

Members

Rep. Timothy Brown, Chairperson  
Rep. Steven Davisson  
Rep. Ronald Bacon  
Rep. Suzanne Crouch  
Rep. Richard Dodge  
Rep. David Frizzell  
Rep. Donald Lehe  
Rep. Eric Turner  
Rep. Charlie Brown  
Rep. John Day  
Rep. Craig Fry  
Rep. Scott Reske  
Rep. Peggy Welch  
Sen. Patricia Miller, Vice-Chairperson  
Sen. Ryan Mishler  
Sen. Vaneta Becker  
Sen. Ed Charbonneau  
Sen. Beverly Gard  
Sen. Ron Grooms  
Sen. Jean Leising  
Sen. Jean Breaux  
Sen. Earline Rogers  
Sen. Vi Simpson



# HEALTH FINANCE COMMISSION

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Casey Kline, Attorney for the Commission

Authority: IC 2-5-23

## MEETING MINUTES<sup>1</sup>

Meeting Date: August 23, 2012  
Meeting Time: 1:00 P.M.  
Meeting Place: State House, 200 W. Washington St.,  
House Chamber  
Meeting City: Indianapolis, Indiana  
Meeting Number: 1

**Members Present:** Rep. Timothy Brown, Chairperson; Rep. Steven Davisson; Rep. Ronald Bacon; Rep. Suzanne Crouch; Rep. Richard Dodge; Rep. David Frizzell; Rep. Donald Lehe; Rep. Charlie Brown; Rep. Scott Reske; Rep. Peggy Welch; Sen. Patricia Miller, Vice-Chairperson; Sen. Ryan Mishler; Sen. Ed Charbonneau; Sen. Beverly Gard; Sen. Ron Grooms; Sen. Jean Leising; Sen. Jean Breaux.

**Members Absent:** Rep. Eric Turner; Rep. John Day; Sen. Vaneta Becker; Sen. Earline Rogers; Sen. Vi Simpson; Rep. Craig Fry.

The first meeting of the Health Finance Commission was called to order at 1:05 P.M. by Representative Tim Brown, M.D., Chairman.

Members were asked to introduce themselves and the Chairman discussed future meeting dates.

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<sup>1</sup> These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at <http://www.in.gov/legislative> Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of \$0.15 per page and mailing costs will be charged for hard copies.

**The effectiveness of current laws and rules in Indiana and best practices used by other states for the regulation and monitoring of pain management facilities and prescribers of controlled substances.**

*Michael Whitworth, M.D., Indiana Pain Society (See slide presentation - Exhibit 1).* Dr. Whitworth discussed the need for increased education and regulation concerning the ownership and use of scheduled drug products.

He described the benefit of using opioids for the treatment of acute or chronic pain versus the harm caused by the drugs. While opioids are an effective and inexpensive way to treat chronic pain, substance abuse and accidental drug deaths are becoming increasingly common due to the diversion of legally obtained controlled substances. Dr. Whitworth explained that drug diversion is so commonplace that 70% of new abusers obtain their drugs from other people who have legitimate prescriptions for the scheduled drugs. He commented that patients with prescriptions or their family members can make a lot of money selling the drugs and that this is a powerful temptation to divert the drugs.

After reviewing statistics concerning opioid sales, admissions for drug treatments, substance abuse, and accidental drug deaths, Dr. Whitworth recommended a legislative framework for the regulation of controlled substances consisting of the formation of a controlled substance commission. The proposed commission would be given the authority to promulgate regulations concerning the prescribing practices of all controlled substance prescribers. He discussed the need for increased communications from coroners and hospitals concerning deaths and overdoses to the prescribing professionals and the need for prescribers to use the Indiana Scheduled Prescription Electronic Collection and Tracking (INSPECT) Program. Also included in the framework are education of patients regarding the patient's responsibility for the drugs in their possession and requirements for increased monitoring of patients through the use of drug screens, more frequent visits to the prescribing professional, and pill counting to discourage diversion. He recommended that the Indiana Pain Society standards of care be adopted.

Dr. Whitworth described several of the problem drugs involved in substance abuse and accidental deaths. Hydrocodone is a Schedule III drug and can have up to five refills, explaining why there are so many pills out on the street. The FDA backed off of making hydrocodone a Schedule II drug, but Indiana can legislate the change to increase the level of this drug. Methadone was described as a particularly deadly, cheap drug responsible for 30% of all drug deaths, due to its chemical properties.

Dr. Whitworth mentioned that the INSPECT federal grant funding is being discontinued. He would recommend a \$0.25 tax on each controlled substance prescription to provide ongoing funding for this valuable tracking and management tool.

Commission questions followed concerning the use of electronic medical records, Dr. Whitworth's specific mention of the high percentage of drug diversion by Medicaid patients, and effective methods to restrain the diversion of drugs.

*Joan Duwve, M.D., Indiana State Department of Health (ISDH) (See slide presentation in Exhibits 2 and 3) -* Dr. Duwve reviewed statistics related to prescription drug abuse, unintentional poisoning deaths, and the causative factor of drug overdoses. She stated that methadone alone is responsible for 30% of Indiana drug deaths due to opioids.

Asked to comment on the recommendation for the controlled substance commission and the \$0.25 fee for INSPECT funding, Dr. Duwve commented that she would be on the Attorney General's task force on drug diversion and believes that the INSPECT program is vital to controlling prescription drug abuse.

Commission questions followed with regard to why prescriptions are for unnecessary numbers of controlled substances; whether a change from Schedule III to Schedule II would be a good idea for hydrocodone; and the source of the death statistics illustrated in the presentation.

*Mike Rinebold, Indiana State Medical Association (ISMA).* Mr. Rinebold commented about the following: (1) the use of INSPECT is the gold standard for prescribing practices; (2) state-level prescription drug take-back and disposal programs are necessary; (3) ISMA conducts education programs on opioid prescribing and standards of care; (4) ISMA works with the State Police and the licensing boards on enforcement actions; (5) fully funded and operational substance abuse treatment programs are needed; and (6) INSPECT needs an ongoing source of operational funding. He stated that the INSPECT program costs approximately \$475,000 annually. Two-thirds of the funding, or about \$316,000, is provided by a federal grant which is ending, leaving a funding gap that will need to be filled.

*Dick Huber, M.D. (See Exhibit 4).* Dr. Huber introduced himself as a volunteer giving over 100 annual drug education presentations in schools. He explained that due to methadone's long half-life, 75% of methadone-related drug deaths are unintentional. He recommended that methadone prescribing should be limited to short-term use and confined to a limited number of physician prescribers.

Senator Miller stated that she would like to revisit the issue of limits on methadone clinics and requested an updated report from FSSA.

*Jackie Rowles, Indiana Association of Nurse Anesthetists.* Ms. Rowles commented that INSPECT is a helpful resource and that her association is in support of the concept of a controlled substance commission that would regulate all prescribers and for increasing the oversight for the disposal of drugs and for patients sharing controlled substances.

*Becky Carter, Indiana Hospice and Palliative Care Organization.* (See Ms. Carter's written testimony in Exhibit 5.) Ms. Carter stated that the Indiana Hospice and Palliative Care Organization would like to be included in discussions as this issue is addressed and that the formation of a controlled substance commission and increased use of the INSPECT system would be considered steps in the right direction.

*Senator Ron Grooms.* Senator Grooms commented that Jeffersonville has an epidemic of drug diversions. Kentucky laws have changed, prompting a pain clinic to move from Kentucky to Indiana. Jeffersonville has since passed an ordinance banning pain clinics. Current Indiana regulations treat pain clinics as physician offices which are unregulated. Senator Grooms supported the concept of the controlled substance abuse commission, but wants to see it implemented in less time since he believes the problem will get worse the longer it is left unaddressed. He said that the INSPECT Program is a good step, but that it addresses the end of the legal supply line. Issues such as patient ownership, registration, sharing practices, and pain clinics need to be addressed as well.

Rep. Charlie Brown commented that he would consider a preliminary draft of proposed legislation at a future meeting of the Health Finance Commission.

**Specified health insurance plans and the number of covered people with copayments, coinsurance amounts, and out-of-pocket costs incurred for prescription drugs that exceed specified amounts for the coverage**

*Michelle Rice, National Hemophilia Foundation.* (See Ms. Rice's written testimony in Exhibit 6 concerning the use of limited drug formularies and specialty drug tiering for copayment

purposes by insurance companies.) Ms. Rice requested that the state's essential benefit defined for the purposes of federal healthcare reform include a cap on the out-of-pocket costs or ban specialty Tier IV practices.

In response to a question from the Chairman, Ms. Rice explained that adult male hemophiliacs have a difficult time qualifying for Social Security Disability (SSD) because the treatment qualifiers are out of date. If men do qualify for SSD, it is due to comorbidities of HIV, hepatitis C, or joint disease. She added that some children with hemophilia do qualify for SSD. Rep. Charlie Brown asked what conditions the specialty drugs included in the Tier IV would treat? She said cancer, epilepsy, hepatitis C, and hemophilia among others. In response to a further question regarding the Department of Insurance, she commented that the specialty tiering is a recent phenomena and the language in the ACA does not necessarily address this particular issue.

*Bob Massie, Marketing Informatics/ Indiana Minority Epidemiology Center.* (See Exhibit 7 by individual districts.) Mr. Massie distributed summary reports for each legislator's district illustrating a summary report of self-reported chronic conditions that may be treated with drugs on specialty tiers. He described the process of data-mining complex data bases for useable information and discussed the self-reporting process used.

*Lesa Paddock, Family Voices,* discussed problems her family has had with Level II drug copayments. She added that if not for the Medicaid waiver, the expense would have been financially disastrous for her family. She added that the paperwork is very complicated to complete.

*Tony Gillespe, Sr., Indiana Minority Health Coalition.* Mr. Gillespie commented that specialty tiering of drugs affects the affordability and subsequently the accessibility of appropriate healthcare. He stated that a reasonable cap needs to be placed on copayments and deductibles. He cited the state's experience with using the high-risk pool to provide HIV patients with care; people get appropriate care but there is a waiting list due to limited federal funding. He asked that since specialty tiering impacts mainly persons with chronic conditions, is it discriminatory to target these populations?

In response to a question regarding whether the ACA would affect this problem, he responded that the ACA should afford some relief but the impact will depend on the specific condition and drug.

*Jean Castor, Executive Director, American Academy of Pediatrics.* Ms. Castor stated that principals of healthcare financing are violated when children cannot access medically necessary drugs due to cost. Cost should be spread across all payers so that individual out-of-pocket expenditures are affordable. She commented that costs should not be shifted to providers.

*Keith Beesley, General Counsel, State Personnel Department.* Mr. Beesley spoke only to provide information for the Commission. He stated that federal law regarding high-deductible insurance plans require the deductible to be satisfied first before any monthly cap on expenditures would be allowed. He added that 94% of state employees are on the high-deductible plan.

*Lesley Ray, Indiana Pharmacists Alliance.* Ms. Ray testified that pharmacists are put in the position of letting patients know what the copayments will be. Often a very high copay will result in an alternate medication being prescribed or the patient declining the drug.

*Christopher Schrader, Indiana Chamber of Commerce/IN Chapter, Society of Human Resource Managers.* Mr. Schrader spoke in opposition to setting limitations on out-of-pocket expenses for

prescription drugs. (See Mr. Schrader's written testimony in Exhibit 8.)

*Logan Harrison, Chief Deputy for Health and Legislative Affairs, Department of Insurance.* Mr. Logan stated that the department regulates 950,000 covered lives; 750,000 have prescription drug coverage and 1% to 5% use specialty-tiered drugs. More insurance plans are increasingly using tiered plans - this is a choice the party contracting for insurance makes when determining the premiums. The department does not have data on large employers' self-insured plans. Mr. Logan commented that the ACA does not address the out-of-pocket cost-sharing issue, nor does it address the underlying cost of products and services.

In response to Commission questions, Mr. Logan stated that the department would require specific legislation to impose limits or caps for copayments and deductibles.

Senator Ron Grooms commented that there are limits on surgical procedures, Medicare Part D, and auto insurance, but not for specialty-tiered medications. This practice may result in patients with chronic conditions being shifted to public coverage. He stated that limits exist in nonprescription areas and that it is now time to do this with drugs.

Commission questions included how does the imposition of out-of-pocket limits avoid shifting increased costs to the price of premiums? Representative C. Brown suggested that since this issue affects 1%-5% of the population, there may be a better way to deal with the high-risk population without penalizing the whole system.

#### **Whether any limitation should be placed on the dispensing of a prescription drug by pharmacies.**

Senator Ron Grooms introduced the concept previously included in SB 407-2012, which would allow a pharmacist to dispense a 90-day supply of certain drugs in specific instances. For example, certain employee prescriptions for 30 days may be filled for 90 days if the provision is by mail-order pharmacy. A community pharmacy may currently fill the same prescription for only 30 days. The issue is one of parity for community pharmacies.

*Lesley Ray, Indiana Pharmacists Alliance.* Ms. Ray commented that community pharmacies are seeking parity with pharmacy benefits managers and mail-order pharmacies that are allowed to fill 30-day scripts for 90 days under certain circumstances.

Chairman Tim Brown announced the next meeting of the Health Finance Commission would be September 19, 2012, at 10:00 A.M. The House Chamber is scheduled for another meeting, so the Health Finance Commission must adjourn by 1:00 PM.

After Commission discussion of possible topics for future meetings, the Chairman adjourned the meeting at 3:40 P.M.

# Indiana Pain Society

## Special Report on Controlled Substance Prescription Medications: Indiana State Legislature Interim Study Committee August 2012

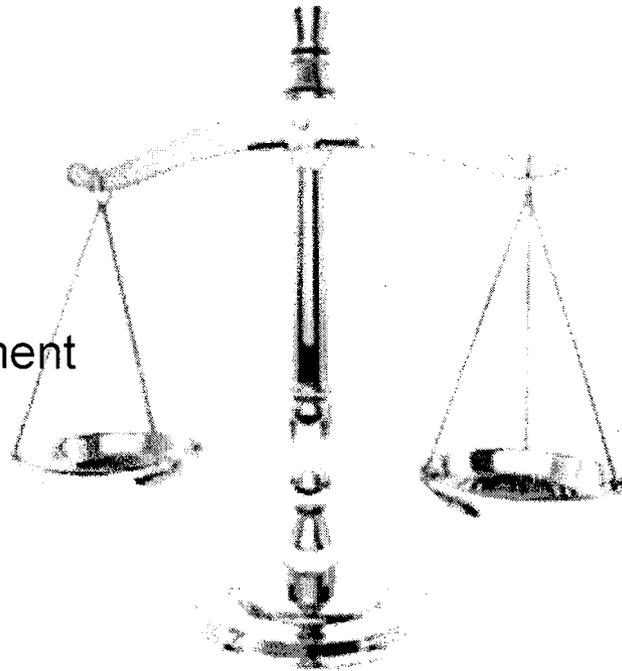
Michael L. Whitworth, MD  
Chairman of the Board of Directors  
Indiana Pain Society

**Exhibit 1  
Health Finance Commission  
Meeting #1 August 23, 2012**



# Benefit vs Harm of Opioid Treatment of Chronic Pain

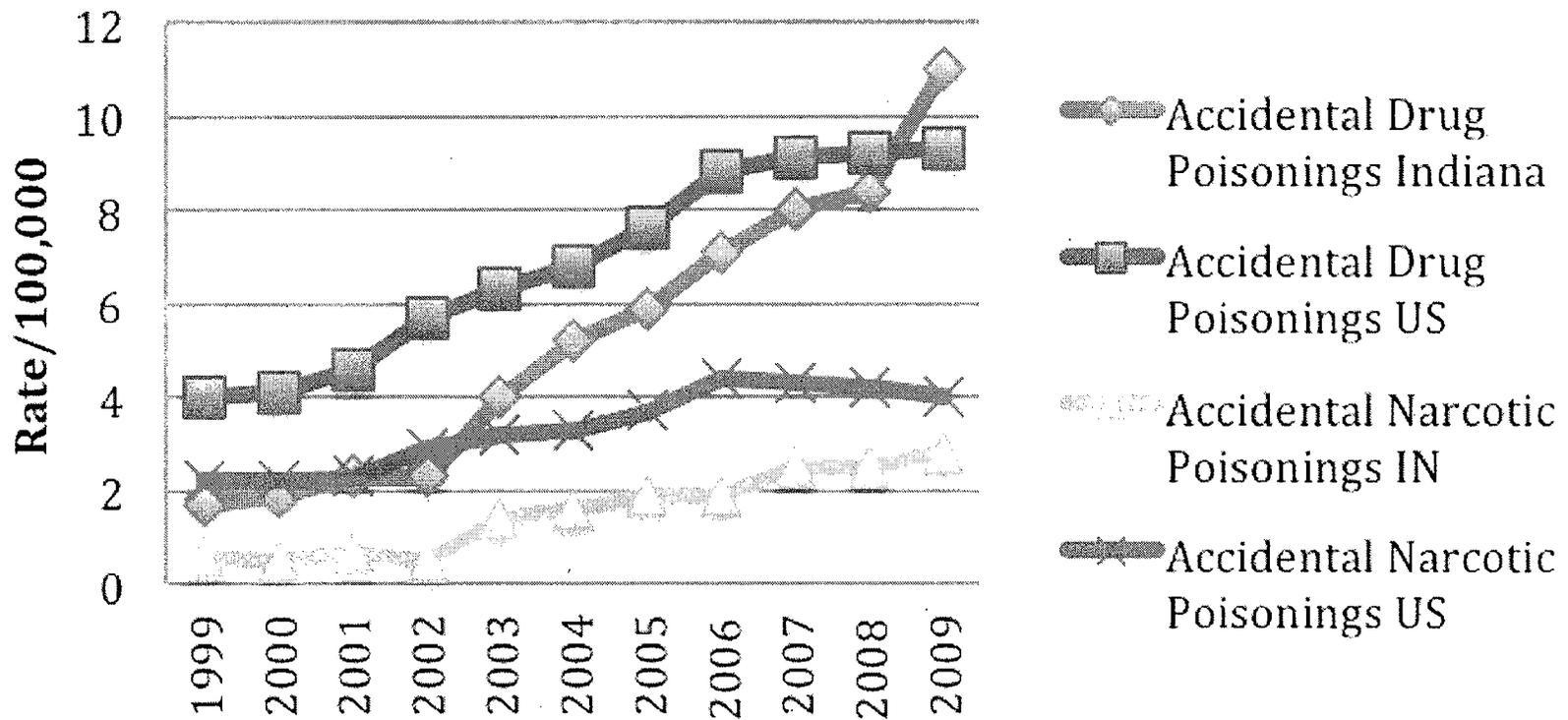
Effective pain control  
Suicide reduction  
Improved function  
May be only effective treatment  
May be only affordable treatment



