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July 3, 2019

Submitted electronically to mro@azica.gov

Arizona Self-Insurers Association
7375 E. 6th Ave., Suite 9
Scottsdale, Arizona 85251
asia@azselfinsurers.org

Industrial Commission of Arizona
c/o Jacqueline Kurth, Manager
Medical Resource Office
P.O. Box 19070
Phoenix, Arizona 85005-9070

Re: July 1, 2019 Public Hearing on Proposed 2019/2020 Arizona Physicians' and Pharmaceutical Fee Schedule

Dear Chairman Schultz and Members of the Industrial Commission of Arizona:

The Arizona Self-Insurers Association (ASIA) writes in support of the proposed 2019/2020 Arizona Physicians' and Pharmaceutical Fee Schedule, specifically the reimbursement guidelines related to physician dispensed medications and closed pharmacies. ASIA was established in 1983 to provide professional development and networking opportunities to self-insured entities throughout the state, and to promote and protect the rights of public and private sector employers to self-insure. ASIA is committed to compensation and insurance programs administered fairly and responsibly, with proper and effective economic consideration. With our mission in mind, we are especially thankful for the numerous stakeholder meetings, previous public hearing, and the external consultation which resulted in the Public Consulting Group's report on the impacts of physician dispensed medications on worker's compensation systems.

While ASIA's membership includes both public and private sector self-insured companies, the public sector self-insured organizations are the only ones impacted by the increased costs of physician dispensed medications. These taxpayer-funded organizations include cities and towns, counties, and school districts. Nationally, medications dispensed by a physician or through a closed pharmacy have been found to be 60-300% more expensive than medications dispensed through a publicly accessible retail pharmacy. In our comments dated August 23, 2018 related to the previous public hearing on physician dispensed medications, we shared data for a variety of medications both comparing the costs when physician dispensed and when dispensed by a retail pharmacy. The increased medication costs ranged from NEW TEROCIN (Prescription Cost at $932.45/Retail Price at $859.26 for a 9% increase in costs) to ESZOPICLONE (Prescription Cost at $349.80/Retail Price at $106.57 for a 228% increase in costs). This trend has held true to today.

MEDICATION	QTY	DAY SUPPLY	B/G	PHYSICIAN DISPENSED COST	RETAIL PRICE	DOLLAR INCREASE	PERCENT INCREASE
CYCLOBENZAPRINE HCL	90	30	Generic	$ 463.71	$ 297.52	$ 166.19	64.16%
DULOXETINE HCL	60	30	Generic	$ 452.40	$ 261.10	$ 191.30	57.71%
DULOXETINE HCL	30	30	Generic	$ 199.30	$ 126.43	$ 72.87	63.44%
DULOXETINE HCL	30	30	Generic	$ 207.22	$ 131.55	$ 75.67	63.48%
ESZOPICLONE	30	30	Generic	$ 349.80	$ 106.57	$ 243.23	30.47%
ESZOPICLONE	30	30	Generic	$ 349.80	$ 194.42	$ 155.38	55.58%
ESZOPICLONE	30	30	Generic	$ 349.80	$ 127.19	$ 222.61	36.36%
GABAPENTIN	90	30	Generic	$ 109.65	$ 68.42	$ 41.23	62.40%
GABAPENTIN	90	30	Generic	$ 200.70	$ 85.46	$ 115.24	42.58%
LIDOCAINE	30	30	Generic	$ 269.03	$ 171.55	$ 97.48	63.77%
LIDOPRO	121	30	Generic	$ 468.68	$ 429.67	$ 39.01	91.68%
MELOXICAM	60	30	Generic	$ 168.60	$ 106.57	$ 62.03	63.21%
MELOXICAM	60	30	Generic	$ 190.20	$ 106.56	$ 83.64	56.03%
NEW TEROCIN	240	60	Brand	$ 932.45	$ 859.26	$ 73.19	92.15%
ONDANSETRON HCL	60	30	Generic	$2,062.30	$1,331.90	$ 730.40	64.58%
TIZANIDINE	60	30	Generic	$ 81.72	$ 50.35	$ 31.37	61.61%
TOPIRAMATE	540	90	Generic	$3,009.57	$1,944.83	$1,064.74	64.62%
TRAMADOL HL	60	30	Generic	$ 49.20	$ 29.49	$ 19.71	59.94%

