



## **AGENDA**

### **State and Public School Life and Health Insurance Board Benefits Sub-Committee**

**October 7, 2016  
10:00 a.m.**

**EBD Board Room – 501 Building, Suite 500**

- I. Call to Order ..... Jeff Altemus, Chairman***
- II. Approval of September 16, 2016 Minutes..... Jeff Altemus, Chairman***
- III. ASE-PSE Financials September, 2016..... Marla Wallace, EBD Fiscal Officer***
- IV. Opioid Utilization..... Dr. Carlos Ramon, Chairman Pain Mgmt. Review Committee***
- V. ACA Nondiscrimination Mandate 1557..... Chris Howlett, EBD Executive Director***
- VI. Director's Report..... Chris Howlett, EBD Executive Director***

**2016 upcoming meetings:**

**November 4, 2016**

**NOTE: All material for this meeting will be available by electronic means only  
[ethel.whittaker@dfa.arkansas.gov](mailto:ethel.whittaker@dfa.arkansas.gov)**

**Notice: Silence your cell phones. Keep your personal conversations to a minimum.  
Observe restrictions designating areas as "Members and Staff only"**

**State and Public School Life and  
Health Insurance Board  
Benefits Sub-Committee  
Minutes  
October 7, 2016**

The Benefits Sub-Committee of the State and Public School Life and Health Insurance Board (hereinafter called the Committee) met on October 7, 2016, at 10:00 a.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, Arkansas.

**Members Present**

Becky Walker  
Dan Honey  
Shelby McCook  
Jeff Altemus  
Claudia Moran  
Ronnie Kissire  
Susan Gardner  
Carla Haugen  
Janis Harrison

**Members Absent**

Chris Howlett, Executive Director, Employee Benefits Division (EBD)

**Others Present**

Dr. Carlos Ramon, M.D., Chairman Pain Mgmt. Review Committee, Geri Bemberg, Jill Johnson, Dwight Davis, Sherry Bryant, UAMS; Janna Keathley, Marla Wallace, Ethel Whittaker, Eric Gallo, Drew Higginbotham, Matt Turner, Terri Freeman, EBD; Kristi Jackson, Jennifer Vaughn, Com Psych; Pam Lawrence, AHH; Sylvia Landers, Minnesota Life; Marc Watts, ASEA; Mike Boyd, Wayne Whitley, AHTD; Jessica Atkins, Takisha Sanders, Health Advantage; Karyn Langley, QualChoice; Liz Tullos, WageWorks; Jackie Baker, ASP; Stephen Carroll, All Care Specialty; Elizabeth Whittington, Mike Motley, ACHI; Martha Hill; MW, Suzanne Woodall, MedImpact; Erica Gee, Attorney; Steve Althoff, MTI; Sean Seago, Merck; Treg Long, ACS; Martha Carlson, ABCBS; Marc Bagby, Lilly; Teri Kerr, SRAC

**CALL TO ORDER**

The meeting was called to order by Jeff Altemus, Chairman

**APPROVAL OF MINUTES**

A request was made by Altemus to approve the minutes from September 16, 2016. Kissire made the motion to approve. Harrison seconded; all were in favor.

**Minutes Approved.**

**ASE PSE FINANCIALS:** *by Marla Wallace, EBD Fiscal Officer*

Wallace reported financials for September 2016. For September PSE, five (5) weeks of medical and pharmacy claims were paid. The fifth week of claims totaled \$5.479 million. The FICA savings for the month is \$483,959. There was a net loss of \$638,000 for the month and a net gain of \$24.5 million year-to-date. Net assets available are \$55 million.

For ASE the month of September, five (5) weeks of medical and pharmacy claims were paid. The fifth week of claims totaled \$4.6 million. The net loss was \$1.6 million. The year-to-date gain is \$15.4 million. Net assets available are \$15.7 million.