Substance abuse  
Drug diversion  
Significant side effects  
Death  
Societal crime  
Societal attitudes

# Do We Have A Problem in Indiana?

## Accidental Drug Deaths IN vs US CDC Wonder Data X40-44 and X42



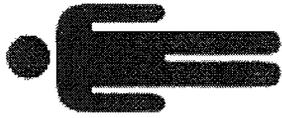
# Accidental Death Coding 1999-2009: % in Each Category

CDC Data

	Opioids/Psycho dysleptics	Unknown	Non-opioids
US	48	44	8
Indiana	28	67	5

# # Deaths is Just the Tip of the Iceberg

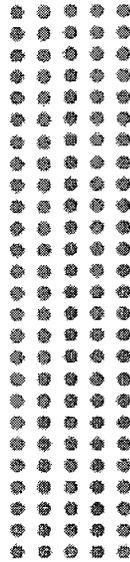
For every **1** death there are...



treatment admissions for abuse<sup>3</sup>



**32** emergency dept visits for misuse or abuse<sup>4</sup>

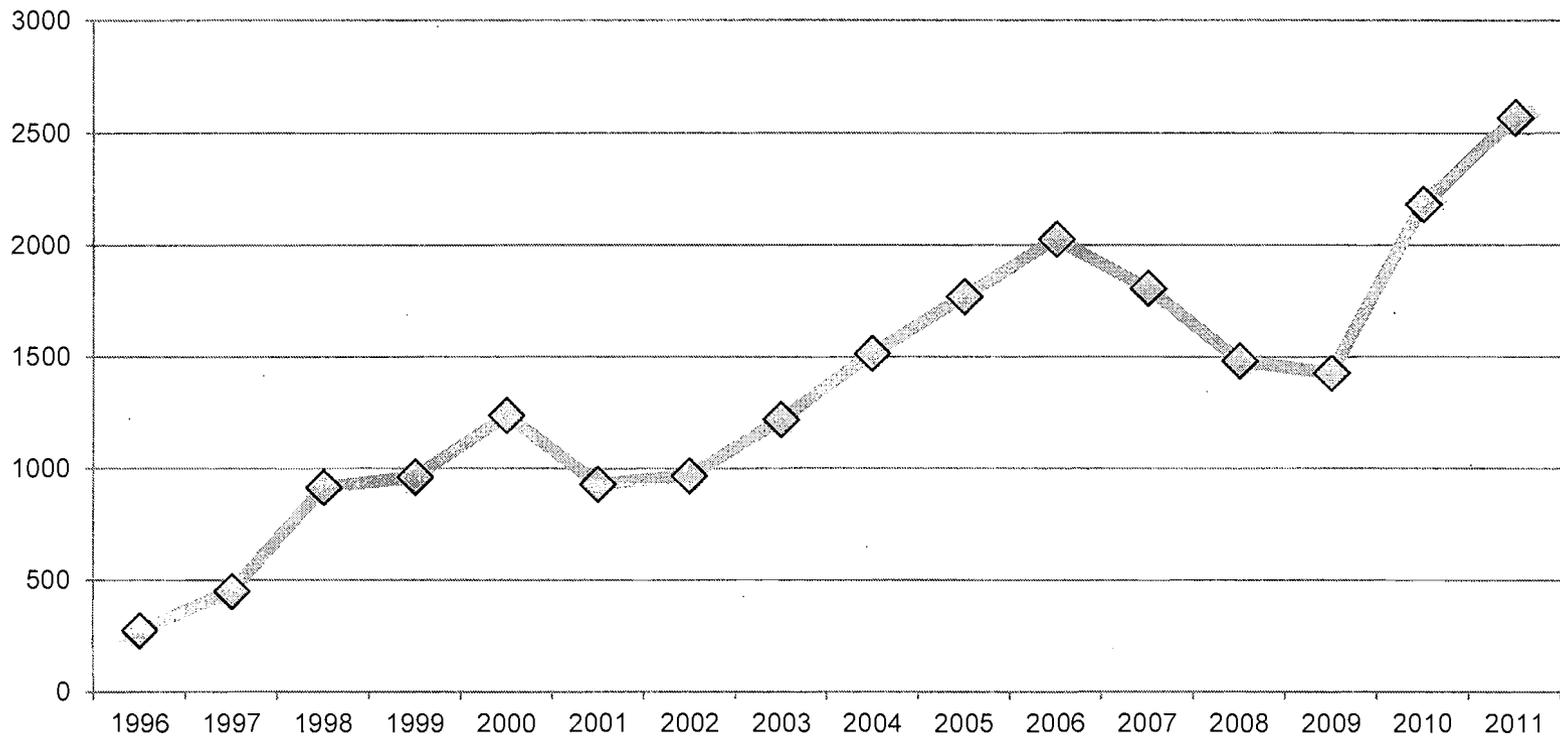


**130** people who abuse or are dependent<sup>7</sup>

nonmedical users<sup>7</sup>

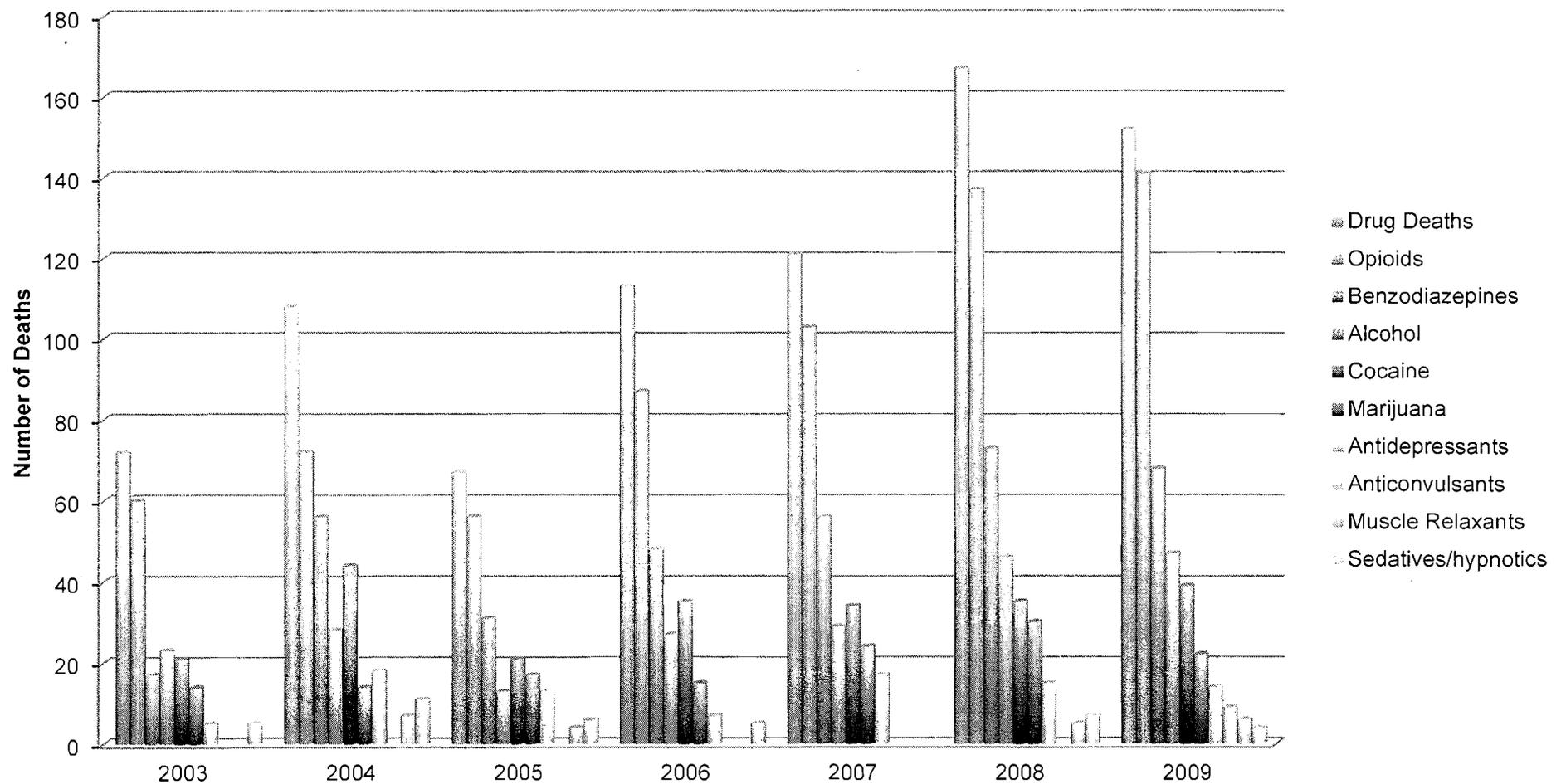
... (The text in this block is extremely small and illegible, appearing as a dense block of grey characters.)

## Indiana Admissions for Drug Treatment Opioids Other than Heroin



# Polypharmacy is the Rule Rather than the Exception

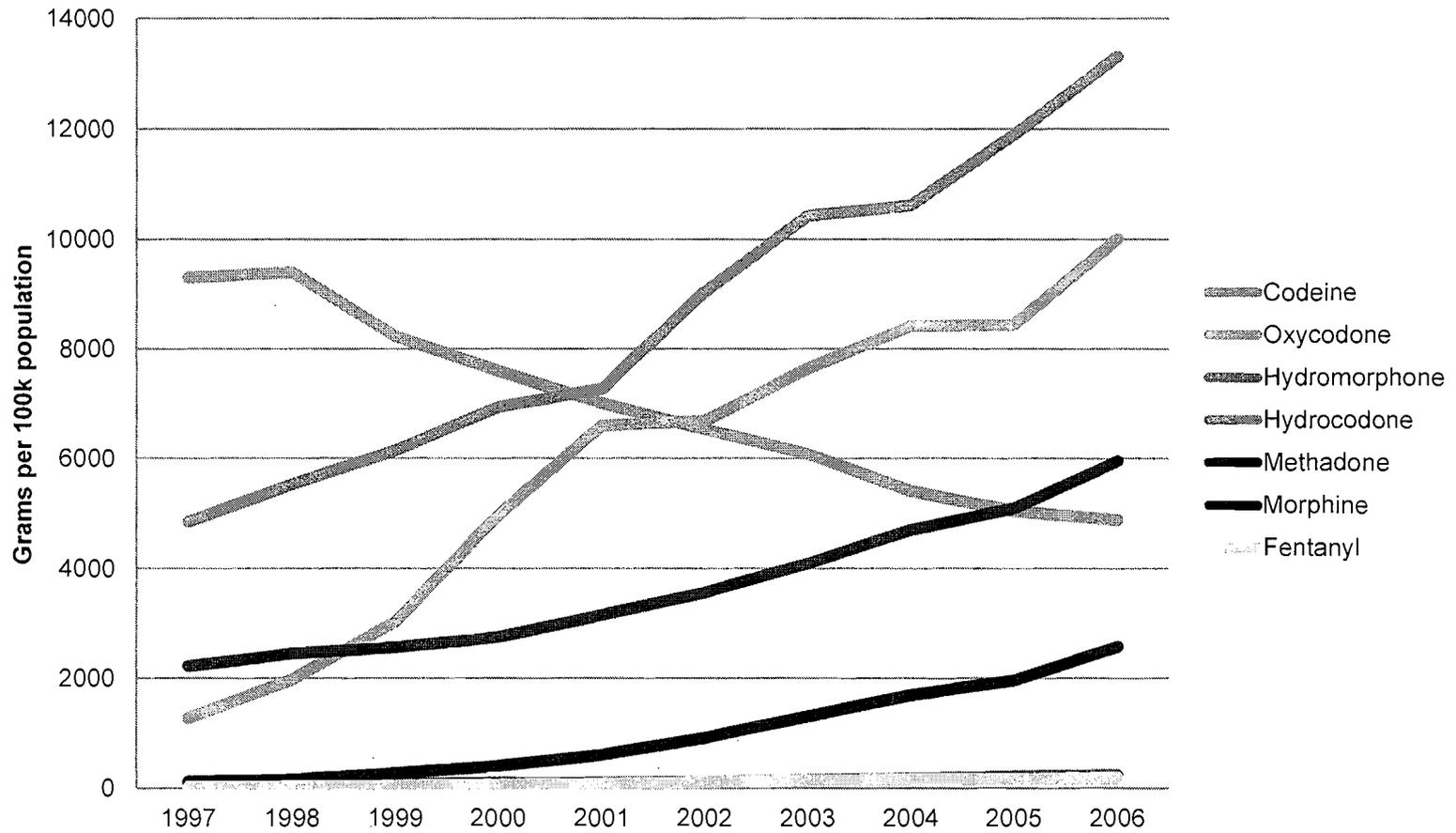
**Marion County Metro Data Drug Related Deaths**  
DAWN DATA: Drugs Found in Decedents



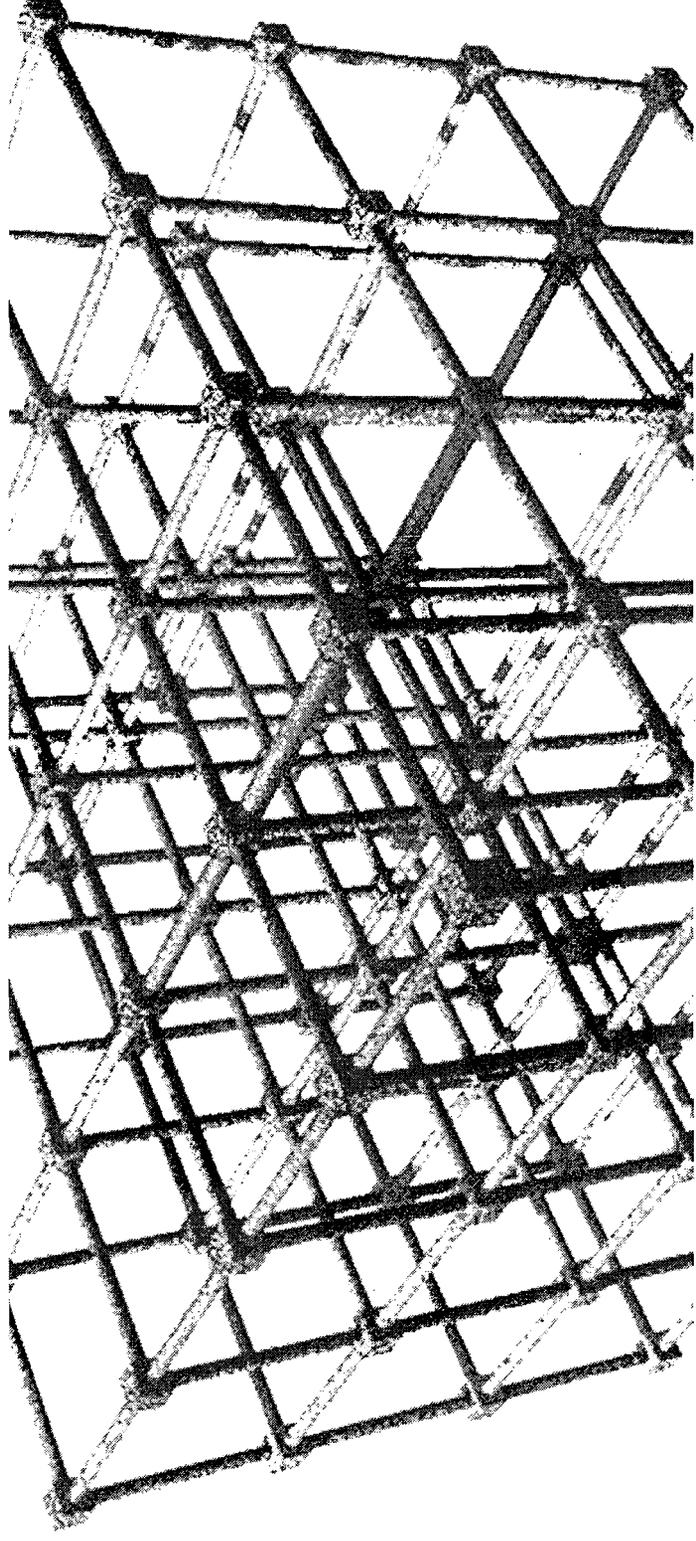
# Sources of Meds in Substance Abuse and Death

- ◆ 90% originate with prescribers legal prescriptions
- ◆ In recent initiates of substance abuse, 55% of the time friends gave them medications (obtained from a physician) for free and 15% of the time the medications were sold to the person
- ◆ Several studies show that over 50% of the time those dying from prescription opioid overdoses had no prescription for the drugs responsible for the overdose death

# Indiana Opioid Sales (ARCOS)



# Legislative Framework for Controlled Substance Regulations: the CSC



# Controlled Substance Commission

- ◆ Given the power to promulgate regulations regarding the prescribing of controlled substances by all prescribers
- ◆ Regulations would be identically implemented by each professional licensure board
- ◆ Paradigms of communication, education, enforcement to be created.
- ◆ Create mandatory patient responsibilities and prescriber responsibilities
- ◆ Re-evaluate progress in yearly reports to the ISL
- ◆ If substantial progress in death reduction and reduction in substance abuse/diversion does not occur in 2 years, then consider broad legislative action

