The Insurance Federation of Pennsylvania, Inc.

1600 Market Street
Suite 1720
Philadelphia, PA 19103
Tel: (215) 665-0500 Fax: (215) 665-0540
E-mail: smarshall@ifpenn.org

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To: The Honorable Members of the House Republican and Democrat Policy Committees, and the Senate Democrat Policy Committee

From: Samuel R. Marshall

Re: Confronting opioid addiction

Thank you for the opportunity to be here and for your interest in confronting opioid addiction. We see the problem across all lines of insurance, we see it nationally, we see it as insurers of the private sector and as insurers of government programs, and we see it uniquely in Pennsylvania. Today, I want to share some thoughts and some specific legislative initiatives we think will help.

First is the treatment side – what insurers are required to cover, whether they are covering it, and what should they cover.

We have a state law – Act 106 of 1989 – and a federal law – the Mental Health Parity and Addiction Equity Act of 2008 – mandating insurance coverage of drug and alcohol addiction. And yet here we are, confronting an opioid addiction crisis. That raises a number of realizations and questions.

- **The best treatment is prevention.** Yes, treatment programs are important – but with any addiction, success rates only measure recovering from a problem. A full-bore focus on prevention has been lacking but is needed in Pennsylvania.

- **Are the current laws being properly enforced?** Some in the treatment community have suggested insurers aren't complying with these laws. We've asked for specifics, and we renew that request. In early April, the Insurance Department testified before the Senate Democratic Policy Committee that it was instituting market conduct exams of all health insurers on this, so we should hear from it. Beyond that, my experience is that the Department and other agencies are open and vigorous in acting on complaints from providers and patients and their families. So is the General Assembly.

    - If there are compliance problems, let's learn about them first and then address them. Rep. Murt has a bill – HB 2173 – that calls for extensive reporting by the Insurance Department on insurers' compliance with federal and state laws. That may be more reporting than enforcing, but if there are compliance problems, let's fix them.

    - Don't confuse an insurer questioning and examining a provider's treatment plan with not complying with state and federal the law. Some providers may complain that insurers ask too many questions or engage in too much ongoing monitoring and periodic check-ups. That's a good thing: A mandate isn't a carte blanche for unquestioned treatment to the limits of the mandate. HB 2173 imposes limits on this type of questioning. We think that's a bad thing: Each of us should be able to explain what we do – it makes us do things better. The phrase "treatment parity" has an appeal – but different conditions and different levels of experience demand different approaches.

- **Should the current mandates – federal and state - be reassessed?** Provider treatments often evolve to match the statutorily-mandated coverage, rather than the coverage evolving to apply to the best types of treatment. I don't know the most effective practices for opioid addiction; I don't know the variations depending on the particular patient, whether inpatient versus outpatient, or the duration. I do know that's what we should be discussing, and it should be ongoing and spark a true discussion, not just the expanded mandated coverage in HB 2173.

- The General Assembly should hear from a wide group of providers who have studied this before mandating any level of expanded coverage. And if you decide to change the mandated coverage, make sure it is based on evidence-based medicine with a focus on results, and that it applies to the Medicaid program as well as the private sector coverage.

- Cost has to be a consideration. Nobody benefits from false promises and hope, especially not the families and those addicted to opioids. Insurance coverage has to focus on treatment that works, and with opioid addiction, that may mean doing things differently than for other conditions with longer track records of treatment. And insurers have to give policyholders coverage that meets their budgets as much as their needs. We – insurers and our policyholders – are seeing significant rate increases. Don't leave that out of your deliberations.

Second – and I think more important – is the prevention side. Opioid addiction starts with a legal prescription. The best way to treat an addict is to prevent an addiction – and with opioids, the best way to deal with this is to limit their being prescribed in frequency and amount. As insurers, we are ever-mindful of excess utilization: We are focused on value-based, not volume-based, treatment and claims payments. With opioids, the excesses in prescription aren't just the cost of a few too many pills or provider visits. The excesses have real and sustained financial, and most of all human, costs.

If the goal is curbing opioid addiction, the focus has to be on reducing the amounts of opioids being prescribed. We offer some ideas:

- **Treatment guidelines in workers compensation:** In the world of opioid prescriptions, workers compensation sees a uniquely high percentage. And Pennsylvania is one of the very highest states - so we are, sadly, the outlier of the outlier: Injured workers are getting prescribed opioids that get them worse, not better. The solution is readily done and we hope will be part of any bills you enact this fall:

- **Establish evidence-based treatment guidelines on prescribing opioids to injured workers.** Rep. Mackenzie proposed this in HB 1800 for medical treatment generally. While we support that, others raised concerns with the breadth and innovativeness of it. Still, it could be done for opioid prescriptions. Other states have done so, and their opioid prescriptions have dropped – but not the quality of their medical care in getting injured workers better.