**OPIOID UTILIZATION:** *by Dr. Carlos Ramon, Chairman Pain Management Review Committee*

**Prescription Drug Epidemic:**

- Opioids kill more people than car accidents every year. The Centers for Disease Control and Prevention (CDC) classified it as an epidemic, and the World Health Organization (WHO) reported it threatened the achievements of modern medicine.
- Americans account for 99 percent of the world's hydrocodone (Vicodin) consumption, 80 percent of the world's oxycodone (Percocet and Oxycontin) consumption and 65 percent of the world's hydromorphone (Dilaudid) consumption, according to the New York Times.
- Deaths from overdoses involving prescription painkillers quadrupled since 1999.
- Every day, at least 50 Americans die from prescription painkiller overdoses.
- Every year, prescription pain killers cause more than 16,000 deaths and 475,000 emergency room visits.
- Louisiana has more opioid prescriptions than residents.

McCook has concerns about the outcome of prescribing opiates if there is not a process to offset the addictions.

Dr. Ramon reported pharmaceutical companies have a tendency to report information that is not with the guidelines of the Centers for Disease Control. For instance, controlling the patient's opiates dependency in four (4) days; it could take six months to 1 year for a physician to monitor the patient's dependence, which is dependent on how long the patient has taken medicine and the patient's activity level.

Dr. Kirtley reported the Drug Enforcement Agency (DEA) will make drastic cuts with opiates in 2017 that could potentially create additional pharmacy security issues.

McCook is concerned that drug screens are not performed before hiring and on a random basis.

Harrison reported drugs screens are carried out for certain positions. However, to show screens for all positions, it must pass through legislation.

**ACA NONDISCRIMINATION MANDATE 1557:** *by Chris Howlett, EBD Executive Director*

Howlett reported EBD is prepared to implement the new ACA mandate 1557 October 18<sup>th</sup>.

There is litigation regarding the Transgender policy also known as the "Bathroom Mandate." There is not a ruling or decision at this time.

**EBD DIRECTOR'S REPORT:** *by Chris Howlett, EBD Executive Director*

Howlett reported Lori Eden, EBD Deputy Director, resigned September 30, 2016, and the process for hiring a replacement is underway.

PSE open enrollment began October 1<sup>st</sup> and will go through October 15<sup>th</sup>.

The procurement process for actuarial services is in the evaluation phase. EBD hopes to announce the winner of the contract by month end.

The procurement process for medical management has ended. Active Health is the new vendor. EBD and Active Health implementation process began October 3<sup>rd</sup>.

Howlett requested an extension of up to three months for the AHH contract to allow processing time for the new vendor.

Howlett met with WageWorks regarding future recommendations to the Board concerning administrative fees in 2017 to be paid to BNY Mellon.

**Meeting adjourned**

**Arkansas State Employees (ASE) Financials - January 1, 2015 through September 30, 2015**

	EMPLOYEE ONLY				EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL	ACTIVES	RETIREES	MEDICARE	TOTAL
<b>BASIC</b>	997	23		1020	1712	39		1751
<b>CLASSIC</b>	1817	69		1886	3103	99		3202
<b>PREMIUM</b>	23707	2188		25895	41409	2839		44248
<b>PRIMARY</b>		217	8929	9146		445	11723	12168
<b>TOTAL</b>	26521	2497	8929	37947	46224	3422	11723	61369

**REVENUES & EXPENDITURES**

	Current Month	Year to Date (9 Months)
<b>Funding</b>		
State Contribution	\$ 14,693,616	\$ 130,236,596
Employee Contribution	\$ 7,878,187	\$ 71,727,905
Other	\$ 787,495	\$ 10,512,235
Allocation for Actives - Plan Year 2015	\$ 971,667	\$ 8,745,000
<b>Total Funding</b>	<u>\$ 24,330,964</u>	<u>\$ 221,221,736</u>
<b>Expenses</b>		
Medical Expenses		
Claims Expense	\$ 13,352,953	\$ 116,491,847
Claims IBNR	\$ -	\$ -
Medical Administration Fees	\$ 1,050,516	\$ 9,659,908
Refunds	\$ -	\$ (89,076)
Employee Assistance Program (EAP)	\$ 55,374	\$ 505,127
Life Insurance	\$ 54,028	\$ 492,674
Pharmacy Expenses		
RX Claims	\$ 5,950,451	\$ 53,354,466
RX IBNR	\$ -	\$ -
RX Administration	\$ 247,102	\$ 1,901,773
Plan Administration	\$ 603,332	\$ 4,738,838
<b>Total Expenses</b>	<u>\$ 21,313,756</u>	<u>\$ 187,055,557</u>
<b>Net Income/(Loss)</b>	\$ 3,017,208	\$ 34,166,179