# Why Not Adopt Other States Opioid Policies

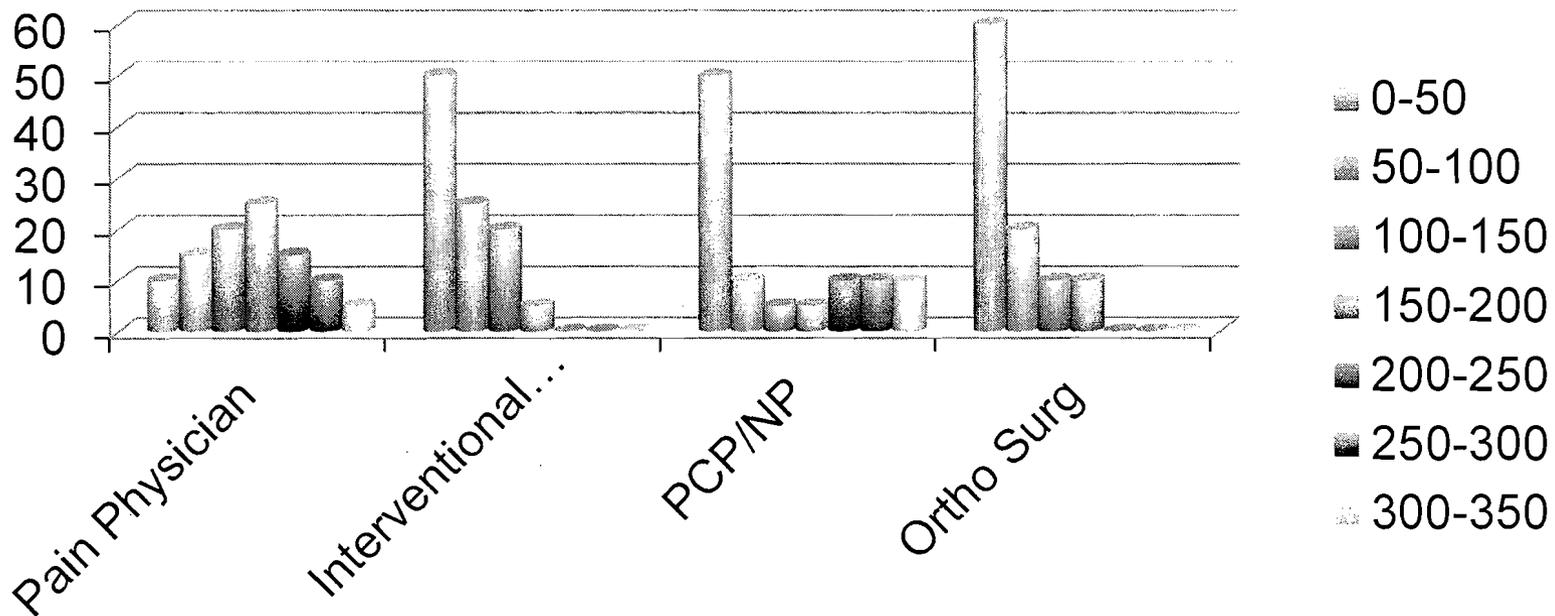
## Indiana is Not in Panic Mode

- ◆ Very infrequent pill mill operation compared to other states such as Florida, KY
- ◆ Most prescribing of opioids is by PCPs and most emergency disciplinary actions regarding opioid excess prescribing involves PCPs, not pain clinics.
- ◆ Maximum arbitrary amounts of opioids, exceptions for hospital based clinics, or percentage based regulations have no medical or scientific basis

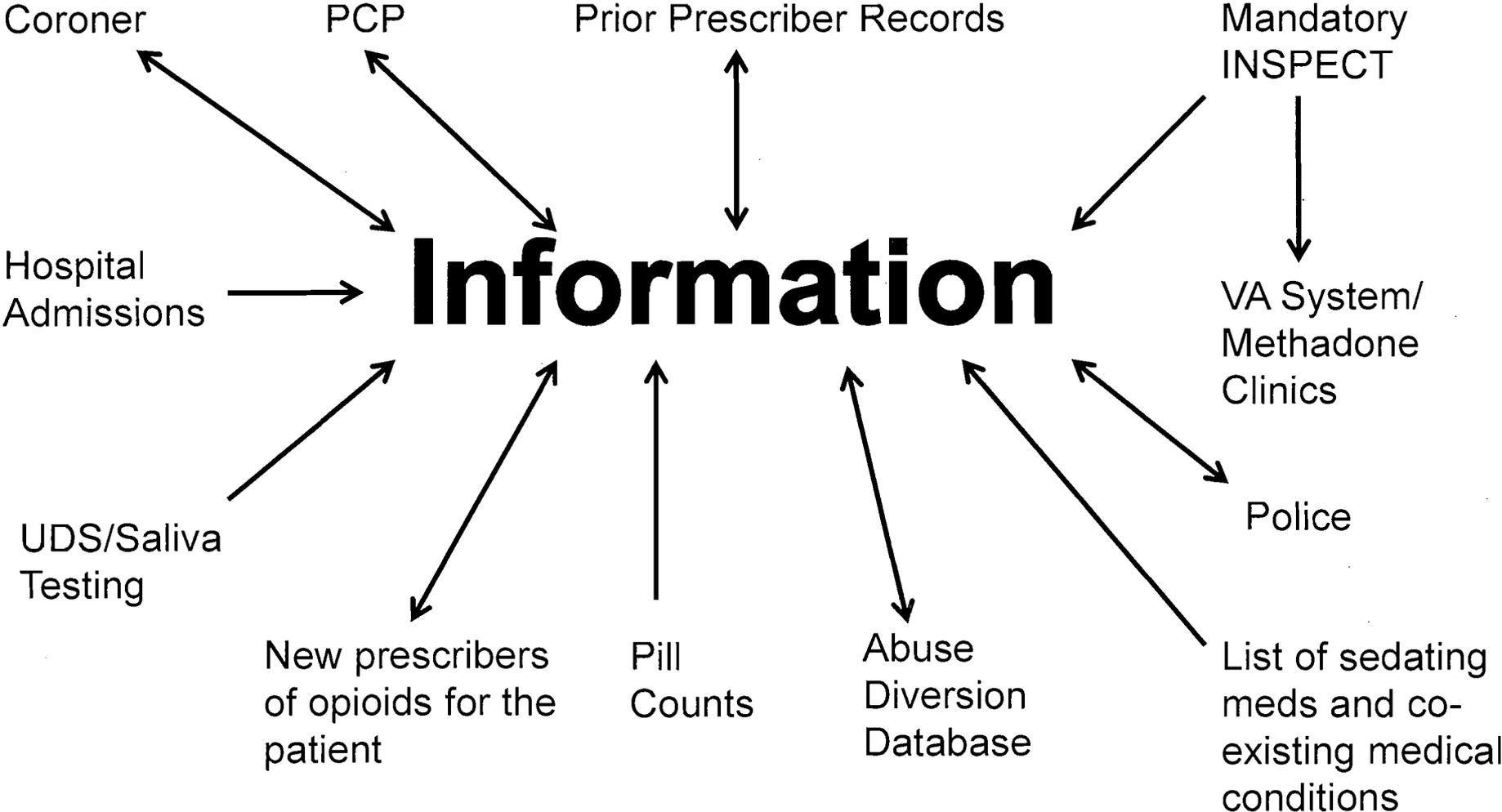
## Improved Data Available

- ◆ Causes of death and overdose are multifactorial and include obesity, sleep apnea, concurrent use of benzodiazepines, severe COPD
- ◆ Not enough prescribing pain physicians in the state
- ◆ Tight controls on patients via monitoring reduces substance abuse rates

# Prescribing Patterns Long Term Opioids >3 months Morphine mg equivalents



# *Communication of Information*



**Improvement on  
Statute Comprehensibility**

**Handbook of  
Controlled Substance  
Prescribing**

**Mandatory Physician  
Provided Material on  
Controlled Substance  
Laws and OD**

# **Education**

**Coroner Manner  
And Cause of  
Death Education**

**Mandatory Pharmacy  
Provided Info on CS  
Laws and OD**

**Mandatory CS  
Education for  
CSR Holding  
Providers  
(CME/CNE)**

**Mandatory  
REMS  
For CS  
Prescribed**

**Restrictions  
On Methadone  
Usage for Chronic  
Non-Malignant Pain**

**Uniform  
Regulation  
Penalties for  
Deviant  
Prescribers**

**Link CSR to  
INSPECT  
Enrollment**

**Stronger  
Laws for  
Those  
Sharing  
CS**

# **Enforcement**

**Database or  
Database Pointer  
for Substance Abusers/  
Diverters**

**Insurer Requirement  
To Cover CS Urine  
Or Saliva Testing**

**Indiana Pain Society  
Opioid Standards of  
Care**

# IPS Suggested First Steps

- ◆ Adoption of IPS Opioid Standards of Care as an initial framework to immediately require improved monitoring and standard practices
- ◆ Funding INSPECT in perpetuity by imposing a 25 cent fee for each controlled substance prescription
- ◆ Creation of the CSC to create controlled substance regulations that will be equally implemented in all professional licensing boards involved with controlled substances
- ◆ Elimination of non-physician ownership of private pain clinics
- ◆ Requirement that insurers cover controlled substance monitoring tests

# IPS OPIOID STANDARDS

- ◆ *Summary of IPS Standards of Care for Opioids (Adopted November, 2011)*
- ◆ **STANDARD 5.1.1** Opioid treatment may be initiated in medically and psychologically appropriate patients that have tried and failed other conservative treatments, and after a substance abuse screening tool or substance abuse history survey result has been evaluated for appropriateness of prescribing opioids.
- ◆ **STANDARD 5.1.2** Opioids should not be the only therapy employed in pain control efforts in chronic non-malignant pain
- ◆ **STANDARD 5.1.3** An opioid agreement will be signed by the patient prior to the prescribing of any opioids when long-term opioid prescribing is anticipated or in any case, after 3 months of the patient taking opioids at least weekly. This agreement makes clear the policies of the clinic, the responsibilities of the patient being prescribed chronic opioids, the possible consequences of substance abuse or drug diversion, and may include the required consent for opioid treatment.
- ◆ **STANDARD 5.1.4** Opioids may be prescribed only for the legitimate medical purpose of reduction of pain or improvement of function unless addiction is being actively treated under a Drug Enforcement Agency special license.
- ◆ **STANDARD 5.2.1** Referral to other specialists may be required of the patient as a part of the continuation of opioid therapy.

**STANDARD 5.3.1** Patients receiving initiation or continuation of opioid therapy should be seen at least every 4 weeks until the patients compliant behavior and therapeutic efficacy are established. Subsequently, patients receiving more than 120mg a day morphine (or equivalent) or less must be seen in follow-up at least every 8 weeks or less under normal circumstances. Patients receiving 180mg a day or more morphine (or equivalent) must be seen in follow-up at least every 6 weeks or less under normal circumstances.

**STANDARD 5.4.1** Patients receiving chronic opioids must have an INSPECT report generated at least every 6 months.

**STANDARD 5.4.2** Urine, blood, or saliva levels of the prescribed substances and illicit substances are a critical part of chronic opioid therapy management and for assuring patient compliance. These tests should be employed in cases of suspected substance abuse or drug diversion, and randomly at reasonable intervals.

**STANDARD 5.5.1** Patients will be monitored by the opioid prescriber for substance abuse and diversion, and will take decisive action to eliminate these issues in their patient population. Identified substance abuse may include referral to an addictionologist, co-management with a psychiatrist or psychologist, use of more frequent follow-ups, or referral to a drug treatment center. Drug diversion must be treated with cessation of prescribing of controlled substances.

**STANDARD 5.6.1** Sudden cessation of opioid prescribing should not be used in patients with known symptomatic coronary artery disease and should not be used in general unless there is evidence of drug diversion, use of illicit drugs, or

**STANDARD 5.6.2** When opioids are no longer to be prescribed due to substance abuse or diversion, the prescriber will offer referral to a drug rehabilitation center or addiction treatment center. Gradual weaning may be employed if there has been substance abuse but no drug diversion or illicit substance use.

**STANDARD 5.6.3** The opioid prescriber may withdraw opioid treatment at any time for failure to achieve adequate pain relief, excessive or life threatening side effects, substance abuse, addiction, or drug diversion without discharging the patient from their practice. There is no obligation of the prescriber to continue opioid treatment in such situations.

**STANDARD 5.6.4** The withdrawal of opioids due to addiction, substance abuse, or diversion will be prominently noted in the medical record and will be communicated to all known currently treating physicians of record and those identified by INSPECT as prescribing opioids recently.

**STANDARD 5.6.5** It is inappropriate to refer a patient to another opioid prescriber or back to their primary care provider for continued opioid therapy for pain when the patient has engaged in substance abuse, drug diversion, or exhibits signs of addiction. In such situations patients should be withdrawn from opioids for at least 6 months prior to re-engaging opioids, and then only under tight control with addictionology co-management if available, otherwise with psychological



# Prescription Drug Abuse

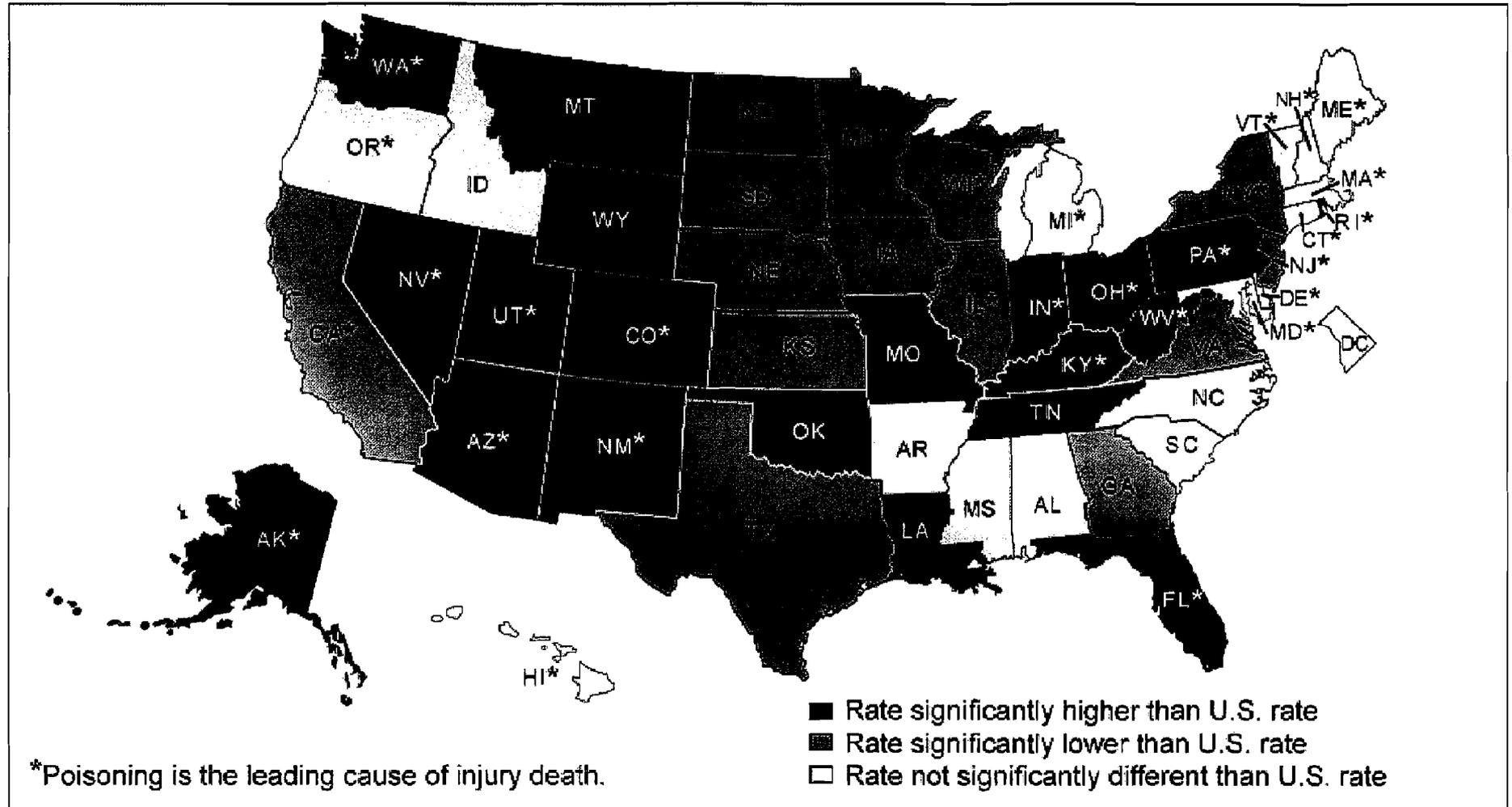
Joan Duwve, M.D., M.P.H.

Chief Medical Officer

Indiana State Department of Health

**Exhibit 2  
Health Finance Commission  
Meeting #1 August 23, 2012**

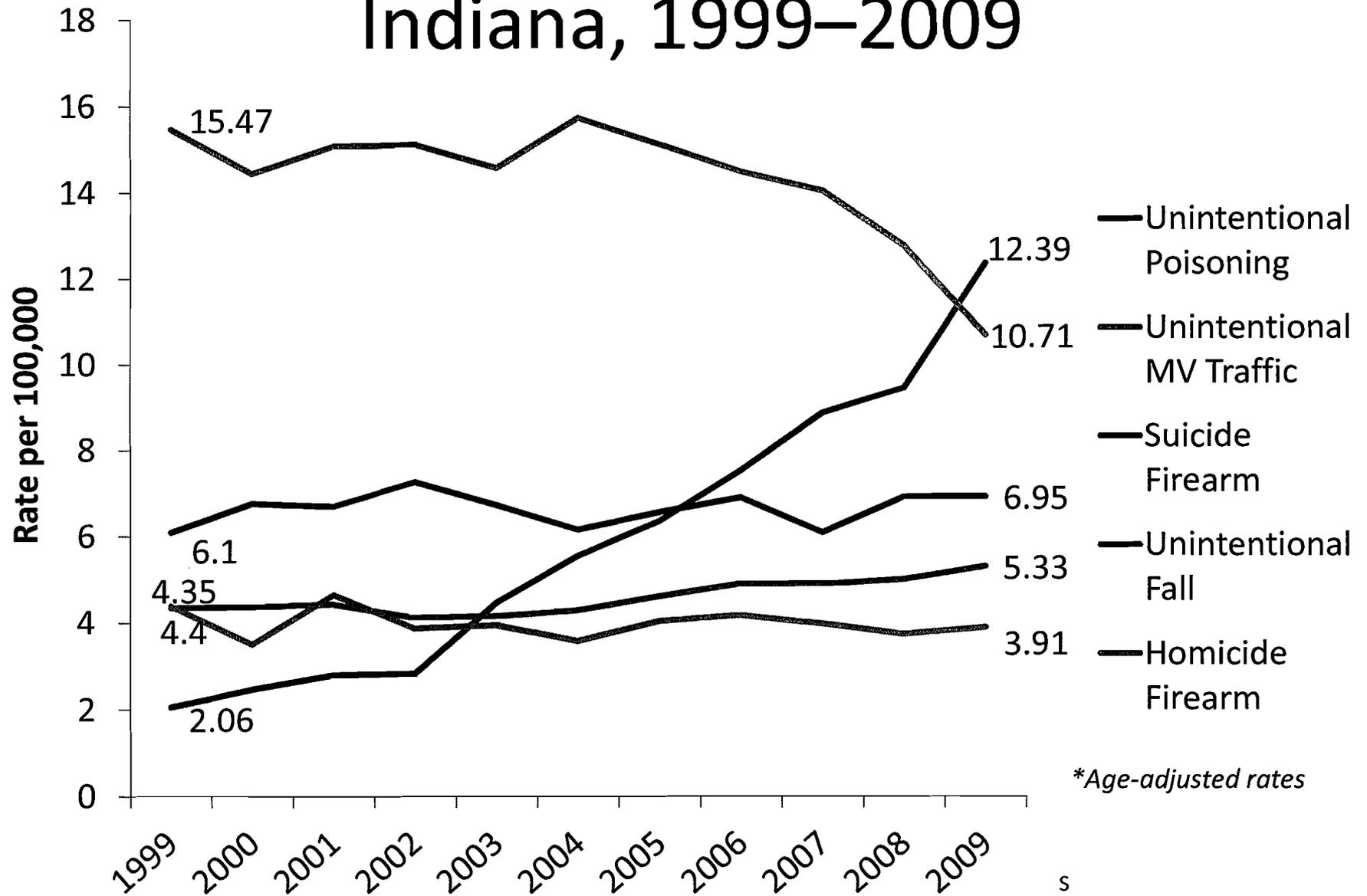
# Age-Adjusted Poisoning Death Rates: Comparison of State and U.S. Rates, 2008



NOTES: The poisoning death rate for Georgia may not be based on the final numbers of poisoning deaths. See "Data source and methods" for details. Figure 2 at [http://www.cdc.gov/nchs/data/databriefs/db81\\_tables.pdf#2](http://www.cdc.gov/nchs/data/databriefs/db81_tables.pdf#2).

