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Implications for the Federal Employees'

Compensation Act"

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Good morning, Chairman Byrne, Ranking Member Desaulnier and distinguished members of the Subcommittee.

My name is Joe Paduda and I am the president of CompPharma, LLC, a consortium of pharmacy benefit managers in workers' compensation. I have 34 years of experience in medical management and managed care with specific expertise in workers' compensation pharmacy. I founded CompPharma to advocate for solutions to drug issues in workers' compensation with a focus on patient safety and the effective use of evidence-based guidelines.

I consult with regulators, large insurers and employers, state funds, claims administrators, and state governments on issues related to the medical management of occupational injuries and illnesses through my other business, Health Strategy Associates.

Finally, most of my family served in the government; my father in the Army Air Corps, my parents in the CIA and my sister as a special agent in the FBI. This is very close to my heart.

Over a decade ago, workers' compensation payers (insurers, funds, governments, and employers) began to recognize the opioid issue. They noticed that injured workers taking opioids had longer durations of disability, that these patients could not work while recovering due to opioids. They saw early indications of diversion, and the State of Washington noticed evidence of patient deaths associated with opioid prescriptions.

Since then, great strides have been made. The latest data indicates workers' compensation has reduced its opioid spend by over one-third over the past two years, compared to all payers' reduction of less than half. In 2017 alone, opioid costs in workers' compensation were down by nearly one-fifth.

Unfortunately, when it comes to dealing with the opioid crisis, FECA is five or six years behind the rest of the workers' compensation industry, and time is running out for patients who have been on opioids far too long. Other agencies are even worse off. DOD spends 34% of its medical costs on drugs, and is only now beginning to address drug prices, something the commercial world did over a decade ago. The DFEC's initial effort is far too permissive and wildly inconsistent with all credible opioid guidelines. Prescribers are allowed to prescribe two different opioids for up to 60 days without any letter of medical necessity, much less any pre-screen, drug testing, opioid agreement, or functionality impact evaluation. Most guidelines allow no more than 7 days, and then only if prescribing meets stringent tests.

Specific examples of governmental agencies making great strides include Ohio, under Gov. Kasich's strong leadership. The state has seen the number of opioid-dependent injured workers in the Bureau of Workers' Compensation (BWC) system fall by 19% last year, which was its 6th year of decline.

After six years of smart policy and tireless effort there are 4,714 fewer workers at risk for

addiction, overdose and death thanks to efforts of the Pharmacy Program Directors, first John Hanna and now Nick Trego and the medical directors at BWC. This reduction in opioid use will also save employers and taxpayers millions in direct costs.

Washington's state fund has been the leader in fighting opioid misuse. Working with other state agencies, Dr. Gary Franklin developed the first opioid treatment guidelines in widespread use and got them adopted statewide. He and Dr. Jaymie Mai have been instrumental in reducing opioid usage, saving dozens of lives in the process, and doing it very efficiently; Labor and Industry's administrative expenses are about a third of most commercial insurers. Since 2010, less than 4% of drug spend in the state of Washington is for opioids.

Since 2014, the California State Compensation Insurance Fund (SCIF) has reduced the number of opioid scripts by 3/5ths and reduced the number of patients taking high levels of opioids from 1,458 to 186. SCIF is perhaps the best example of how the hardest problem in opioids can be solved.

Its long-term opioid reduction program **begins with the adjuster, who remains involved in the claim throughout the process**. The program involves multiple vendors, a variety of approaches, an openness to innovative treatment, and a lot of communication. There is no "canned" approach: Cognitive Behavioral Therapy, acupuncture, counseling, physical therapy and exercise programs, and Functional Restoration Programs have all been employed. Medication-assisted therapy (MAT) has been used in selected cases, but for the most part, the state fund is trying to stay away from using opioids to solve opioid problems (my wording, not theirs).

Key to addressing the long-term use issue has been using vendors to conduct peer-to peer conversations with the prescribing physician(s). According to SCIF's Medical Director Dinesh Govindarao, MD, MPH, this peer-to-peer education of prescribing physicians has been instrumental in the success of the program, as many treating providers don't have adequate training on pain management and opioid prescribing.

For those patients with significant chronic pain, the state fund developed a program specifically aimed at helping those patients cope with their condition. Patients willing to participate were enrolled in this program.

State formularies have gotten a lot of attention in the past few years. A formulary is essentially a list of medications that are automatically approved and a list of drugs that are not approved without prior authorization. Formularies like the states are using prevent the initial fills of prescriptions for inappropriate drugs, but it's important to note that patient-centric formularies, which are usually developed with a pharmacy benefit manager, should be used in the long term. These medication regimens are customized for a specific injured employee and consider such things as drug interactions and co-morbidities.

As a state-regulated industry, workers' compensation has shown us what works and what

is not effective, but sometimes the picture isn't as clear as one would think. Nonetheless there are lessons we can learn and apply to FECA.

It took FECA far too long to even begin to address the opioid crisis. Then, its policy of allowing 60 days of two different opioids is wildly inconsistent with all credible clinical guidelines, which limit initial scripts to seven days, with strict requirements for any additional opioids.

FECA can and must move now to build an approach to prevent further needless deaths among its 20,000+ chronic opioid using patients. This should include:

- Institute random drug screening for all patients who are prescribed opioids. (This is not to be confused with employment drug testing.) (Data from Millennium Health indicates about 1 in 5 patients tested show no evidence of the prescribed drug in their specimen.)
- Require a prescriber utilize a written screening tool for all potential opioid patients to assess risk prior to writing a script. There's a strong correlation between tobacco usage and opioid addiction risk, yet few physicians even ask patients if they smoke or chew.
- Require opioid agreements signed by the prescriber and patient, committing the patient to one prescriber and one pharmacy.
- Require documentation of changes in functionality and pain status for all opioid patients.
- For chronic users, follow the California state fund's lead, e.g., understand each patient is unique, each may require a slightly different approach, and recognize that being open and creative is essential to saving lives and keeping families together.

I'll close with this – some may be concerned that FECA or its PBM will try to replace physicians' decision-making authority and dictate the drugs patients take. Let's understand two critical things.

- Physicians want to do the right thing – and getting their patients off opioids – or using much lower doses – is absolutely the right thing.
- Physicians often don't have the training, education, tools or understanding to do this. It's FECA's job to provide peer-to-peer education and guidance, to help those physicians through the process, to identify the local therapists, to authorize MAT or physical therapy. FECA must accept that responsibility

Thank you for listening and for taking action.