**BALANCE SHEET**

<b>Assets</b>	
Bank Account	\$ 7,957,708
State Treasury	\$ 91,282,008
Due from Cafeteria Plan	\$ 5,195,886
Due from PSE	\$ -
Receivable from Provider	\$ -
Accounts Receivable	\$ 230,241
<b>Total Assets</b>	<u>\$ 104,665,843</u>
<b>Liabilities</b>	
Accounts Payable	\$ 7,040
Deferred Revenues	\$ -
Due to Cafeteria	\$ 50
Due to PSE	\$ 13,427
Due to Federal Government (\$44 fee)	\$ 1,119,712
Health IBNR	\$ 24,700,000
RX IBNR	\$ 1,800,000
<b>Total Liabilities</b>	<u>\$ 27,640,230</u>
<b>Net Assets</b>	\$ 77,025,614
Less Reserves Allocated	
Premiums for Plan Year 1/1/15 - 12/31/15 (\$6,260,000 + \$5,400,000)	\$ (2,915,000)
Premiums for Plan Year 1/1/16 - 12/31/16 (\$3,600,000 + \$12,600,000)	\$ (16,200,000)
Premiums for Plan Year 1/1/17 - 12/31/17 (\$7,560,000))	\$ (7,560,000)
Premiums for Plan Year 1/1/18 - 12/31/18 (\$5,040,000)	\$ (5,040,000)
Catastrophic Reserve (2015 \$10,400,000)	\$ (10,400,000)
<b>Net Assets Available</b>	<u>\$ 34,910,614</u>

Fifth Week of Claims \$0

**Arkansas State Employees (ASE) Financials - January 1, 2016 through September 30, 2016**

	EMPLOYEE ONLY					EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL		ACTIVES	RETIREES	MEDICARE	TOTAL
<b>BASIC</b>	1333	42		1375		2197	57		2254
<b>CLASSIC</b>	1792	67		1859		3001	89		3090
<b>PREMIUM</b>	22698	2164		24862		39544	2776		42320
<b>PRIMARY</b>		205	9348	9553			419	12220	12639
<b>TOTAL</b>	<b>25823</b>	<b>2478</b>	<b>9348</b>	<b>37649</b>		<b>44742</b>	<b>3341</b>	<b>12220</b>	<b>60303</b>

**REVENUES & EXPENDITURES**

<b>Funding</b>	<b>Current Month</b>	<b>Year to Date (9 Months)</b>
1 State Contribution	\$ 14,704,872	\$ 132,266,176
2 Employee Contribution	\$ 7,847,295	\$ 71,486,547
3 Other	\$ 142,629	\$ 9,336,902
4 Allocation of Reserves	\$ 1,350,000	\$ 12,150,000
<b>Total Funding</b>	<b>\$ 24,044,796</b>	<b>\$ 225,239,624</b>
<b>Expenses</b>		
Medical Expenses		
5 Claims Expense	\$ 16,901,060	\$ 132,397,348
6 Claims IBNR	\$ -	\$ 3,300,000
7 Medical Administration Fees	\$ 1,137,747	\$ 9,832,449
8 Refunds	\$ -	\$ 265
9 Employee Assistance Program (EAP)	\$ 54,308	\$ 495,465
Life Insurance	\$ 78,150	\$ 712,328
Pharmacy Expenses		
11 RX Claims	\$ 7,142,223	\$ 57,265,982
12 RX IBNR	\$ -	\$ (100,000)
13 RX Administration	\$ 119,512	\$ 1,630,105
14 Plan Administration	\$ 249,727	\$ 4,280,479
<b>Total Expenses</b>	<b>\$ 25,682,727</b>	<b>\$ 209,814,420</b>
15 <b>Net Income/(Loss)</b>	<b>\$ (1,637,931)</b>	<b>\$ 15,425,204</b>