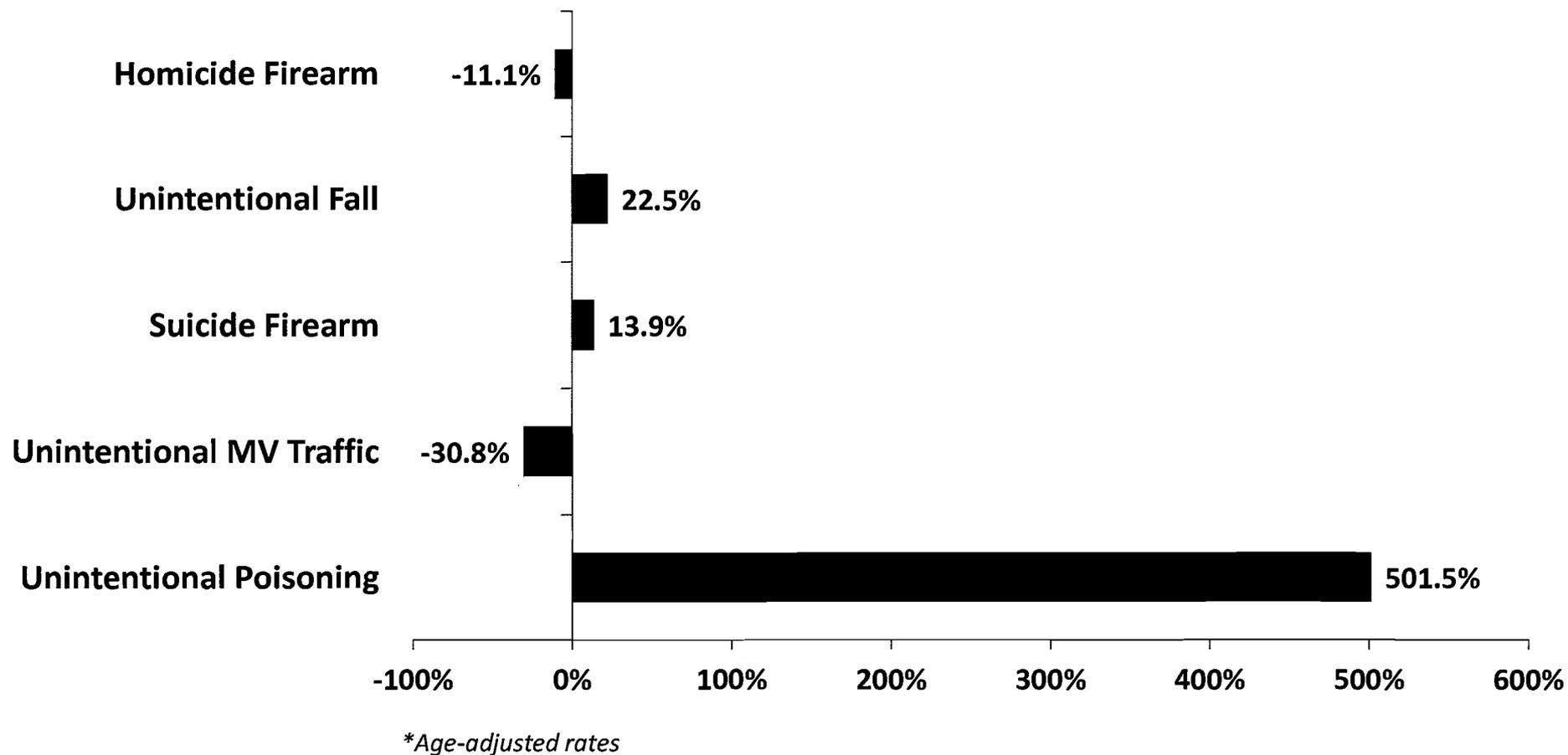
SOURCE: CDC/NCHS, National Vital Statistics System.

# Leading Causes of Injury Death\* — Indiana, 1999–2009



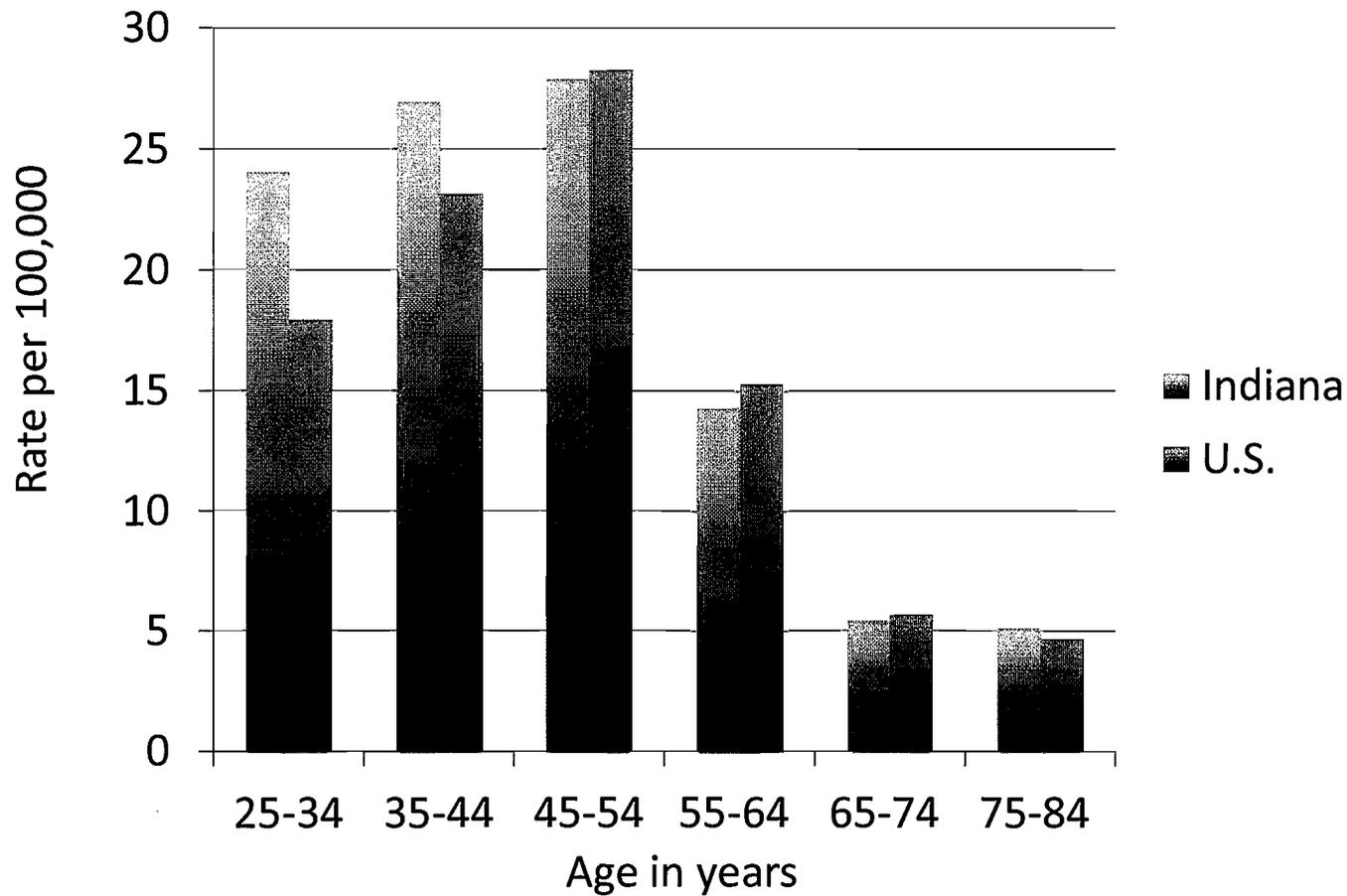
\*Age-adjusted rates

# Percent Change in Leading Causes of Injury Death\* — Indiana, 1999–2009



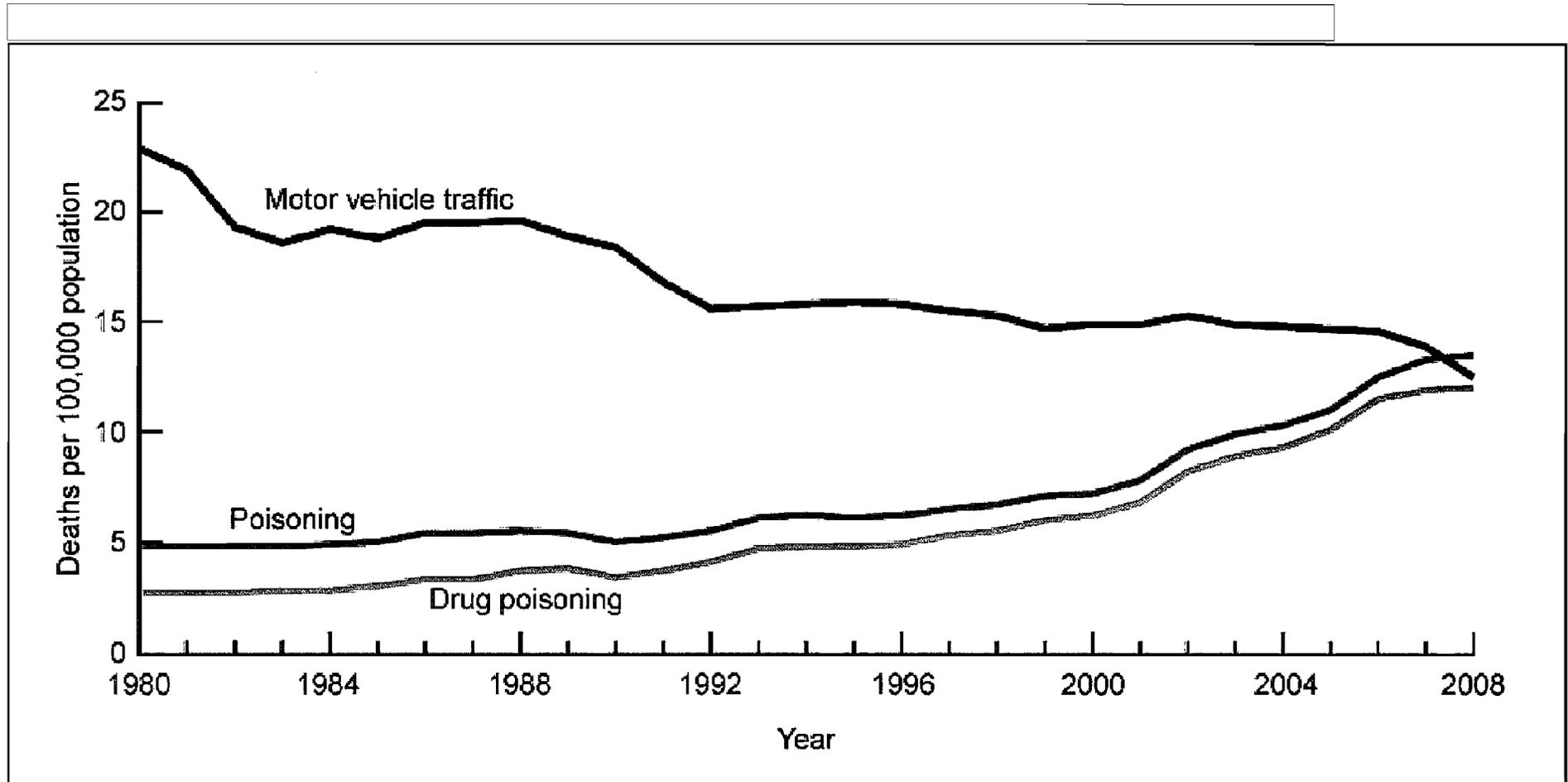
Source: WISQARS

# Poisoning Death Rates Indiana and U.S. 2007 – 2009



Source: CDC/WISQARS

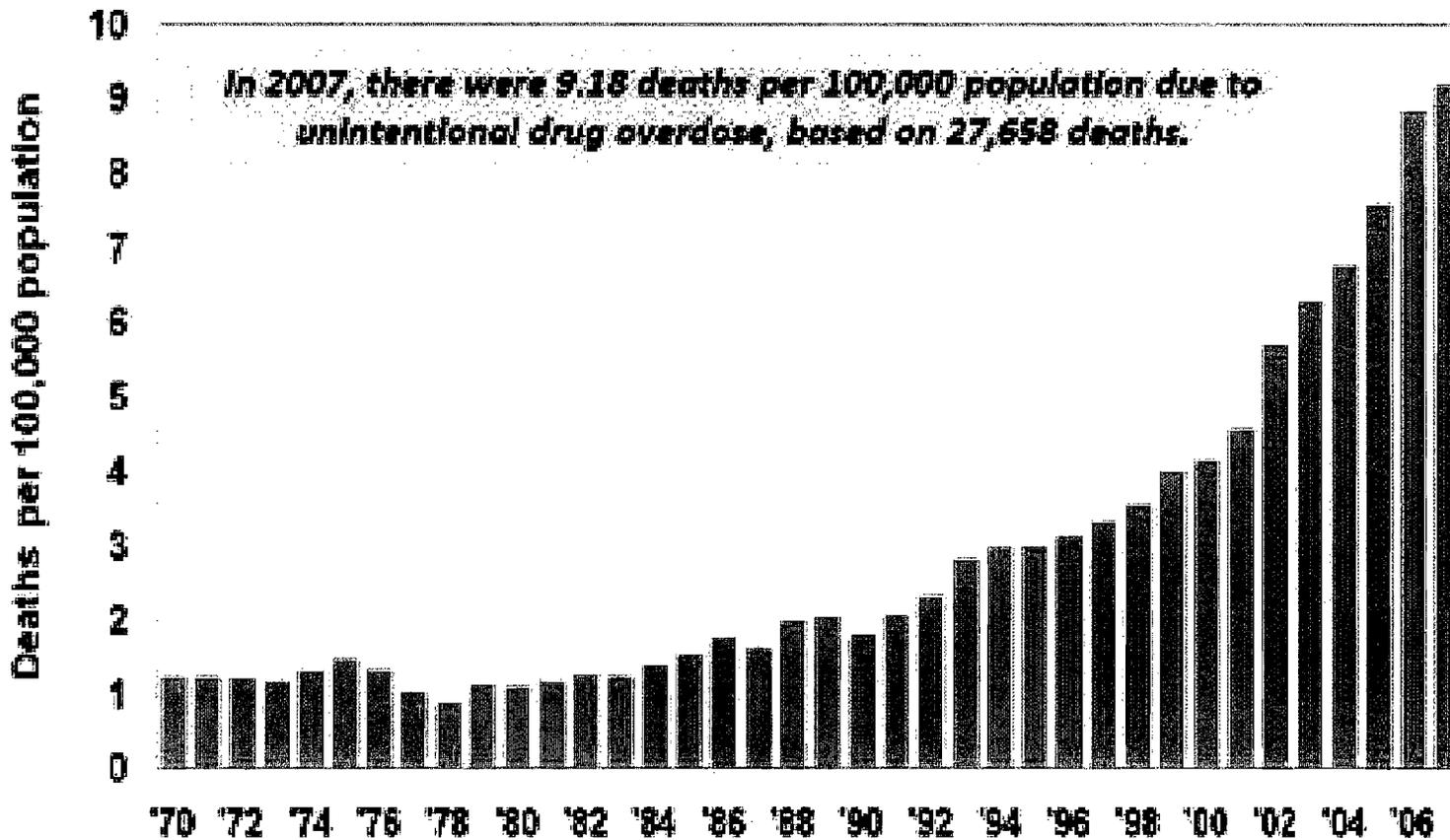
# Motor Vehicle Traffic, Poisoning, and Drug Poisoning Death Rates, U.S., 1980 – 2008



NOTE: In 1999, the *International Classification of Diseases, Tenth Revision (ICD-10)* replaced the previous revision of the ICD (ICD-9). This resulted in approximately 5% fewer deaths being classified as motor-vehicle traffic-related deaths and 2% more deaths being classified as poisoning-related deaths. Therefore, death rates for 1998 and earlier are not directly comparable with those computed after 1998. Access data table for Figure 1 at [http://www.cdc.gov/nchs/data/databriefs/db81\\_tables.pdf#1](http://www.cdc.gov/nchs/data/databriefs/db81_tables.pdf#1).