These above dispensed medications incurred a total increased cost of $3,485.29 compared to retail pharmacy costs for one public sector member of ASIA. This public sector self-insurer anticipates a 15% reduction in pharmacy costs for FY2019 if closed pharmacy dispensing was eliminated. The Workers' Compensation Research Institute found that claims involving physician dispensing resulted in a 17% higher average total claim cost.[1] For another public sector self-insured member, four physician dispensers accounted for $288,212.05 in medication costs through either physician dispensed medications or physician closed pharmacies. Of these, only $32,950.72 would still be permitted under the new fee schedule with only 11% of the prescriptions being first fills. These costs are associated are associated with 76 injured workers. Between July 1, 2018 and May 31, 2019, this self-insured member paid those four physicians a total of $27,404.29 for dispensed medications to fourteen injured workers. Had the prescriptions been acquired through Good Rx, those same medications would have cost between $3,683.52 and $8,509.61 or 13% to 31% of the costs paid to the physicians.

These increased costs create a burden on taxpayer supported organizations that are self-insured, such as city, town, and county governments as well as school districts, and come at the benefit of many physician offices as an increased form of revenue in an economic environment when reimbursement rates are decreasing in other areas of healthcare. Tools, technology, and companies that make in-office and closed pharmacy dispensing easier to implement typically promote their products as an opportunity to increase revenue and profits, decrease non-compensable claims, minimize risk, short pays and losses, and decrease staff costs.[2]

[1] Freeman, Mitch. "Physician Dispensing and Opioid Abuse: Drug Dilemma Prevention Strategies: MPower." *MPower by Mitchell*, Mitchell MPower, 25 Apr. 2019, www.mpower.mitchell.com/drug-dilemmas-pharmacy-program/.

[2] "Way 3 Workers' Compensation Is More Profitable and Easier Than You Think." *RxInsider*, 2016, www.rxinsider.com/20ways/articles/3_servrx_20_wayspring16_way.pdf.

As these methods increase payments for physicians, they also increase costs to the public self-insured organizations which are paying for their workers' medications. These increased costs would only be reasonable if the practice of closed pharmacy dispensing resulted in better worker outcomes and increased patient safety, but several studies have shown the opposite to be true. Research by the California Worker's Compensation Institute shows that the average paid total disability days across all claims were 9% higher on claims that had physician-dispensed medications than claims that did not.[3] Arguments that physician dispensed medications ensure higher rates with which a patient fills their prescription also leave out a core component of worker's compensation care – that it deals with pain management. In instances of noncompliance with pain medication prescriptions, that can mean that a patient feels the pain is manageable without the medication.[4]

Analysis in the state of Illinois also found a 2.99 times higher number of prescriptions dispensed from a physician's office in comparison to the pharmacy[5] and a WCRI study in Florida found that after a ban was established for in-office dispensing of opioids rather than transition patients to obtain the same strength opioids from a pharmacy, which was still permissible, physician-dispensers transitioned patients to other pain medications that could be dispensed from their office. The report notes, "The physician-dispensers could have continued to prescribe the stronger opioids (e.g., hydrocodone-acetaminophen), but would have been required to send the patients to pharmacies."[6] The results appear to correlate the claim that physicians have a reason to maintain dispensing unrelated to patient care. Worker's compensation physicians, in most instances, are also not a patient's primary care provider. Meaning, that when a dispensing worker's compensation doctor is prescribing medication they are relying on a patient's memory of other medications when they are determining possible drug-to-drug reactions. Directing patients to a retail pharmacy, online pharmacy, or other registered entity through the Board of Pharmacy establishes an additional safety measure to protect injured workers from drug interactions.

The Industrial Commission's approach to addressing reimbursement guidelines through rule is also mirrored by the Arizona Health Care Cost Containment System which established the following limitation to pharmaceutical services: "A medication personally dispensed by a physician, dentist, or a practitioner within the individual's scope of practice is not covered, except in geographically remote areas where there is no participating pharmacy or if accessible pharmacies are closed."[7] Physician dispensed medications through a closed pharmacy unregulated by the state's Board of Pharmacy is a phenomenon only seen in the state's worker's compensation system.