**BALANCE SHEET**

<b>Assets</b>	
16 Bank Account	\$ 5,174,781
17 State Treasury	\$ 91,131,106
18 Due from Cafeteria Plan	\$ 5,018,599
19 Due from PSE	\$ 177,363
20 Receivable from Provider	\$ -
21 Accounts Receivable	\$ (451,304)
<b>Total Assets</b>	<b>\$ 101,050,545</b>
<b>Liabilities</b>	
22 Accounts Payable	\$ 4,846
23 Deferred Revenues	\$ 4,292
24 Due to Cafeteria	\$ 862
25 Due to PSE	\$ 1,573
26 Due to Federal Government (\$27 fee)	\$ 664,295
27 Health IBNR	\$ 28,000,000
28 RX IBNR	\$ 1,700,000
<b>Total Liabilities</b>	<b>\$ 30,375,868</b>
<b>Net Assets</b>	<b>\$ 70,674,677</b>
Less Reserves Allocated	
29 Premiums for Plan Year 1/1/16 - 12/31/16 (\$3,600,000 + \$12,600,000)	\$ (4,050,000)
30 Premiums for Plan Year 1/1/17 - 12/31/17 (\$7,560,000 + \$13,770,000)	\$ (21,330,000)
31 Premiums for Plan Year 1/1/18 - 12/31/18 (\$5,040,000 + \$8,262,000)	\$ (13,302,000)
Premiums for Plan Year 1/1/19 - 12/31/19 (\$5,508,000)	\$ (5,508,000)
32 Catastrophic Reserve (2016 \$10,700,000)	\$ (10,700,000)
33 <b>Net Assets Available</b>	<b>\$ 15,784,677</b>

34 Fifth Week of Claims \$4,622,501

**Public School Employees (PSE) Financials - January 1, 2015 through September 30, 2015**

	EMPLOYEE ONLY				EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL	ACTIVES	RETIREES	MEDICARE	TOTAL
<b>BASIC</b>	2766	231		2997	4077	289		4366
<b>CLASSIC</b>	21494	1944		23438	39555	2375		41930
<b>PREMIUM</b>	19863	1210		21073	25586	1294		26880
<b>PRIMARY</b>		102	10410	10512		206	11373	11579
<b>TOTAL</b>	<b>44123</b>	<b>3487</b>	<b>10410</b>	<b>58020</b>	<b>69218</b>	<b>4164</b>	<b>11373</b>	<b>84755</b>

**REVENUES & EXPENDITURES**

	Current Month	Year to Date (9 Months)
<b>Funding</b>		
Per Participating Employee Funding (PPE Funding)	\$ 8,078,976	\$ 73,310,766
Employee Contribution	\$ 9,141,251	\$ 82,024,995
Department of Education \$35,000,000 & \$15,000,000	\$ 3,181,818	\$ 52,998,498
Other	\$ 844,909	\$ 5,677,952
Allocation for Actives	\$ 1,666,667	\$ 15,000,000
<b>Total Funding</b>	<u>\$ 22,913,620</u>	<u>\$ 229,012,211</u>
<b>Expenses</b>		
Medical Expenses		
Claims Expense	\$ 13,942,441	\$ 125,301,424
Claims IBNR	\$ -	\$ -
Medical Administration Fees	\$ 1,540,899	\$ 13,994,582
Refunds	\$ -	\$ (66,503)
Employee Assistance Program (EAP)	\$ 74,814	\$ 687,649
Pharmacy Expenses		
RX Claims	\$ 3,889,499	\$ 34,209,506
RX IBNR	\$ -	\$ -
RX Administration	\$ 347,025	\$ 2,620,802
Plan Administration	\$ 672,128	\$ 6,182,647
<b>Total Expenses</b>	<u>\$ 20,466,806</u>	<u>\$ 182,930,107</u>
<b>Net Income/(Loss)</b>	\$ 2,446,815	\$ 46,082,104