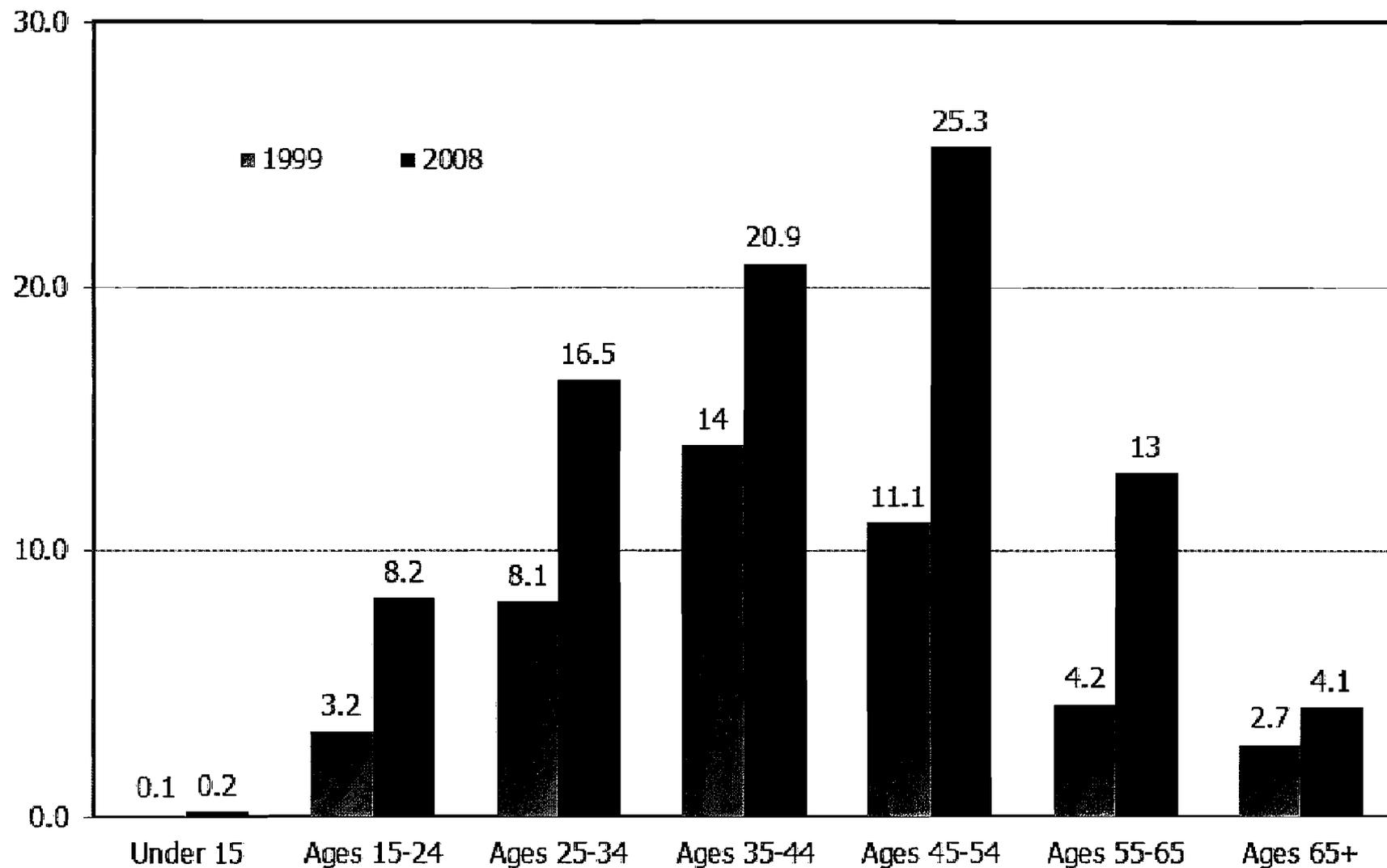
SOURCE: CDC/NCHS, National Vital Statistics System.

# Unintentional Drug Overdose Deaths United States, 1970-2007



Source: Centers for Disease Control and Prevention. *Unintentional Drug Poisoning in the United States* (July 2010).

## U.S. Drug Poisoning Deaths Per 100,000 People, by Age (1999-2008)

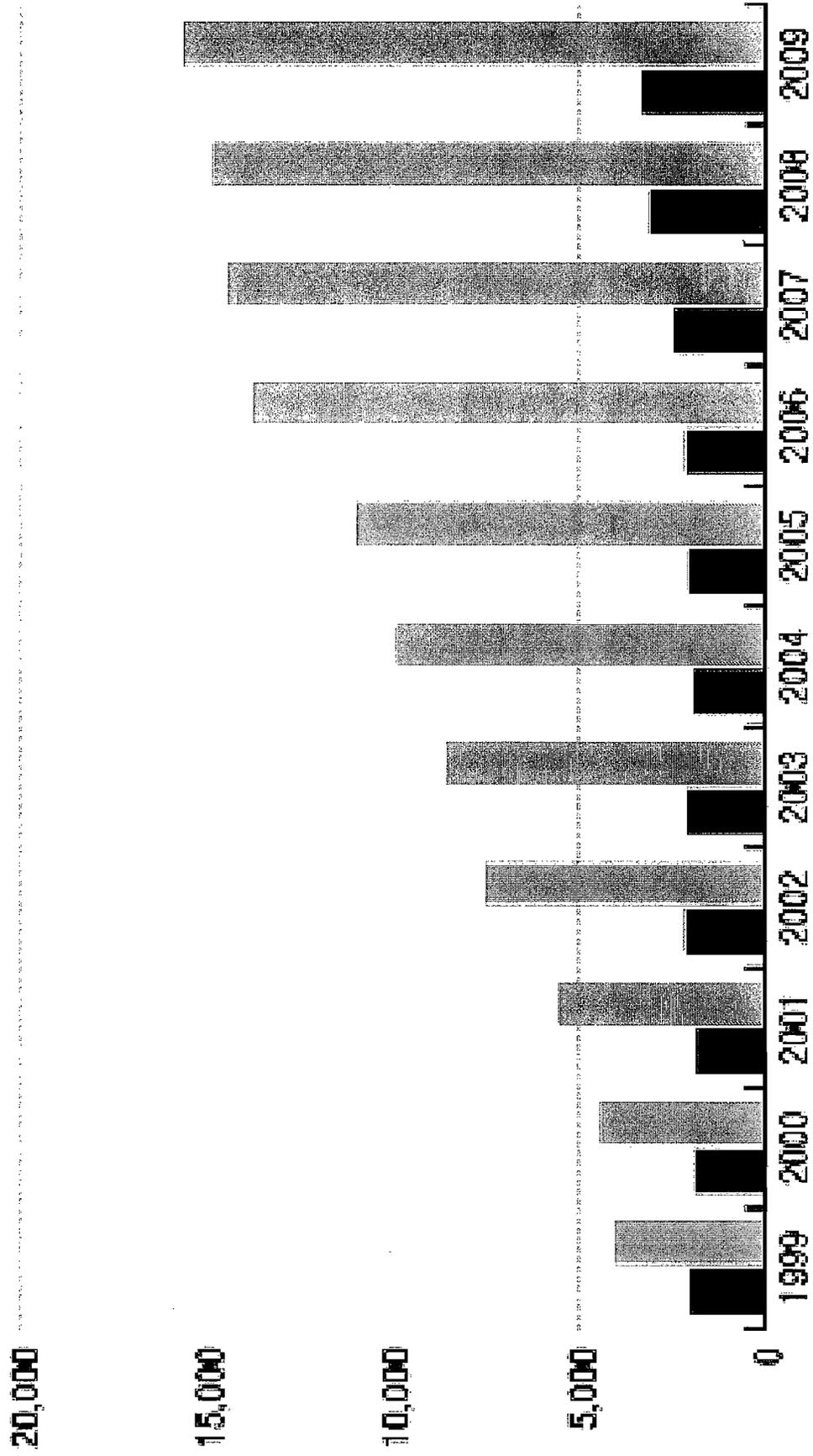


Source: CDC/NCHS, National Vital Statistics System

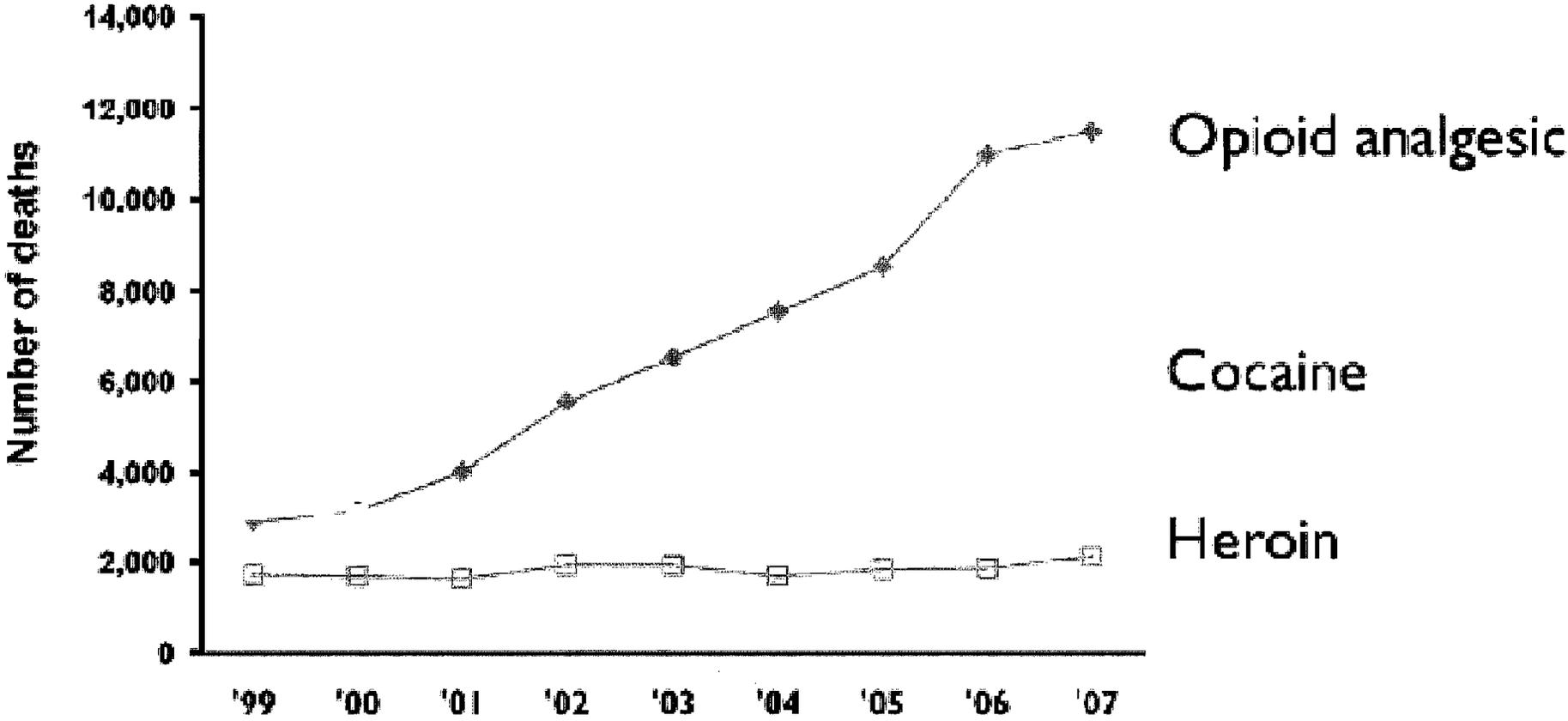
# U.S. Deaths Caused By Drug Overdose

■ Heroin

■ Opioid-Based Prescription Drugs

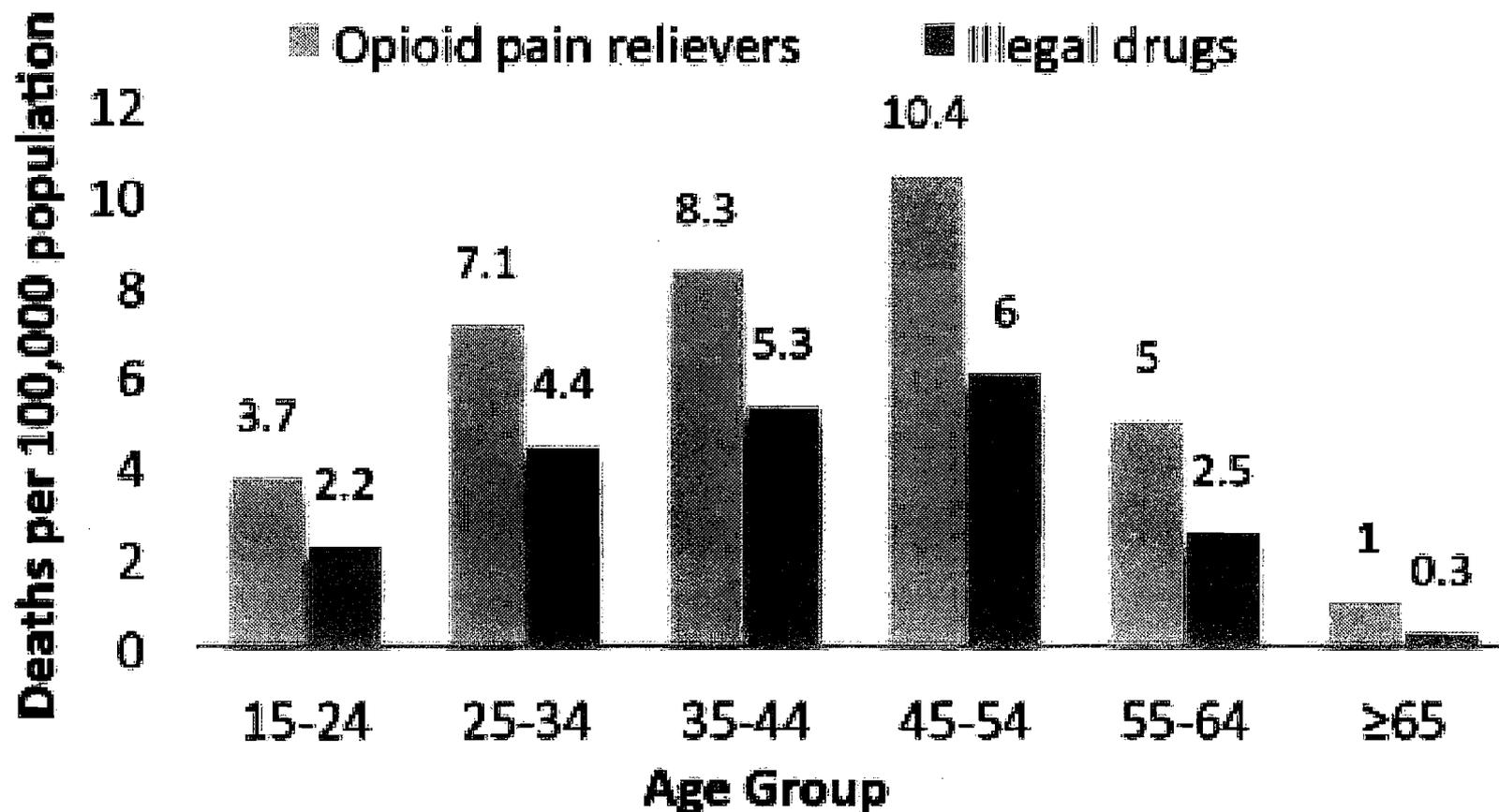


# Unintentional Drug Overdose Deaths by Major Type of Drug, U.S., 1999 – 2007



Source: National Vital Statistics System

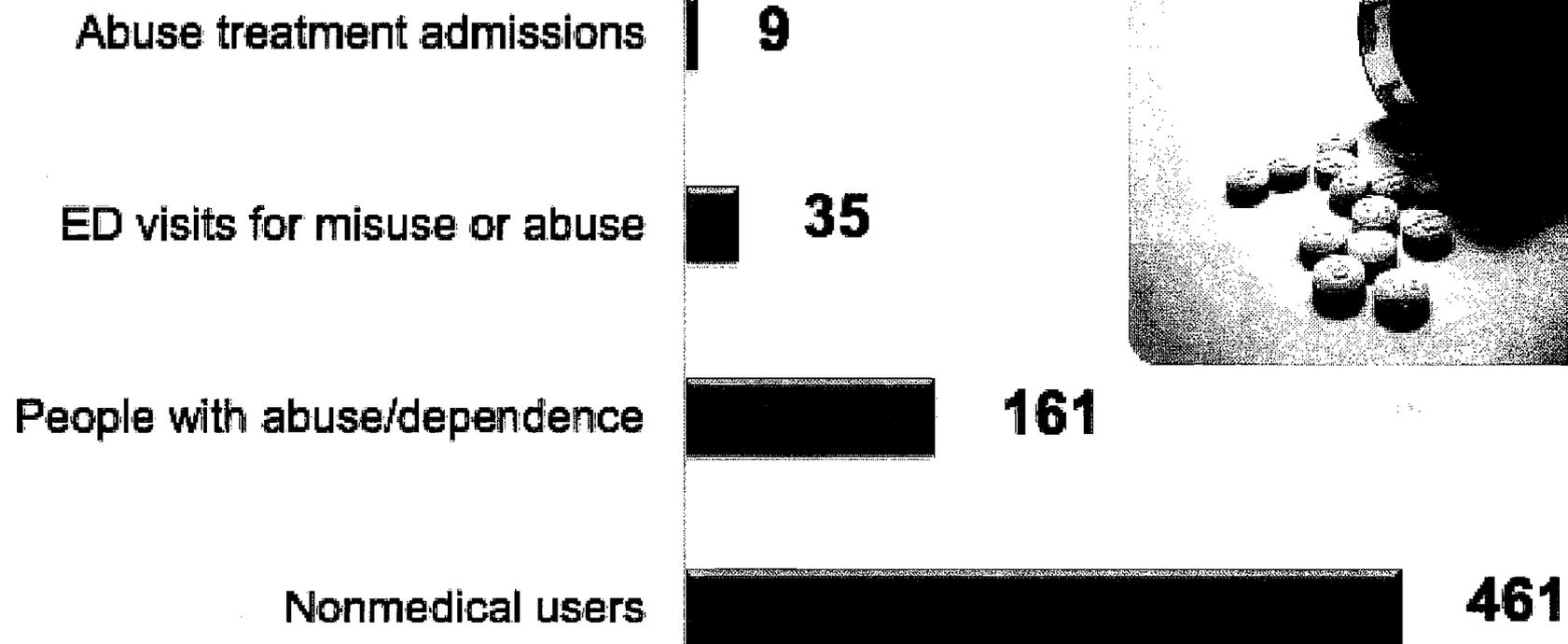
## Deaths from Opioid Pain Relievers Exceed Those from All Illegal Drugs



Source: CDC, Morbidity and Mortality Weekly Report, 60(43): 1489, 2011.