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[3] Physician Dispensing, An Overview of the Practice In Workers' Compensation, April 2014 https://www.workcompauto.optum.com/docs/default-source/White-Paper/physician-dispensing-overview.pdf

[4] Rabb, Roger. "Uncovering the True Costs of Physician Dispensing of Drugs." *LexisNexis® Legal Newsroom*, 3 Feb. 2017, www.lexisnexis.com/legalnewsroom/workers-compensation/b/recent-cases-news-trends-developments/posts/uncovering-the-true-costs-of-physician-dispensing-of-drugs.

[5] "Physician Dispensing of Narcotics Linked to Poor Outcomes in Workers' Compensation Claims: AF Group." *Physician Dispensing of Narcotics Linked to Poor Outcomes in Workers' Compensation Claims | AF Group*, 30 May 2014, www.afgroup.com/news/physician-dispensing-of-narcotics-linked-to-poor-outcomes-in-workers-compensation-claims/.

[6] Aschkenasy, Janet. "Putting a Cap on Physician Dispensing." *Risk & Insurance*, 1 Sept. 2013, riskandinsurance.com/putting-a-cap-on-physician-dispensing/.

[7] Arizona Administrative Code, Chapter 22 R9-22-209 https://apps.azsos.gov/public_services/Title_09/9-22.pdf

During the public hearing on July 1, 2019 at the Industrial Commission of Arizona, opponents of the proposed fee schedule argued the language included related to physician dispensing and closed pharmacies had been previously rejected by the Legislature and had been introduced on multiple occasions. A legislative history search of the phrase "closed-door pharmacy," a key component to the legislation SB 1111 and a portion of the conversation related to the reimbursement guidelines, occurs in only one piece of legislation between 1999 and 2019 - SB 1111 from the Second Session of the 53rd Legislature.

In the February 12, 2018 Senate Commerce and Public Safety Committee hearing, Senator Karen Fann, the bill's prime sponsor, acknowledged that an amendment was being negotiated with ARMA to reach consensus on the dispensing portion of the legislation. Senator Fann noted that if a consensus could not be reached the dispensing portion of the legislation would be removed. Later testimony from Kathy Senseman, lobbyist for ServeRx, noted that the issue of physician dispensing is "best served at the Industrial Commission." Senator Warren Petersen, who expressed concern that restricting physician dispensing could limit consumer choice, asked Senseman why the issue was not being addressed at the Industrial Commission of Arizona. In response, Senseman stated that the ICA has the "expertise to be able to have an intelligent conversation about this and not put [the Legislature] in a situation to legislate winners and losers in the marketplace."

During the July 1, 2019 public hearing at the Industrial Commission of Arizona, it was claimed that the Legislature rejected the concept of restricting physician dispensing, however at the Senate Commerce and Public Safety hearing which considered the legislation with its full dispensing prohibition, the two legislators who explained their votes, Senators Sean Bowie and Catherine Miranda, cited the need to reach consensus on a floor amendment, which Senator Fann had committed to, and voted yes while reserving their right to oppose the legislation in later votes if a consensus was not reached.[8] After the adoption of a floor amendment removing the initial language related to restricting physician dispensing and instead referring the issue to the Industrial Commission of Arizona for study and a required public hearing, no debate, discussion or protest occurred during either the Committee of the Whole on February 27, 2018[9] nor the Third Reading[10] on the same date. Two legislators, Senator Nancy Barto and Senator Warren Petersen, voted against the legislation with the amended referral to the ICA.

Later in the public hearing process, no organization or individual opposed the referral to the ICA during the House Banking and Insurance Committee meeting on March 12, 2018, nor was opposition noted related to the physician dispensing prohibition in the original bill.[11]

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[8] "02/12/2018 - Senate Commerce and Public Safety." *02/12/2018 - Senate Commerce and Public Safety - Feb 12th, 2018*, 2018, azleg.granicus.com/MediaPlayer.php?view_id=13&clip_id=20460.