**BALANCE SHEET**

<b>Assets</b>	
Bank Account	\$ 20,961,625
State Treasury	\$ 81,679,540
Receivable from Provider	\$ -
Accounts Receivable	\$ 5,462,995
Due from ASE	\$ 13,427
<b>Total Assets</b>	<u>\$ 108,117,588</u>
<b>Liabilities</b>	
Accounts Payable	\$ 983
Due to ASE	\$ -
Deferred Revenues	\$ 28,157
Due to Federal Government (\$44 fee)	\$ 1,613,216
Health IBNR	\$ 28,000,000
RX IBNR	\$ 1,400,000
<b>Total Liabilities</b>	<u>\$ 31,042,356</u>
<b>Net Assets</b>	\$ 77,075,231
Less Reserves Allocated	
Premiums for Plan Year 1/1/15 - 12/31/15 (\$20,000,000 rec'd from Dept. of Education)	\$ (5,000,000)
Premiums for Plan Year 1/1/16 - 12/31/16 (\$9,600,000)	\$ (9,600,000)
Premiums for Plan Year 1/1/17 - 12/31/17 (\$5,760,000)	\$ (5,760,000)
Premiums for Plan Year 1/1/18 - 12/31/18 (\$3,840,000)	\$ (3,840,000)
Premium Assistance (FICA Savings)	\$ (4,208,376)
Catastrophic Reserve (2015 \$10,900,000)	\$ (10,900,000)
<b>Net Assets Available</b>	<u>\$ 37,766,856</u>

Fifth Week of Claims \$0

**Public School Employees (PSE) Financials - January 1, 2016 through September 30, 2016**

	EMPLOYEE ONLY					EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL		ACTIVES	RETIREES	MEDICARE	TOTAL
<b>BASIC</b>	3507	335		<b>3842</b>		5243	412		<b>5655</b>
<b>CLASSIC</b>	22242	2101		<b>24343</b>		41421	2548		<b>43969</b>
<b>PREMIUM</b>	18782	975		<b>19757</b>		24613	1039		<b>25652</b>
<b>PRIMARY</b>		83	11191	<b>11274</b>			167	12198	<b>12365</b>
<b>TOTAL</b>	<b>44531</b>	<b>3494</b>	<b>11191</b>	<b>59216</b>		<b>71277</b>	<b>4166</b>	<b>12198</b>	<b>87641</b>

**REVENUES & EXPENDITURES**

	Current Month	Year to Date (9 Months)
<b>Funding</b>		
1 Per Participating Employee Funding (PPE Funding)	\$ 8,045,925	\$ 72,828,839
2 Employee Contribution	\$ 9,393,695	\$ 83,656,202
3 Department of Education \$35,000,000 & \$15,000,000 & Other Funding	\$ 3,181,818	\$ 36,704,545
4 Other	\$ 600,418	\$ 5,691,932
5 Allocation of Reserves	\$ 3,975,000	\$ 35,775,000
<b>Total Funding</b>	<u>\$ 25,196,856</u>	<u>\$ 234,656,518</u>
<b>Expenses</b>		
Medical Expenses		
6 Claims Expense	\$ 18,648,776	\$ 147,522,251
7 Claims IBNR	\$ -	\$ 2,000,000
8 Medical Administration Fees	\$ 1,179,044	\$ 14,290,455
9 Refunds	\$ -	\$ -
10 Employee Assistance Program (EAP)	\$ 76,063	\$ 690,033
Pharmacy Expenses		
11 RX Claims	\$ 4,873,829	\$ 37,399,125
12 RX IBNR	\$ -	\$ (300,000)
13 RX Administration	\$ 640,677	\$ 2,819,929
14 Plan Administration	\$ 416,904	\$ 5,645,862
<b>Total Expenses</b>	<u>\$ 25,835,293</u>	<u>\$ 210,067,654</u>
16 <b>Net Income/(Loss)</b>	\$ (638,437)	\$ 24,588,864