# Public Health Impact of Opioid Analgesic Use

For every 1 overdose death there are



Treatment admissions are for primary use of opioids from Treatment Exposure Data set  
Emergency department (ED) visits are from DAWN, Drug Abuse Warning Network, <https://dawninfo.samhsa.gov/default.asp>  
Abuse/dependence and nonmedical use in the past month are from the National Survey on Drug Use and Health



# 2010 Nonmedical Use of Vicodin and OxyContin during past year

## Vicodin

- 2.7% of 8<sup>th</sup> graders
- 7.7% of 10<sup>th</sup> graders
- 8.0% of 12<sup>th</sup> graders

## OxyContin

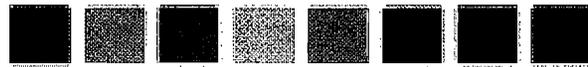
- 2.1% of 8<sup>th</sup> graders
- 4.6% of 10<sup>th</sup> graders
- 5.1% of 12<sup>th</sup> graders



*Source:*

*Source: Monitoring the Future (University of Michigan Web Site).*

# 2011 INDIANA

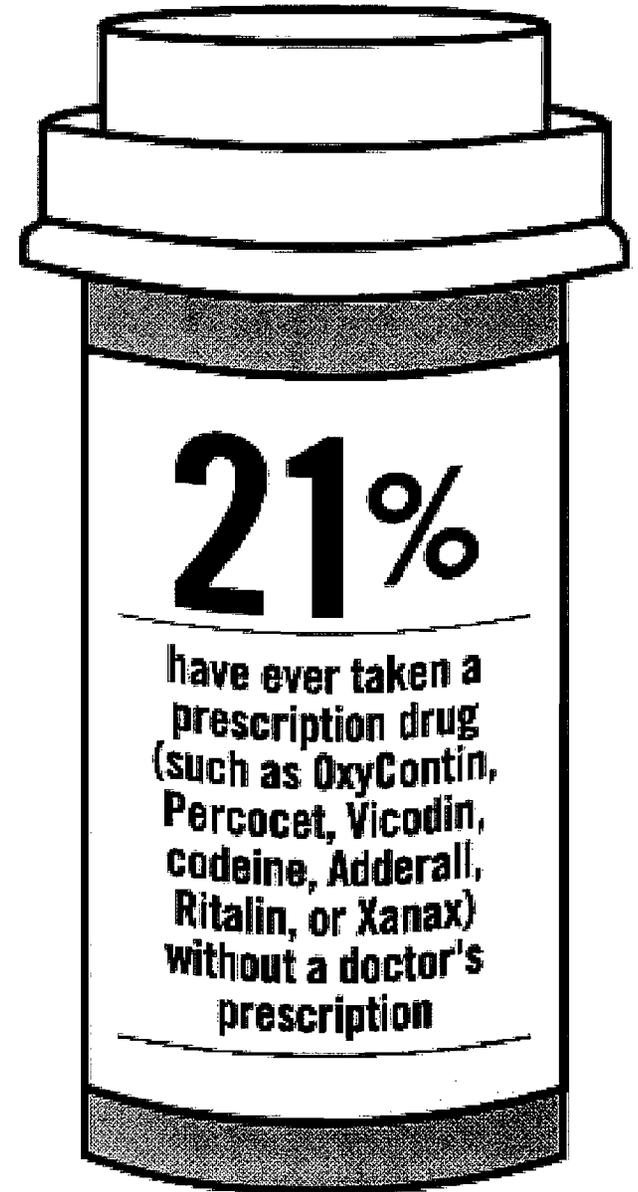


• ALCOHOL AND  
OTHER DRUG USE •

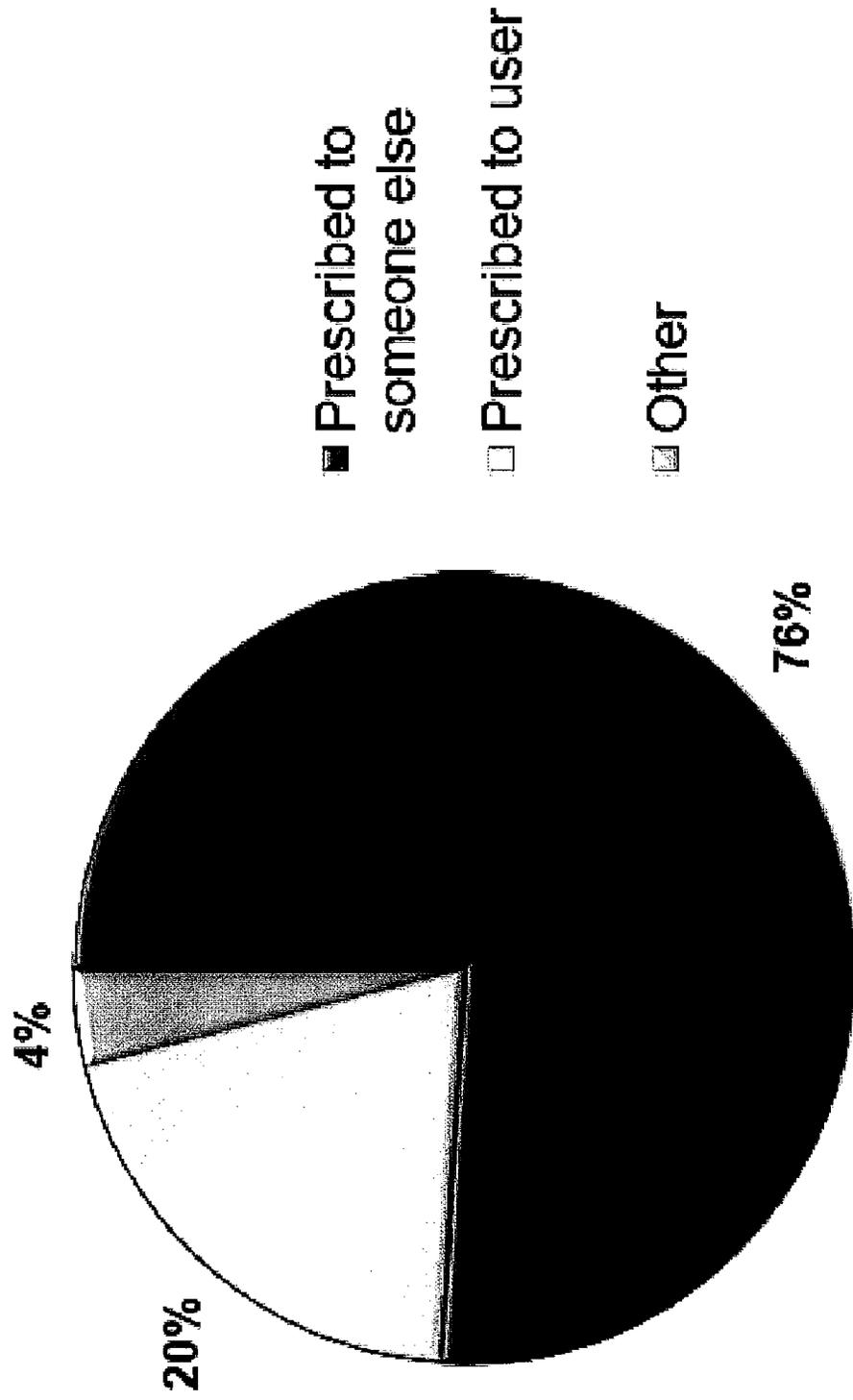
# FACTS

*about*

**HIGH SCHOOL STUDENTS**



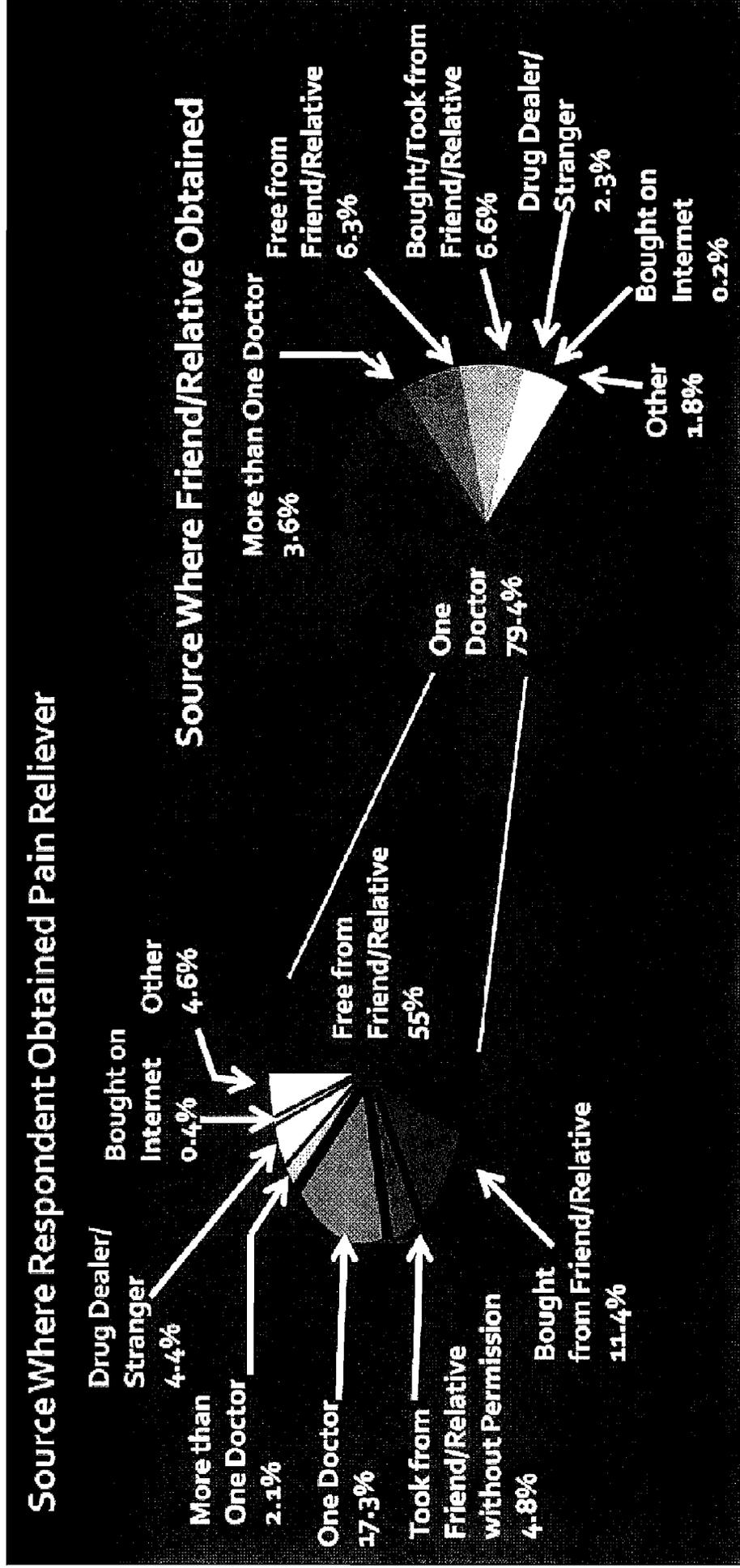
# Opioid Analgesics: Sources for Nonmedical Users United States, 2009



National Survey on Drug Use and Health. Summary of national findings, 2008-2009  
<http://www.oas.samhsa.gov>



# Sources of Diverted Pain Relievers 2009-2010

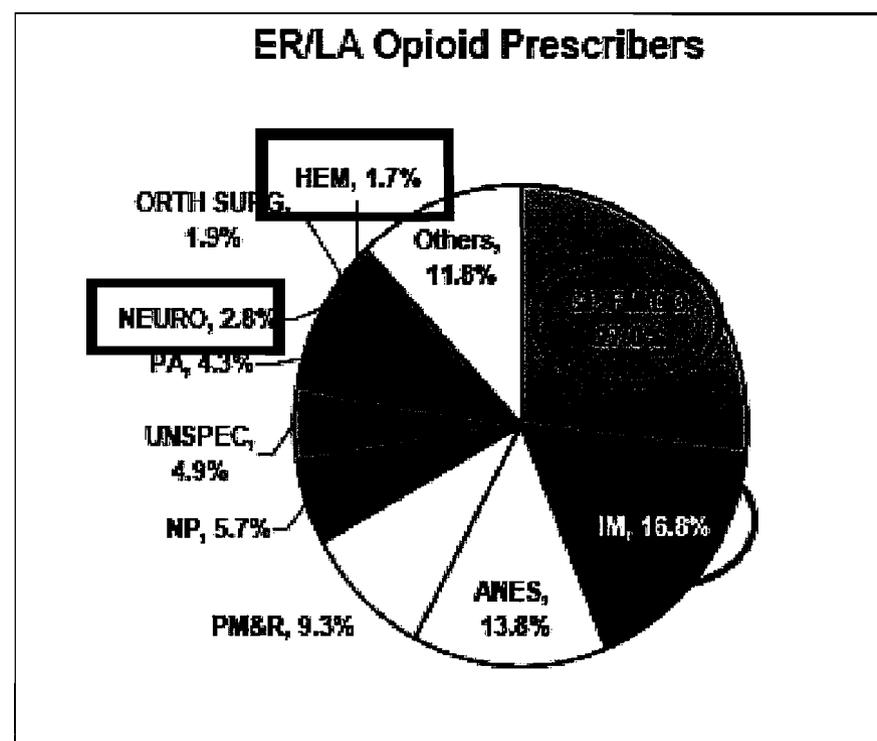
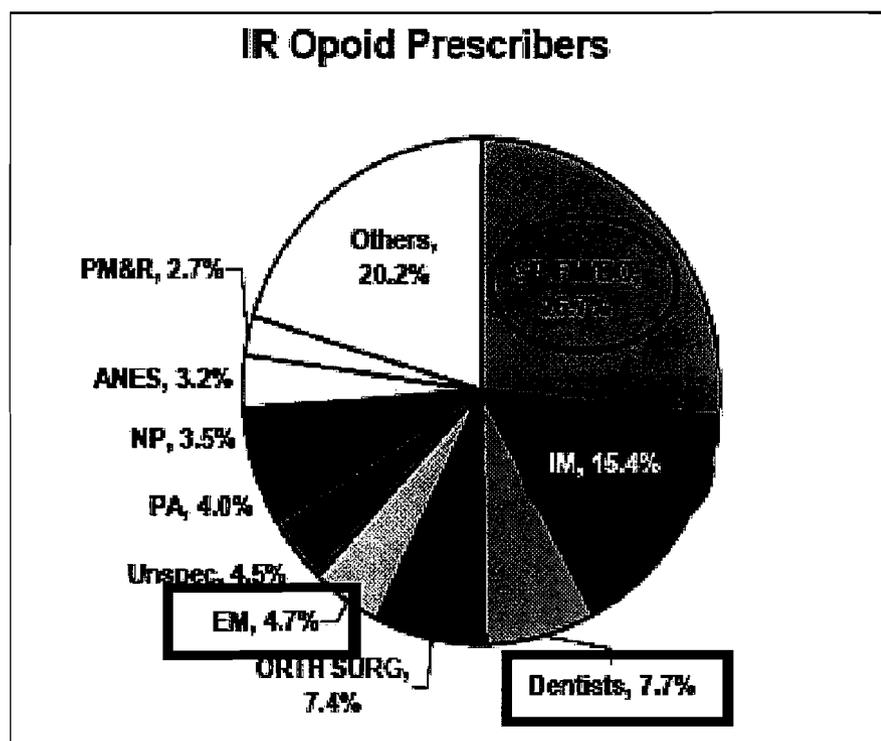


National Survey on Drug Use and Health, 2010



## Total number of prescriptions dispensed in the U.S. by top 10 prescribing specialties for IR and ER/LA opioids, Year 2009

SDI: Vector One®: National. Extracted June 2010.

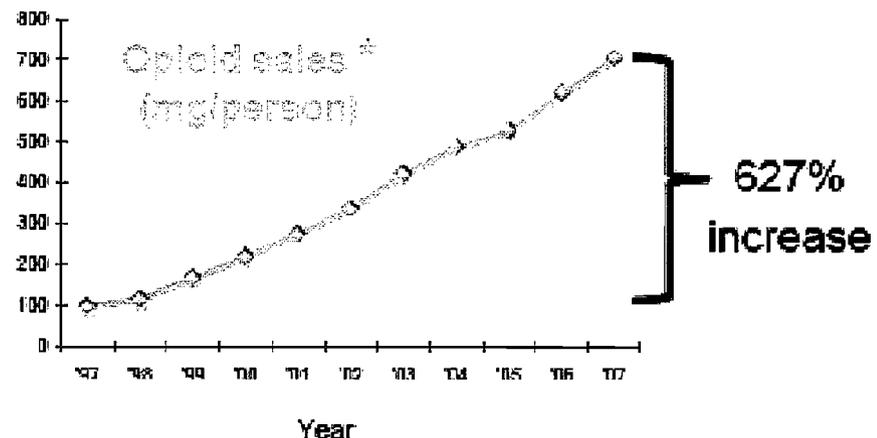


- GP/FM/DO, and IM were top 2 prescribers for IR and ER/LA opioids
- IR opioid prescribers:
- Dentists and EM specialists accounted for about 18 million and 11 million IR dispensed prescriptions

# Unintentional Overdose Deaths involving Opioid Analgesics Parallel Opioid Sales United States, 1997–2007

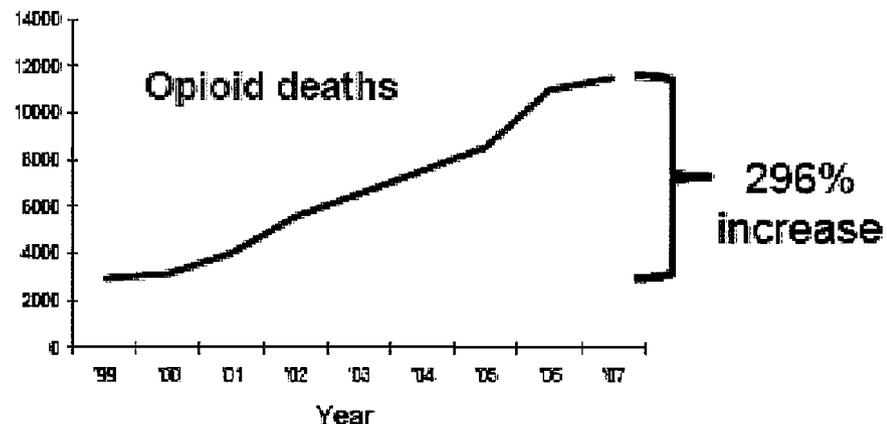
## Distribution by drug companies

- 96 mg/person in 1997
- 698 mg/person in 2007
  - Enough for every American to take 5 mg Vicodin every 4 hrs for 3 weeks



## Overdose deaths

- 2,901 in 1999
- 11,499 in 2007

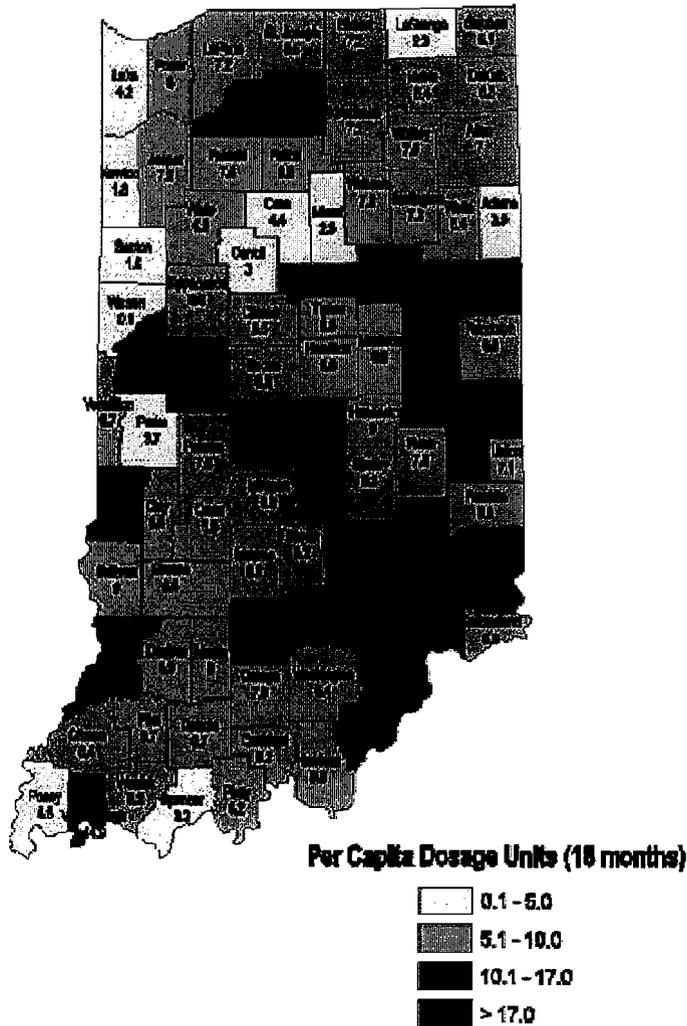


National Vital Statistics System, multiple cause of death data set and Drug Enforcement Administration ARCOS System  
\* 2007 opioid sales figure is preliminary



