP, LEWM
Ph: 800 284 3130, Ext 260
Cell: 419 351 7354
Mike.holmes@qcprx.com

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

March 15, 2011

ATTN: Senator Rosalyn Baker, Chair, Senator Brian Taniguchi, Vice Chair and Committee members

Re: **HB1243 - 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

Aloha Pain Clinic
(808) 885-PAIN

Big Island
68-1845 Waikoloa Rd #216
Waikoloa, Hawaii 96738

Maui
53 S. Puunene Ave #100
Kahului, HI 96732

March 15, 2011

Opposing: **HB1243 Relating to Repackaged Drugs and Compound Medications**

Dear Senator Rosalyn Baker, Chair and Senator Brian Taniguchi, Vice Chair and Committee members

I am an interventional pain management physician. My partners and I have two multidisciplinary clinics, one in Kahului and the other in Waikoloa, i.e. Aloha Pain Clinic (APC). Following is a brief description of the reasons we are against house bills 1243:

- Analysis of APC's account receivables illustrates the extreme lag time between treating workman's compensation (WC) patients and receiving reimbursement; e.g. WC pays an average of 34% expected payments vs. 71% by other major carriers including Medicare, HMSA, Quest, and Alohacare within 120 days
- Physician dispensing is an available tool to marginally increase revenue to aid in maintaining collections at a sufficient level to continue to treat WC patients during the extended collection period
- Clinic/Physician controlled dispensing allows for greater control of opioids and other habit forming medications. The most rigid control of addictive prescription drugs, and thus prevention of abuse, would be achieved by only permitting patients to receive these medications at the clinic level by one specific provider for the patient.
- WC documentation, billing, collections, etc., time commitment requires much greater time than any other carrier. Perhaps, as much as 4-5 times more.
- Passing these Bills will greatly decrease the number of providers treating WC patients, including APC.

Sincerely,
James F. Van Natta MD
frankvannatta@hotmail.com

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

Pauahi Tower, Suite 2010
1003 Bishop Street
Honolulu, Hawaii 96813
Telephone (808) 525-5877
Facsimile (808) 525-5879

Alison Powers
Executive Director

TESTIMONY OF ALISON POWERS

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

Thursday, March 17, 2011
10:00 a.m.

HB 1243, HD2

Chair Baker, Vice Chair Taniguchi, and members of the Committee, my name is Alison Powers, Executive Director 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** HB 1243, HD2 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

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	$15.98	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	$35.48	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	$211.68	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	$238.81	$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

Committee on Commerce and Consumer Protection
Chairperson Senator Roz Baker

TESTIMONY: Opposing HB 1423

Dear Distinguished Chair Roz Baker and Honorable Committee Members:

Hawaii's physicians take issue with and wish to refute the inflammatory testimony given by this bills chief proponent in the following ways.

First, we challenge the basic premise of this legislation, which is that costs are in some way "out of control"; therefore it is justified to functionally strip doctors of their historic rights to dispense medications to their patients. Workers comp premiums have been falling in our state for the last five years thanks, in part, to the efficient delivery and cost control efforts of the very doctors this bill will injure most (i.e. Hawaii's Orthopedist and Occupational Medicine Doctors).

Next, the doctors of this state; and especially those who are still willing to care for injured workers; take offense at HEMIC's derogatory and accusatory remarks inferring that the long standing practice of physician dispensing is akin to tax evasion and a "loophole" that must be "nipped in the bud" because it is costing them and other payers too much. Actually HEMIC has done so well lately they have accumulate over ¼ of a billion dollars in investment assets and enjoys an enviable loss ration of less then 40 cents paid out in benefits out of every employer premium dollar that passes thru its hands. So where's the fire?