[9] "02/27/2018 - Senate Floor Session Part 1 - Committee of the Whole #1 (Technical Difficulties) - Feb 27th, 2018." *02/27/2018 - Senate Floor Session Part 1 - Committee of the Whole #1 (Technical Difficulties) - Feb 27th, 2018*, 2018, azleg.granicus.com/MediaPlayer.php?view_id=13&clip_id=20690.

[10] "02/27/2018 - Senate Floor Session Part 2 - Third Reading #2 (Technical Difficulties) - Feb 27th, 2018." *02/27/2018 - Senate Floor Session Part 2 - Third Reading #2 (Technical Difficulties) - Feb 27th, 2018*, 2018, azleg.granicus.com/MediaPlayer.php?view_id=13&clip_id=20713.

[11] "03/12/2018 - House Banking and Insurance - Mar 12th, 2018." *03/12/2018 - House Banking and Insurance - Mar 12th, 2018*, 2018, azleg.granicus.com/MediaPlayer.php?view_id=13&clip_id=20855.

Additionally, no opposition to the referral to the ICA or the original physician dispensing language was mentioned during the House Third Reading of the legislation on March 22, 2018, where Representatives Eddie Farnsworth, Travis Grantham, and Kevin Payne voted against the legislation as amended,[12] a far cry from rejection of either the original concept or the issue's referral to the ICA for further consideration.

For the moment, Arizona has seen lower instances of physician and closed pharmacy dispensing than many other states. Prior to reforms in Illinois and Florida, more than 60% of the worker's compensation prescriptions were physician dispensed, creating a higher fiscal impact to the practice. The Industrial Commission of Arizona's approach of gathering data and identifying new reimbursement guidelines while the practice is small, rather than waiting for the practice to increase in scope and impact, protects Arizona companies from the significant challenges that occurred in other states. While much of the data related to the impacts of physician dispensed medications is several years old and addresses problems seen in other states, the data contains important lessons on the potential negative impacts and wide scope of the problem if the practice is permitted to grow unchecked. Physician dispensing has been regulated in more than twenty other states with the first revisions in a fee schedule to address physician-dispensed drugs occurring in California in 2007.[13] The language included in the Reimbursement Guidelines follows national trends for regulating this issue and includes similar provisions as the National Council of Insurance Legislators 2018 adopted guidelines on this practice.[14] Additionally, the Reimbursement Guidelines resolves a critical issue that other states have found when attempting to address physician dispensed medications through revisions in the fee schedule alone, a transition to medications that are not regulated through fee schedule due to novel dosages and repackaging[15] as was seen in California, Florida and Illinois following initial reform efforts.[16]

I want to thank the Industrial Commission of Arizona for its careful consideration of this issue and the cost and patient outcome impacts related to physician dispensed medications. The Arizona Self-Insurers Association and its Board believe this is a critical issue that if left unaddressed could have a significant impact on public and private sector self-insurers without corresponding improvements to patient outcomes.

Thank you for your consideration of these comments.

Sincerely,

Russell D. Smoldon
CEO, B3 Strategies
Designated Lobbyist, Arizona-Self Insurers Association

[12] "03/22/2018 - House Floor Session Part 3 - Third Reading #1 - Mar 22nd, 2018." *03/22/2018 - House Floor Session Part 3 - Third Reading #1 - Mar 22nd, 2018*, 2018, azleg.granicus.com/MediaPlayer.php?view_id=13&clip_id=21015.
[13] Aschkenasy, Janet. "Putting a Cap on Physician Dispensing." *Risk & Insurance*, 1 Sept. 2013, riskandinsurance.com/putting-a-cap-on-physician-dispensing/.
[14] *Tentative General Schedule NCOIL Spring Meeting*. 2 Feb. 2018, ncoil.org/wp-content/uploads/2018/02/atlanta-30-day-1.pdf.
[15] Johnson, Denise. "Workers' Compensation Still Under Pressure from Drug Repackagers, Compounding Pharmacies." *Insurance Journal*, 27 Nov. 2017, www.insurancejournal.com/news/national/2017/11/27/472190.htm.
[16] Kuehner-Hebert, Katie. "In the News." *WCRI*, 24 Aug. 2017, www.wcrinet.org/news/in-the-news/addressing-the-physician-dispensing-challenge.