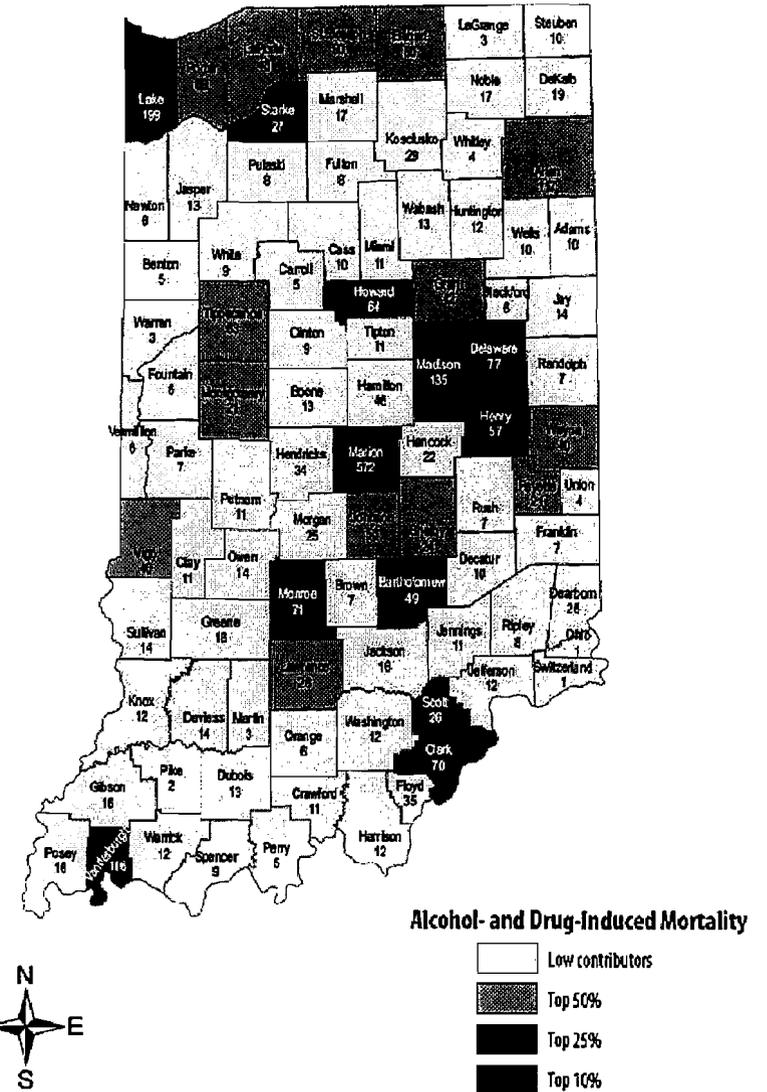
CDC  
CENTERS FOR DISEASE CONTROL AND PREVENTION

# Oxycodone Distribution to Indiana Retail Registrants, January 1, 2007, through June 30, 2008



Source: U.S. Drug Enforcement Administration, 2008

# Number of Drug Induced Deaths in Indiana, 1999-2005



Source: Indiana State Department of Health, 2007



## Office of National Drug Control Policy

# \$193 billion

Estimated cost of drug use to  
the U.S. society in lost  
productivity, health care and  
criminal justice costs in 2007

(Source: NDIC)

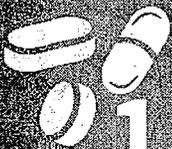
[http://www.keeprxsafe.com/contest/psa2012.html --1,-1,FIRST](http://www.keeprxsafe.com/contest/psa2012.html--1,-1,FIRST)

CDC  
**Vital Signs**  
November 2011

# Prescription Painkiller Overdoses in the US

**15,000** 

Nearly 15,000 people die every year of overdoses involving prescription painkillers.

  
**1 in 20**

In 2010, 1 in 20 people in the US (age 12 or older) reported using prescription painkillers for nonmedical reasons in the past year.

  
**1 Month**

Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for a month.

Deaths from prescription painkillers\* have reached epidemic levels in the past decade. The number of overdose deaths is now greater than those of deaths from heroin and cocaine combined. A big part of the problem is nonmedical use of prescription painkillers—using drugs without a prescription, or using drugs just for the “high” they cause. In 2010, about 12 million Americans (age 12 or older) reported nonmedical use of prescription painkillers in the past year.

Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for a month. Although most of these pills were prescribed for a medical purpose, many ended up in the hands of people who misused or abused them.

Improving the way prescription painkillers are prescribed can reduce the number of people who misuse, abuse or overdose from these powerful drugs, while making sure patients have access to safe, effective treatment.

\* “Prescription painkillers” refers to opioid or narcotic pain relievers, including drugs such as Vicodin (hydrocodone), OxyContin (oxycodone), Opana (oxymorphone), and methadone.

→ See page 4

Want to learn more? Visit

<http://www.cdc.gov/vitalsigns>

National Center for Injury Prevention and Control  
Division of Unintentional Injury Prevention



# Overdose deaths from prescription painkillers have skyrocketed during the past decade.

## Problem

### **Prescription painkiller overdoses are a public health epidemic.**

- ◇ Prescription painkiller overdoses killed nearly 15,000 people in the US in 2008. This is more than 3 times the 4,000 people killed by these drugs in 1999.
- ◇ In 2010, about 12 million Americans (age 12 or older) reported nonmedical use of prescription painkillers in the past year.
- ◇ Nearly half a million emergency department visits in 2009 were due to people misusing or abusing prescription painkillers.
- ◇ Nonmedical use of prescription painkillers costs health insurers up to \$72.5 billion annually in direct health care costs.

### **Certain groups are more likely to abuse or overdose on prescription painkillers.**

- ◇ Many more men than women die of overdoses from prescription painkillers.
- ◇ Middle-aged adults have the highest prescription painkiller overdose rates.
- ◇ People in rural counties are about two times as likely to overdose on prescription painkillers as people in big cities.
- ◇ Whites and American Indian or Alaska Natives are more likely to overdose on prescription painkillers.

- ◇ About 1 in 10 American Indian or Alaska Natives age 12 or older used prescription painkillers for nonmedical reasons in the past year, compared to 1 in 20 whites and 1 in 30 blacks.

### **The supply of prescription painkillers is larger than ever.**

- ◇ The quantity of prescription painkillers sold to pharmacies, hospitals, and doctors' offices was 4 times larger in 2010 than in 1999.
- ◇ Many states report problems with "pill mills" where doctors prescribe large quantities of painkillers to people who don't need them medically. Some people also obtain prescriptions from multiple prescribers by "doctor shopping."

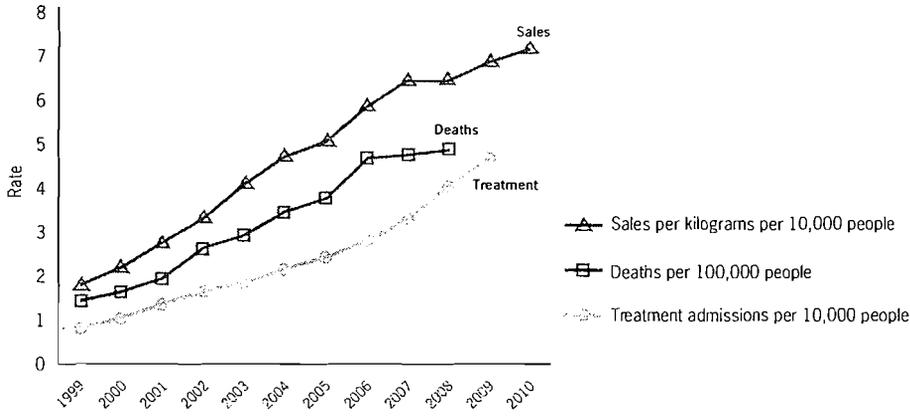
### **Some states have a bigger problem with prescription painkillers than others.**

- ◇ Prescription painkiller sales per person were more than 3 times higher in Florida, which has the highest rate, than in Illinois, which has the lowest.
- ◇ In 2008/2009, nonmedical use of painkillers in the past year ranged from 1 in 12 people (age 12 or older) in Oklahoma to 1 in 30 in Nebraska.
- ◇ States with higher sales per person and more nonmedical use of prescription painkillers tend to have more deaths from drug overdoses.

### **Real Life Stories of the Epidemic**

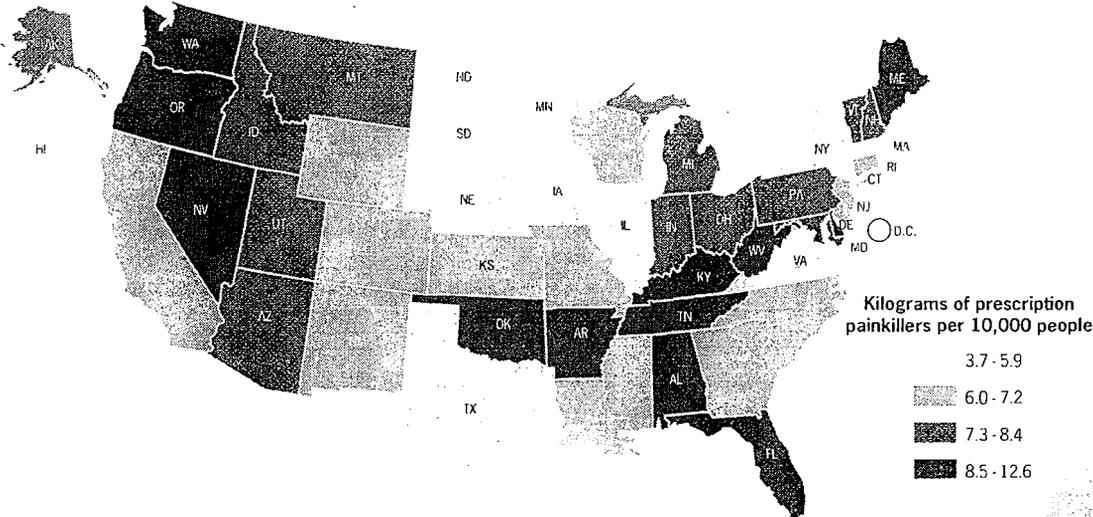
A West Virginia father, age 26, struggling for years with pain and addiction after shattering his elbow in a car crash, died from a prescription painkiller one week after telling his mother he wanted to go to rehab. In New Hampshire, a 20-year-old man overdosed on a prescription painkiller bought from a friend, becoming the 9th person that year to die from drug overdose in his community of 17,000. Stories such as these are all too common.

### Rates of prescription painkiller sales, deaths and substance abuse treatment admissions (1999-2010)



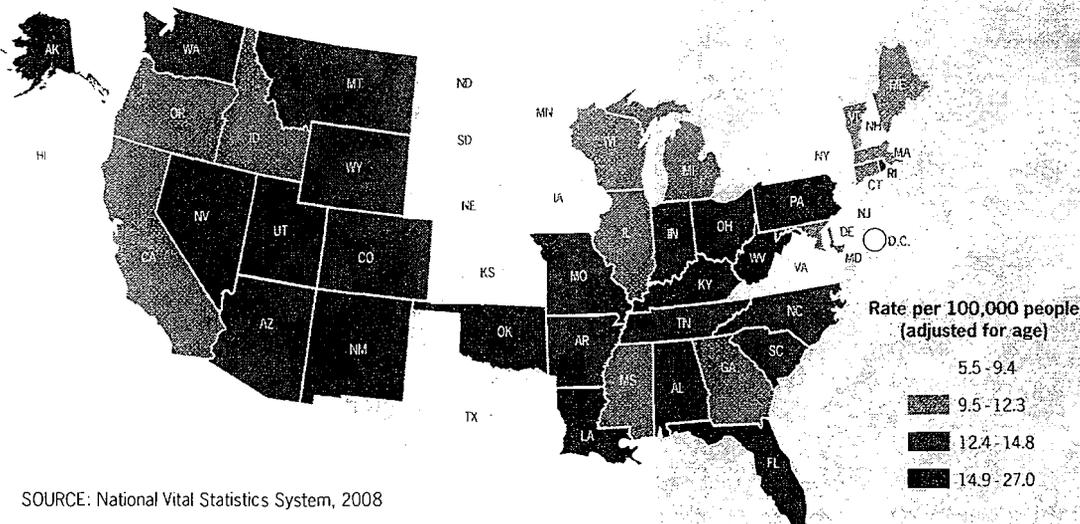
SOURCES: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009

### Amount of prescription painkillers sold by state per 10,000 people (2010)



SOURCE: Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 2010

### Drug overdose death rates by state per 100,000 people (2008)



SOURCE: National Vital Statistics System, 2008

# What Can Be Done

## The US government is

- ◇ Tracking prescription drug overdose trends to better understand the epidemic.
- ◇ Educating health care providers and the public about prescription drug abuse and overdose.
- ◇ Developing, evaluating and promoting programs and policies shown to prevent and treat prescription drug abuse and overdose, while making sure patients have access to safe, effective pain treatment.

## States can

- ◇ Start or improve prescription drug monitoring programs (PDMPs), which are electronic databases that track all prescriptions for painkillers in the state.
- ◇ Use PDMP, Medicaid, and workers' compensation data to identify improper prescribing of painkillers.
- ◇ Set up programs for Medicaid, workers' compensation programs, and state-run health plans that identify and address improper patient use of painkillers.
- ◇ Pass, enforce and evaluate pill mill, doctor shopping and other laws to reduce prescription painkiller abuse.
- ◇ Encourage professional licensing boards to take action against inappropriate prescribing.
- ◇ Increase access to substance abuse treatment.

## Individuals can

- ◇ Use prescription painkillers only as directed by a health care provider.
- ◇ Make sure they are the only one to use their prescription painkillers. Not selling or sharing them with others helps prevent misuse and abuse.
- ◇ Store prescription painkillers in a secure place and dispose of them properly.\*
- ◇ Get help for substance abuse problems if needed (1-800-662-HELP).

## Health insurers can

- ◇ Set up prescription claims review programs to identify and address improper prescribing and use of painkillers.
- ◇ Increase coverage for other treatments to reduce pain, such as physical therapy, and for substance abuse treatment.

## Health care providers can

- ◇ Follow guidelines for responsible painkiller prescribing, including
  - Screening and monitoring for substance abuse and mental health problems.
  - Prescribing painkillers only when other treatments have not been effective for pain.
  - Prescribing only the quantity of painkillers needed based on the expected length of pain.
  - Using patient-provider agreements combined with urine drug tests for people using prescription painkillers long term.
  - Talking with patients about safely using, storing and disposing of prescription painkillers.\*
- ◇ Use PDMPs to identify patients who are improperly using prescription painkillers.

\* Information on the proper storage and disposal of medications can be found at [www.cdc.gov/HomeandRecreationalSafety/Poisoning/preventiontips.htm](http://www.cdc.gov/HomeandRecreationalSafety/Poisoning/preventiontips.htm).

For more information, please contact

**Telephone: 1-800-CDC-INFO (232-4636)**

**TTY: 1-888-232-6348**

**E-mail: [cdcinfo@cdc.gov](mailto:cdcinfo@cdc.gov)**

Web: [www.cdc.gov](http://www.cdc.gov)

Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333

Publication date: 11/01/2011

<http://www.cdc.gov/vitalsigns>

<http://www.cdc.gov/mmwr>



# Indiana Hospice & Palliative Care

ORGANIZATION, INC.

August 23, 2012

Chairman Brown and Members of the Commission,

I thank you for giving me this opportunity to share comments and concerns from the Indiana Hospice & Palliative Care Association (IHPCO). My name is Rebecca Carter and I am the Executive Director of the association. Our hospice members provide care to over 8000 hospice admissions each year.

Today I speak of the needs of the end-of-life patient. End-of-life care very typically includes the control of pain, sometime excruciating pain and related symptoms. The effective management of pain can be a significant factor in whether your end of life experience is peaceful and grace-filled, or not.

Patients can and do enter hospice care 24 hours per day, seven days per week. Last week there was a hospital referral/discharge to hospice for a new patient in a rural area. It was Sunday evening at 11:00 p.m. In addition to all of the "normal" requirements for enrolling a new hospice patient that needed to be completed, the hospice also had to obtain opioids for this new patient, in the middle of the night, in a rural area of the state. There is no 24 hour Walgreens within 60 miles of the patient.

IHPCO members want to be able to continue their practice of **Hospice-Patient-Specific Prescribing**. Hospice and end-of-life palliative patients are different from each other as well as uniquely different from non-terminal patients. For example, Class II controlled substances are used for shortness of breath, agitation and intractable agitation among other symptoms. The current Federal Regulations allow hospice physicians and pharmacies to provide **Patient-specific prescribing**. Specifically we are focused on

- Physician ability to give the narcotic order to RN or Pharmacy via call – need to be able to immediately order narcotics to address pain or other symptom management needs of the patient
- Physician ability to have 72-hour window to fax narcotic order for follow-up – this cannot be any stricter since many physicians do not have access to fax machines at night or on weekends
- Ability to change narcotic medications and dosages frequently (sometimes within hours of previous orders) – this cannot be impeded upon
- Ability to order various amounts of various narcotics due to the use of adjunct medications to maintain better pain control

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MAILING ADDRESS:

P.O. Box 68829  
Indianapolis, IN  
46268-0829

OFFICE LOCATION:

5460 Bearberry Lane  
Indianapolis, IN 46268

Phone:  
317-464-5145

Fax:  
317-733-2385

Web Site:  
[www.ihpco.org](http://www.ihpco.org)

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**Exhibit 5**  
**Health Finance Commission**  
**Meeting #1 August 23, 2012**

- Ability to order narcotic dosage appropriate to individual patient due to varying pain/symptom management needs; each person's pain threshold is different from another's. (example: outlier young man who needed an exuberant amount of pain medication up to 1500 mg/day of morphine per day).
- Ability to provide additional medications for end-of-life patients taking an end-of-life trip where it overlaps a renewal period or additional medications are necessary due to the demands of the trip.