Finally, the real problems of our state's Workers Comp System (i.e. doctors boycotting the System by refusing to see industrial claims) will be exacerbated and made worse by this act. The entire HPH Healthcare System (Straub, Pali Momi, Kapiolani and Wilcox Hospitals) has already opted out--along with the entire psychiatric community and most of the eye specialists. Over the last two decades the number of orthopedist in Hawaii have dwindled from 73 to 23 and if this bill goes through, Oahu's two largest remaining orthopedic groups (Orthopedic Associates and The Bone and Joint Group—11 surgeons) may be unable to continue to care for WC patients because of the lost revenue offset that dispensing provides for these time-intensive, litigious cases.

Since this bill a.) addresses a problem that does not really exist and b.) serves only to make a real crisis worse, I suggest it be declared DOA or Dead on Arrival. It is a shortsighted, destructive approach to the complex ills of this important safety net, which would be best served through the encouragement, and support of our medical community, not visa-versa.

Scott McCaffrey, MD
Emergency and Occupational Medicine
Hawaii Medical Center-West

Work Star
Injury Recovery Center

Meighan Igoe

91-2135 Fort Weaver Road, Ewa Beach, Hawaii 96706

March 17, 2011

Committee on Commerce and Consumer Protection
Chairperson Senator Roz Baker

Subject: House Bill 1243 Relating to Repackaged Drugs and Compound Medications

Chairperson Roz Baker and fellow committee members. My name is Meighan Igoe. I am a Physician Assistant practicing on the island of Oahu. I am writing in opposition to HB 1243. I have firsthand experience of the benefits of physician office dispensing to patients. For a workers compensation clinic it enables injured patients to be able to conveniently receive their medications without the hassle of traveling to a pharmacy and without the possibly of not receiving their medications in a timely fashion. Injured patients find it difficult to drive to and wait at their medical appointments. The opportunity of receiving their medications at the same location should not be an option taken away from them. In addition, it allows the practitioner to better monitor the treatment plan for patients. Practitioners know exactly what is dispensed and when without picking up the phone. This is especially important with controlled substances. The continuation of care is maintained all the way to the dispensing of medication with this system. Physician office dispensing is an established practice used by over 50% of the Hawaii's specialists willing to care for injured workers. It is good for both the patient and the clinic.

Thank you,

Meighan Igoe PA-C

Xuong Tang D.O.

91-2135 Fort Weaver Road, Ewa Beach, Hawaii 96706

March 17, 2011

Committee on Commerce and Consumer Protection
Chairperson Roz Baker

House Bill 1243 Relating to Repackaged Drugs and Compound Medications

It has been brought to my attention that there is legislation that will prevent and limit how physicians dispense prescription medications in clinic for workers' compensation cases.

I am against such legislation. It will be a detriment to all injured workers of Hawaii. Physicians are already limited with their ability to provide adequate care; passing this law will not only cripple the system, but also further harm the patients.

Having the ability to prescribe in clinic allows ease of access of care for the injured worker/patient. Access to care allows treatment option such as physical/massage therapy, specialty consultation, and prescription medication to treat pain. Benefits to access of medication improve continuity of care and overall outcome. Patients will heal faster, return to work sooner, and less likely to abuse narcotic medication.

The currently proposed fee schedule and preauthorization regulation would prevent me from treating my patients. There is only potential for harm and increase the overall cost of care.

Please, do not pass this bill and help ensure the injured workers/patients of Hawaii receive the quality of care they deserve.

Mahalo,

Xuong Tang, D.O.

Todd Uchima

91-2135 Fort Weaver Road, Ewa Beach, Hawaii 96706

To: The Honorable Rosalyn H. Baker and Members of the Senate Committee on Commerce and Consumer Protection

Date: March 12, 2011

RE: H.B. No 1243

I am a Physician Assistant that works in a office that participates with a in office dispensary pharmacy. This has been convenient for the injured worker to pick up there medication after the office visit. I have heard multiple of complaints from patient that have to pick up their medication at another pharmacy. The majority of the complaint was that they would have to wait too long for their prescriptions. For the injured worker that is back to work this makes it very inconvenient that they have to drop off their prescription and come back to pick it up. This will cause these patients to have take longer time off of work, therefore affecting their wages and or having Worker Comp to pay that patient more. I find this not very sufficient to contain cost. With the in house dispensary, they walk out with all their medications in a timely manner and avoid an unnecessary trip to an outside pharmacy. In addition, I have also seen where patients are issued a prescription card by the Worker Comp. carrier, allowing the patient only certain pharmacy that they can use. This becomes another annoying inconvenience for the patient because now they are only allowed to use certain pharmacy which may not be part of their daily driving routine.