**BALANCE SHEET**

<b>Assets</b>	
17 Bank Account	\$ 6,163,588
18 State Treasury	\$ 109,202,195
19 Receivable from Provider	\$ -
20 Accounts Receivable	\$ 8,444,515
21 Due from ASE	\$ 1,573
<b>Total Assets</b>	<u>\$ 123,811,871</u>
<b>Liabilities</b>	
22 Accounts Payable	\$ 2,889
23 Due to ASE	\$ 177,363
24 Deferred Revenues	\$ 303
25 Due to Federal Government (\$27 fee)	\$ 1,010,826
26 Health IBNR	\$ 30,000,000
27 RX IBNR	\$ 1,100,000
<b>Total Liabilities</b>	<u>\$ 32,291,381</u>
28 <b>Net Assets</b>	\$ 91,520,490
Less Reserves Allocated	
29 Premiums for Plan Year 1/1/16 - 12/31/16 (\$9,600,000 + \$20,000,000 DOE + 18,100,000 DOE)	\$ (11,925,000)
30 Premiums for Plan Year 1/1/17 - 12/31/17 (\$5,760,000)	\$ (5,760,000)
31 Premiums for Plan Year 1/1/18 - 12/31/18 (\$3,840,000)	\$ (3,840,000)
33 Premium Assistance (FICA Savings)	\$ (4,365,745)
32 Catastrophic Reserve (2016 \$10,500,000)	\$ (10,500,000)
34 <b>Net Assets Available</b>	<u>\$ 55,129,745</u>
35 Fifth Week of Claims	\$ 0

# Blue Coat Pain Project

Dr. Carlos Roman

Chairman Arkansas State Medical Board  
Pain Management Committee.

Proper Pain Management

# Dr. Roman

- Born: New Orleans, LA. 11-11-68
- 1987: Graduate Catholic High School, Little Rock, AR.
- 1987-1990: Tulane University; Deans List every semester, graduated “Cum Laude”; graduated in 3 years.
- 1990-1994: University of Arkansas College of Medicine. Graduated 19<sup>th</sup> in class. Scored top 8% nationally on Step 1 USMLE.
- 1994-1995: Internship UAMS
- 1995-1998: Tulane University College of Medicine; Residency in Anesthesiology. Board certified in Anesthesiology.
- 1998-present: Private practice St. Vincent Infirmary, Little Rock, AR.

# What's the Problem?

- Prescription Drug Epidemic:
  - kills more people than car accidents every year. The Centers for Disease Control and Prevention (CDC) classified it as an epidemic and the World Health Organization (WHO) reported it threatened the achievements of modern medicine.
  - Americans account for 99 percent of the world's hydrocodone (Vicodin) consumption, 80 percent of the world's oxycodone ([Percocet and Oxycontin](#)) consumption and 65 percent of the world's hydromorphone ([Dilaudid](#)) consumption, according to the New York Times.
  - Deaths by overdoses involving prescription painkillers quadrupled since 1999.
  - Every day, at least 50 Americans die from prescription painkiller overdoses.
  - Every year, prescription painkillers cause more than 16,000 deaths and 475,000 emergency room visits.
  - Louisiana has more opioid prescriptions than residents. Dr. David Holcombe, Office of Public Health LA.. “We have been building to this , it did not happen by accident”.

# How did we get here?

- The trend in prescription drug abuse rises with the creation of sustained release opioid preparations, and the modern practice of “pain management”.
- Oxycontin (released in 1996) was the first sustained release opioid and created sales in excess of \$30 billion.
- Purdue Pharmacia in marketing this drug took over the educational platform of modern Pain Management. In 2001 alone, the company spent \$200 million in an array of approaches to market and promote OxyContin. (Am J Public Health. 2009 February; 99(2): 221–227.)

# Marketing of Oxycontin: The Big Lies

- False narrative that addiction rates with sustained relief narcotics for chronic pain were less than 1 %
- Opioids were safer than NSAIDS. Reminding doctors of side effects that NSAIDS can harm the kidneys and stomach. While claiming that opioids do no harm to any organ system. Grossly ignoring addiction, physical dependence, and respiratory depression.
- Indicating the sustained relief formulations lead to lower rates of abuse than short acting medications.
- Encouraging patients to consume opioids in anticipation of pain. Encouraging prophylactic opioid use.
- Placing in the literature that opioids could be tapered off easily over a few weeks.