We do understand there may be concerns with Pain Management Clinics, inappropriate/illegal prescribing practices of some physicians, and drug diversion issues. If changes are necessary we offer our assistance. There are a number of states that have implemented Prescription Monitoring Programs that also meet the American Society for Automation in Pharmacy (ASAP) standards. They also do not impede the ordering/dispensing of hospice related medications.

We remain committed to Hospice-Patient- Specific Prescribing that includes right medications at the right time regardless of where you are located in the state.

I thank you for your time, I offer our assistance and I am available and can be reached at [rcarter@leadingageindiana.org](mailto:rcarter@leadingageindiana.org) or 317-464-5145.

Sincerely,



Executive Director



**NATIONAL HEMOPHILIA FOUNDATION**  
www.hemophilia.org

**Exhibit 6**  
**Health Finance Commission**  
**Meeting #1 August 23, 2012**

August 23, 2012

Representative Tim Brown  
Indiana House of Representatives  
200 W. Washington Street  
Indianapolis, IN 46204

Re: Prescription Drug Coverage – Specialty Tiers

Dear Chairman Brown:

My name is Michelle Rice and I am the Public Policy Director for the National Hemophilia Foundation (NHF) and the mother of two children with severe hemophilia. My oldest son is also affected by Hepatitis C.

NHF is the nation's oldest and largest advocacy organization for people with hemophilia and related bleeding disorders, including approximately 1200 Hoosiers, that is dedicated to ensuring that all individuals have access to high quality medical care and services, regardless of financial circumstances, place of residence, or other factors.

I am here today to discuss the impact of limited formularies and the use of specialty tiers in pharmacy benefit plans and their impact on those with rare, chronic, costly conditions. NHF appreciates the need to control spiraling health care costs, however it is important to understand that applying "standard" cost saving techniques to these types of rare conditions may have the opposite effect, resulting in increased long-term costs.

For example, insurers often use preferred drug lists (PDL) to control prescription drug costs, which may require patients to consider generic alternatives. While this is appropriate in many cases, this is not an option for those affected by hemophilia. Individuals with hemophilia and other bleeding disorders often require lifelong infusions of blood clotting factor therapies derived from plasma or recombinant technology. These biological products are not interchangeable, nor are there generics available. This practice would force patients with chronic conditions to make a difficult decision between obtaining the optimal treatment (and often paying out-of-pocket) or switching to a suboptimal therapy or prescription regimen that is covered by the limited formulary. Not only is this approach very short-sighted, but it may result in complication that require expensive hospitalizations.

Another cost control trend is the use of specialty tiers or Tier IV pricing for specialty drugs. Traditionally, clotting factor (as well as other biologics) has been reimbursed as a medical benefit. However there has been a recent shift by insurers to have clotting factor be covered as a pharmacy benefit. In addition, some are putting it, into a "Specialty Tier", which shifts more of the cost to the patient. Typically patients pay a standard copayment for prescriptions. For drugs in a "specialty tier" (Tier IV) individuals are required to pay a percentage of the actual cost of the drug (or co-insurance) – often between 25% to 33% or more, rather than a fixed, flat dollar co-

payment.

In response to such high copayments, patients may become less compliant with their prescribed treatment regimen. Currently, the recognized standard of care for a person with severe hemophilia is called prophylaxis and involves preventative self administration of replacement clotting factor therapy at home typically up to three times per week. (If clotting factor is put into a specialty tier, the monthly co-insurance would be thousands of dollars, i.e. cost for my two children would be approximately \$36,000 per month). Faced with such exorbitant costs many will be forced to revert to less effective and more costly treatment options. For those with hemophilia, this will mean receiving their care in a hospital and/or emergency room setting. While lowering pharmacy costs this will drastically increase overall medical costs, decrease quality of life and in some instances, cause permanent disability and/or premature death.

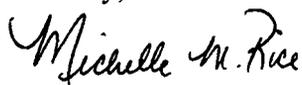
As highlighted in a 2011 article in the Annals of Internal Medicine, the widespread shifting of costs to patients affects the ability of patients to obtain life-saving prescriptions. The authors of the article reported medication compliance decreased with the more money required of patients. When patients do not utilize prescriptions, they jeopardize their health, specialty or patients with rare conditions, such as hemophilia.

The establishment of an “essential health benefits package” by the Affordable Care Act (ACA) recognized the need for plans to provide adequate benefits to their enrollees. Further, the ACA links the essential benefits package to certain cost sharing limits – specifically, plans providing the essential benefits package will be prohibited from imposing an annual cost sharing limit that exceeds those limits that are apply to high deductible plans linked to health savings accounts (currently the limits are \$6,050 for an individual and \$12,100 for a family). One of the ten categories required to be included in an essential benefits package is prescription drugs.

It is worth noting that the law is unclear on whether or not self insured plans will be required to offer an essential benefits package. However, the general consensus is that IF they offer any of the services included in the essential health benefit package decided on by the state, those benefits will be subject to the cost sharing limitations referenced above. In order to ensure that *all plans* (including self-insured) are required to establish reasonable cost sharing for prescription drugs designated as specialty drugs and place in a Tier IV or higher category, H.R. 4209, the **Patients’ Access to Treatments Act of 2012** was introduced by Rep. David McKinley (R-WV) and Rep. Lois Capps (D-CA) in March. The bill currently has 24 co-sponsors and has been referred to the House Committee on Energy & Commerce.

On behalf of Hoosiers affected by rare, chronic conditions, I urge you to investigate this practice and to act now to prevent these life saving therapies from being priced out of the reach of the average American. Thank you for allowing me the opportunity to share the concerns of the National Hemophilia Foundation and for giving them your careful consideration. If you have questions, please do not hesitate to contact me at [mrice@hemophilia.org](mailto:mrice@hemophilia.org) or 371.517.3032.

Sincerely,



Michelle M. Rice  
Director of Public Policy

# District Report

## Distribution of Chronic Diseases Affected by Specialty Tier Classification



### Health Finance Commission

Rep. Timothy Brown, Chairperson  
Rep. Richard Dodge  
Rep. David Frizzell  
Rep. Don Lehe  
Rep. Eric Turner  
Rep. Steven Davisson  
Rep. Ronald Bacon  
Rep. Suzanne Crouch  
Rep. Charlie Brown  
Rep. Peggy Welch  
Rep. John Day  
Rep. Craig Fry  
Rep. Scott Reske  
Sen. Patricia Miller, Vice-Chairperson  
Sen. Ryan Mishler  
Sen. Vaneta Becker  
Sen. Edward Charbonneau  
Sen. Beverly Gard  
Sen. Jean Leising  
Sen. Ron Grooms  
Sen. Jean Breaux  
Sen. Earline Rogers  
Sen. Vi Simpson



**Prepared For: Rep. Timothy Brown**

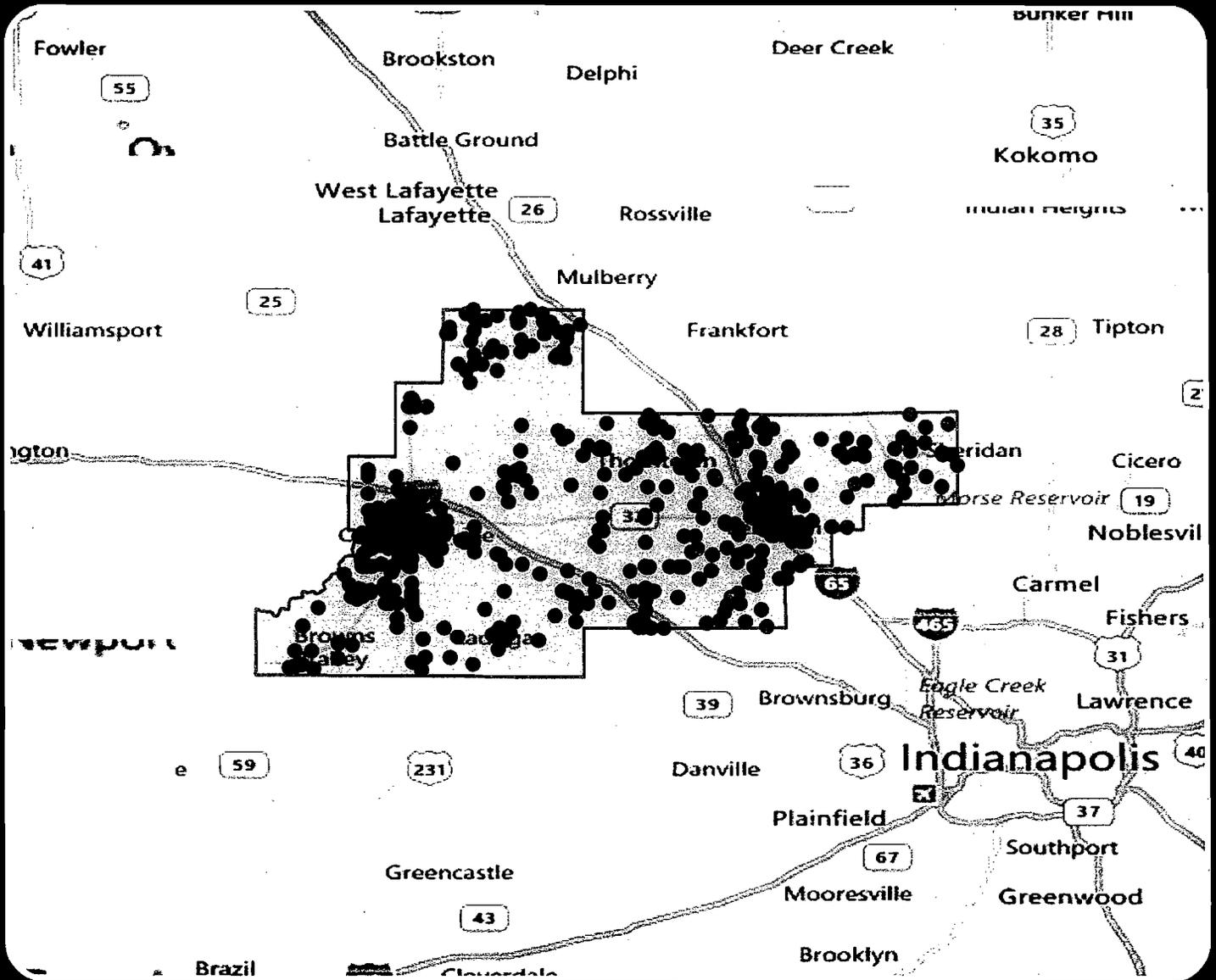
**8/23/2012**

Exhibit 7  
Health Finance Commission  
Meeting #1 August 23, 2012

# Distribution of Chronic Diseases

Treatment options for these diseases include Specialty Tier drugs.

## District 41

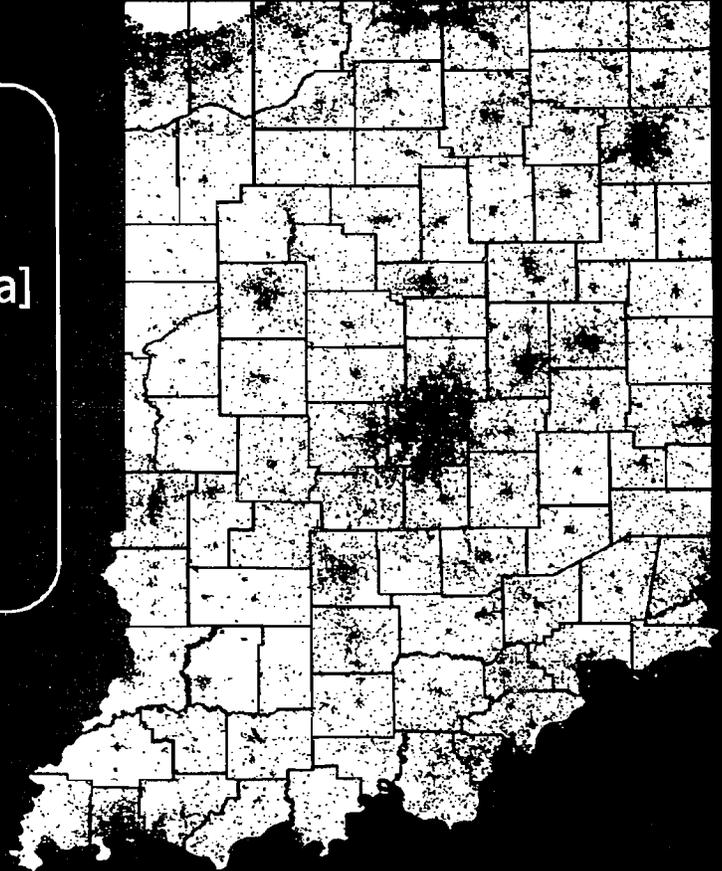


Each dot you see is the location of an individual who self-reported the presence of a chronic disease indicated.

# Indiana Breakdown

## Legend

- Arthritis
- Asthma
- Blood Disorders [Hemophilia]
- Cancer
- Emphysema
- Epilepsy
- Multiple Sclerosis
- Osteoporosis



But what you don't see are the additional cases of the indicated chronic disease for which self-reported data is not available

(Between 4 and 15 cases per dot, depending on the disease in question).

# EXAMPLE: ARTHRITIS

## Most recent Economic Impact Estimates

Doctor Diagnosed Arthritis Centers for Disease Control, Morbidity and Mortality Weekly Report January 12, 2007

TABLE 2. Direct and indirect costs attributable to arthritis and other rheumatic conditions, by state/area — Medical Expenditure Panel Survey and Behavioral Risk Factor Surveillance System (BRFSS), United States, 2003

State/Area	Direct costs (medical expenditures)		Indirect costs (lost earnings)		Total costs (in millions \$)
	No. of adults affected (in thousands)*	Costs (in millions \$)	No. of adults affected (in thousands)*	Costs (in millions \$)	
Alabama	1,132	1,617.9	763	978.9	2,596.8
Alaska	112	160.0	89	114.6	274.7
Arizona	1,082	1,617.9	649	824.6	2,442.5
Arkansas	636	803.5	415	532.6	1,336.1
California	5,503	7,863.9	3,631	4,273.3	12,137.2
Colorado	830	1,186.2	572	733.3	1,919.5
Connecticut	660	843.1	389	499.4	1,342.5
Delaware	163	232.7	102	130.7	363.4
District of Columbia	103	146.7	61	76.7	223.4
Florida	3,535	5,137.5	1,938	2,436.0	7,573.5
Georgia	1,681	2,401.8	1,176	1,508.8	3,910.7
Idaho	171	243.9	102	131.4	375.3
Illinois	248	354.2	163	209.5	563.7
Indiana	1,154	1,649.0	796	1,021.1	2,670.1
Iowa	1,383	1,976.6	939	1,204.4	3,181.0
Iowa	543	832.7	325	417.0	1,249.7
Kansas	490	700.1	316	405.8	1,105.9
Kentucky	1,042	1,488.4	731	936.0	2,424.4

## Projected Growth in Doctor Diagnosed Arthritis, 2005-2030

Centers for Disease Control, Morbidity and Mortality Weekly Report, June 22, 2007

TABLE 3. State-specific 2005 estimates and 2030 projections\* of the numbers of adults with doctor-diagnosed arthritis and arthritis-attributable activity limitations — Behavioral Risk Factor Surveillance System (BRFSS) and U.S. Census

State/Area	No. of adults with doctor-diagnosed arthritis			No. of adults with arthritis-attributable activity limitations			% change in increase (decrease) 2030 versus 2005 (%)
	2005 (1,000s)	2030 (1,000s)	Increase (decrease) (1,000s)	2005 (1,000s)	2030 (1,000s)	Increase (decrease) (1,000s)	
Alabama	1,113	1,360	267	469	576	107	24
Alaska	107	156	49	43	61	18	48
Arizona	1,070	2,526	1,446	396	692	296	134
Arkansas	626	827	201	243	319	76	32
California	5,659	9,119	3,460	2,184	5,361	3,177	61
Colorado	792	1,126	334	276	367	91	42
Connecticut	660	823	164	300	358	58	23
Delaware	125	277	152	61	133	72	50
District of Columbia	99	76	-24	36	27	-9	-24
Florida	3,626	7,266	3,640	1,446	2,781	1,335	101
Georgia	1,668	2,595	927	678	1,041	363	56
Idaho	212	280	68	67	88	21	32
Illinois	253	424	171	106	176	70	70
Indiana	2,347	2,824	477	776	926	150	20
Iowa	1,340	1,826	486	476	662	186	21
Iowa	611	720	109	206	236	30	18
Kansas	546	687	141	185	226	41	22
Kentucky	670	1,118	448	380	476	96	27

Health Finance Commission

August 23, 2012

Issue: Specific limitations on certain out of pocket costs for prescription drugs under coverage provided by a state employee health plan, a policy of accident and sickness insurance, and a health maintenance organization contract.

Testimony of Christopher Schrader, SPHR, Director – Government Affairs, Indiana State Council of SHRM

Please note both the Indiana Chamber of Commerce and the Indiana Manufacturers Association share common cause on this issue with the State Council.

Statement of Record

I rise in opposition to any attempt by the State of Indiana to set limitations on out of pocket costs for prescription drugs under any form of accident or health insurance plan maintained by either public or private employers.

My opposition rests on three points:

- 1) Any attempt by the State to come to the aid of a particular group or sector of citizens invariably experiences the failure of logic known as fallacy of composition (what is good for part is good for the whole). Thomas Sowell, esteemed economist, described such failure the best: “A baseball fan may see the game better by standing up, but if all of the fans stand up, they all will not see the game better.” The nobility or compassion behind the effort has no bearing on outcome. Indeed, all such actions lack the voluntary nature of transactions found in the marketplace; many invariably result in zero sum outcomes that are later addressed with... more legislation.
  
- 2) Price controls have been tried many times, in many cultures and many governments and inevitably disappoint. The early returns on such efforts are invariably positive; indeed, the greater the size and scope of intervention, the more robust the initial impact. Gradually, the disruption in the normal market-clearing process of pricing impacts the cost of operations of the supplier. What follows is the familiar litany of supply constraint, layoffs or reduced hiring, and significant cost reductions in “non-core” areas such as training, research and development. Pharmaceutical companies are particularly exposed because about only one out of every ten thousand discovered compounds actually becomes an approved drug for sale. Significant expense is incurred in the early phases of development of compounds that will not become approved drugs. According to the pharmaceutical industry, new drug development takes about

7 to 10 years and only 3 out of every 20 approved drugs bring in sufficient revenue to cover their developmental costs, and only 1 out of every 3 approved drugs generates enough money to cover the development costs of previous failures. A successful drug company must therefore discover a blockbuster (billion-dollar drug) every few years or face decline.

- 3) Price controls interfere with the health and accident plans voluntarily entered into by employers. It is our firm belief that employers and HR professionals are in the best position to understand their employees and to design myriad reward plans that support their unique value proposition to workers. One size does not fit all, and often times only few.

Thank you.

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