Another benefit with the in office dispensary, it that it allow our practice to grow and meet the needs of this medical community. We are able to recruit new physician that bring expertise to the practice and are to help the injured work to more speedy recovery. Also with the addition for more providers we are able to help more injured workers and provide expanded office hours. These allow better access for the patients, treatments can be implemented sooner for a better outcome and quicker return back to work.

Finally, I fear if this bill comes into law which reduces reimbursements these practices that utilize in house dispensary will be greatly affected. This may force other physicians (Ex. sub-specialist) not participate with Worker Comp cases and that will only hurt the injured patients in the long run because they won't get the needed care and the case won't be able to move forward resulting in more loss time and a greater expense overall.

There many negative implications if this bill moves forward. I feel that it wouldn't contain cost in the long run but rather increase the cost as I mentioned above. Ultimately, the injured worker would be left without proper care thus worsening of their condition. The economical damage form this outcome will not be good when we are already going through high unemployment in a time of recession. We must not be part of the problem but only a solution.

Truly Yours,

Todd Uchima

Work Star

Injury Recovery Center

91-2135 Fort Weaver Road, Suite #170, Ewa Beach, Hawaii 96706

Phone: (808) 676-5331 * Fax: (808) 671-2931

March 14, 2011

Committee on Commerce and Consumer Protection
Chairperson Senator Roz Baker

Subject: House Bill 1243 Relating to Repackaged Drugs and Compound Medications

Chairperson Roz Baker and fellow committee members:

Please allow this correspondence to serve as testimony in complete opposition to the proposed fee schedule which will have a catastrophic domino effect on the way injured people currently receive their medical care.

As a physician assistant who has received daily feedback from thousands of patients over the past seven years it's a simple decision to oppose House Bill 1243. As medical providers we try to provide our patients with the 'tools' they need to navigate successfully through their rehabilitation and get back onto the road of recovery. Unfortunately injuries are sudden and unforeseen events. Often the aftermath is devastating. Patients often become mired in a process that is both time consuming and draining. Injured men and women would like nothing more to be seen in a timely fashion and leave the office with their medications in hand or "on the way out the door!" as one elderly gentleman put it.

Wounded workers or auto injury victims who go to their neighborhood pharmacy have found it's a role of the dice if they can pick up medications. Put yourself in the shoes of an emergency services worker who just tore a ligament in the knee and waits in line at the pharmacy for an hour only to be told there is "no claim on file." Wear the hardhat of the telephone repair worker who received a torn rotator cuff while on the job and is told "we have to wait form a call back for the adjustor...this could take up to 48 hours...well actually it will be 72 hours since its Friday". Patients will walk back in to see us holding a crumpled prescription and telling us they are going to call an attorney.

Reducing the fee schedule will handicap our ability to effectively serve the injured worker at a point-of-care level. As a result injured people from every industry would be severely limited in their access to quality and professional care. This will inevitably reduce their adherence to treatment and retard their recovery through no fault of their own.

Please take this testimony into consideration of opposition to House Bill 1243.

Thank You for your time.

Sincerely,

Gabriel Merrill, MSPA-C

WAVES of HEALTH

March 16, 2011

Committee on Commerce and Consumer Protection

Chairperson Senator Roz Baker

This letter is in opposition to **HB 1243 HD 2**

Delayed access to medication is a high ranking complaint among acute and chronic musculoskeletal injury patients. Physician office dispensing is an established practice used by over 50% of the Hawaii's specialists still willing to see Work mans Compensation and No Fault insurance cases. It is convenient for patients and improves adherence to treatment plans.