- A few weeks ago, the Governor and a number of his agency chiefs announced the treatment guidelines for opioid prescriptions generally, not just tied to workers comp. That's a positive step, but the guidelines are weak when compared with what others are doing. We've attached a comparison chart that may help you think in terms of truly effective, evidence-based treatment guidelines that would apply across the board, not just workers comp. In particular, this could help go after excessive prescriptions in the dental area, too.

- **Better utilization review in workers compensation:** In workers comp, questions on treatment go to Utilization Review Organizations approved by the Bureau of Workers Comp, with appeals from that going to the Bureau's workers comp judges. That's a weak system. First, the UROs approved by the Bureau should meet the standards set by URAC, the Utilization Review Accrediting Council the Commonwealth correctly requires of every health insurer. Second, the decisions of a quality URO shouldn't be cavalierly ignored by the judge – at least require some level of deference to medical expertise.

- **Limit the pills being prescribed.** We endorse measures to limit opioids prescribed in emergency rooms – but why stop there? The problem happens when opioids get prescribed for long stretches by pain management clinics or dentists – 30 and even 45 day prescriptions, with some high daily dosages. Better ongoing monitoring by the providers giving out prescriptions is needed. You get that by imposing a cap on the duration of any one prescription, with the realization that the shorter the use of an opioid, the better.

- This goes to the benefits of utilization review and the recognition that opioids are unique. I mentioned the problem of HB 2173 limiting how insurers can manage the treatment of opioid addiction. This is the other side: You want third-party scrutiny of opioid prescriptions, in amount, duration and how readily given, so you can prevent the addiction, not just treat it.

- **Set up a Prescription Drug Monitoring Program that requires providers and pharmacists to check before they prescribe or dispense.** Some states with programs that have gotten national recognition are Kentucky, Tennessee and our neighboring states, Ohio and New York. We should be emulating them.

- The provider community is stepping up educating their members about the dangers of opioids. That's great, but I wonder if education alone will curb the outliers in prescription practices that have caused this problem. In the world of insurance regulation, the way of stopping a bad practice or bad insurer is to enact a law that outlaws the practice and the practitioner, not just educates the industry generally about the dangers of this. You should consider the same approach for providers. Enough is enough; the time to meaningfully monitor and curb excessive opioid prescriptions is now, and we have no shortage of other states that have taken aggressive and effective steps we can build on.

Again, thank you for the chance to participate in this. We look forward to working toward solutions that will ensure not just proper treatment but meaningful prevention.

Reed
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Opiod / Chronic Pain Guideline Comparison:
ACOEM, CDC, MTUS, PA and ODG

Clinical Issue	ACOEM Opioid Guideline (December 2014)	CDC Opioid Guideline (March 2016)	MTUS Opiod Guideline (July 2015)	PA Guidelines on the Use of Opioids to Treat Chronic Noncancer Pain	ODG Chronic Pain Guideline (May 2016)
Maximum morphine-equivalent dose before additional screening?	50 mg/day	50 mg/day	80 mg/day	100 mg/day	100 mg/day
Physician to consult PDMP (Prescription Drug Monitoring Program) regularly?	YES	YES	YES	NO	NO
Pain agreements for ALL patients on chronic narcotics?	YES	NO	YES	Suggested, but not required	Not Required
Pain agreements for "high risk" patients?	YES	NO	YES	NO	NO
Screen all patients for opioid risks, using a questionnaire?	YES	NO	YES	Suggested, but not required	YES
Initiate opioids only after treatment failure?	YES	YES	YES	NO	2nd or 3rd line treatment for pain
Urine drug screen on all patients on chronic opioids?	YES	YES	YES	NO	YES
Frequency of urine drug screen?	RANDOM (2-4 times per year)	AT LEAST ANNUALLY	RANDOM (randomly in ALL patients 2 times a year and in some patients up to 4 times a year as warranted)	Consideration should be given to routine periodic urine drug screening as a monitoring tool.	(1) If a patient has evidence of a "high risk" of addiction; (2) If dose increases are not decreasing pain and increasing function