This program has helped our practice grow to meet the needs of the community enabling us to recruit new doctors, buy new equipment and expand operational hours. By reducing income from dispensing, this bill will hinder our ability to serve this important patient group which is a key element of the Workman's Compensation state safety net.

While dispensing at the time of office visit insures our patients get the medicine they need in a timely fashion, it also strengthens the compliance for patients with transportation issues.

Our dispensary is heavily weighted with generic medications thereby encouraging their use over more costly brand pharmaceuticals. If dispensing is made impractical as this bill would ensure, doctors are likely to write more brand-name medicines to be filled at local pharmacies thereby driving up the cost of care. Applying the same pricing restrictions currently applied to such things as durable medical equipment supplies and bracing will result, as it has with those items, in less patient compliance thus raising yet another barrier to timely care for those injured at work.

Workers' expedient return to work is essential to the recovery of our economy. As more specialist providers opt out of Workman's Compensation cases—and more will if this Bill is passed, primary care providers will be unable to move cases forward resulting in more costly loss time, diminished access to necessary care, more lawsuits for delay of appropriate care and greater expense overall to our already overwhelmed health care system.

Clayton Everline, MD

Board Certified Diplomate:
Sports Medicine
Internal Medicine

Fellow of the Academy of Wilderness Medicine
Clinical Assistant Professor: Department of Orthopaedic Surgery
Seton Hall University, School of Health and Medical Sciences

Eva Shear PA-C
1429 Ihiloa Loop
Honolulu HI 96821

March 13, 2011

COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
THE SENATE

CHAIRPERSON SENATOR ROZ BAKER

Ref: HB 1243 – Relating to Repackaged Drugs and Compound Medications.

Naturally, abuse of any law should always be prohibited by prudent regulations. But with regard to prices of repacked medications it should be obvious that the costs of a distributing physician's office will always have to be above the costs of a large chain of retail pharmacies.

An acceptable profit for the providing physician should remain if it is one of the few possibilities to continue care for work-comp patients. The treatment of work-comp patients has become so constrained and the reimbursement so limited that only a few remaining practices are willing to accept any more patients with work related injuries. If these few practices are further restricted financially it may not be economically sustainable to continue work-comp care as part of their patient load.

We all agree that Workman's-comp care has innumerous flaws and should be revised in many ways. If not from a medical or ethical stand point, huge costs are wasted when injured workers have to wait many months for proper diagnostic tests, then further months before their injury may be treated appropriately, for example by a surgeon. Often enough patients are kept off-duty for a year a more only due to bureaucratic hurdles, when under regular insurance coverage they would recover and be able to return to work within two or three months. The financial, but especially emotional and physical consequences are incredible and unacceptable.

In the end, the welfare of the work-comp patient should be of the greatest importance. A large number of patients are not able to fill part of their prescriptions at a commercial pharmacy due to authorization issues that can be dealt with immediately at a physician's office. Too often patients will suffer from uncontrolled pain and symptoms because their prescription could not be filled appropriately. Patients are even forced to go through the suffering of narcotic withdrawal when prior authorization at a local pharmacy will take several days. For this reason alone, the ability of a practice to support patients with in-house prescription care should be maintained.

Sincerely,

Eva Shear, PA-C

Testimony for CPN 3/17/2011 10:00:00 AM HB1243

Conference room: 229
Testifier position: oppose
Testifier will be present: No
Submitted by: Norman K. Caceres
Organization: Individual
Address:
Phone:
E-mail: mana@ibehawaiian.com
Submitted on: 3/15/2011

Comments:
I greatly appreciate dispensing and it has helped me get the medicine I need in a timely matter. When having to pick up medication from a pharmacy, sometimes I am having to wait well over a week before I am able to get the medication that I need.