# Am J Public Health. 2009 February; 99(2): 221–227. The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy

- From 1996 to 2001, Purdue conducted more than 40 national pain-management and speaker-training conferences at resorts in Florida, Arizona, and California. More than 5000 physicians, pharmacists, and nurses attended these all-expenses-paid symposia, where they were recruited and trained for Purdue's national speaker bureau.19(p22)
- OxyContin's commercial success did not depend on the merits of the drug compared with other available opioid preparations. The *Medical Letter on Drugs and Therapeutics* concluded in 2001 that oxycodone offered no advantage over appropriate doses of other potent opioids.
- Purdue “aggressively” promoted the use of opioids for use in the “non-malignant pain market.”15(p187)

# Marketing continues:

- “Partners Against Pain” Web site—Purdue claimed that the risk of addiction from OxyContin was extremely small.
- Purdue trained its sales representatives to carry the message that the risk of addiction was “less than one percent.”<sup>50</sup>(p99)
- Sustained release opioid preparations were less addictive than short acting opioids

# Opioid Abuse in Chronic Pain: Misconceptions and Mitigation Strategies Engl J Med 2016;374:1253-1263

Two major facts can no longer be questioned:

First, opioid analgesics are widely diverted and improperly used, and the widespread use of the drugs has resulted in a national epidemic of opioid overdose deaths and addictions.

Second, the major source of diverted opioids is physician prescriptions.<sup>10,11</sup> For these reasons, physicians and medical associations have begun questioning prescribing practices for opioids, particularly as they relate to the management of chronic pain.

# Action has been taken:

- Misrepresenting the risk of addiction proved costly for Purdue. On May 10, 2007, Purdue Frederick Company Inc., an affiliate of Purdue Pharma, along with 3 company executives, pled guilty to criminal charges of misbranding OxyContin by claiming that it was less addictive and less subject to abuse and diversion than other opioids, and will pay \$634 million in fines.61
- Several parallels are seen in the marketing of sustained release opioids and the cigarette companies.
  - They both have an addictive substance to sell
  - They both down played the dangers of their products
  - Imagery of freedom and people being active from their products.
  - Multibillion dollar advertising campaigns

# Workers Comp and Disability

- **Prescription Narcotics: An Obstacle to Maximum Medical Improvement**

*Robert J. Barth, PhD*

- Scientific findings have indicated that narcotics reliably cause an abnormally severe sensitivity to pain, termed hyperalgesia.
- Hypogonadism (central suppression of hypothalamic secretion of gonadotropin-releasing hormone<sup>8</sup>) is one of the most well-documented examples of such endocrine disruption.
- Research has also indicated that narcotics are a risk factor for cognitive impairment, even when the narcotic consumer does not perceive him- or herself to be sedated.
- Another harmful effect of narcotics, specifically compromise of the immune system
- Sleep impairment.
- Depression.

# Opioid therapy for nonspecific low back pain and the outcome of chronic work loss. Pain. 2009 Apr;142(3):194-201.

- Findings included the following: compared with the (no opioid) reference group, odds of chronic work loss were six times greater for claimants with schedule II ("strong") opioids; compared with the reference group, odds of chronic work loss were 11-14 times greater for claimants with opioid prescriptions of any type during a period of  $\geq 90$  days; and three years after injury, costs of claimants with schedule II opioids averaged \$19,453 higher than costs of claimants in the reference group
- The strong associations observed suggest that for most workers opioid therapy did not arrest the cycle of work loss and pain.

# What's the cost?

- Treating the epidemic: drug overdoses, emergency room visits, drug rehab costs etc..
- Increasing disability rates.
- A recent workers comp “My Matrix Invoice” on a new patient of mine showed monthly drug cost: Oxycontin 80mg disp. #90 cost \$1,398.50 per month vs. oxycodone 15mg disp. #90 \$73.44 vs. Lidoderm patch \$289.04.

# A Pain Practice Comparison

- In my clinical practice I have approximately 4,000 patients.
- I have relieved the burden or prevented the creation of opioid dependency in every single patient in my care for the last 18 years.
- The average cost savings PER YEAR alone in sustained narcotic prescriptions is approximately \$60,000,000. ( $\$15,000 \times 4000 = \$60,000,000$ ). That does not include the cost savings of polypharmacy, work loss, unnecessary procedures, emergency room visits, addiction services, associated with opioid dependency.

# Summary:

## Money over Medicine

1. The practice of “Pain management” as a medical specialty was targeted and educated to overprescribe opioids by the pharmaceutical companies (Product sales).
2. Sustained release narcotics create physical drug dependency more severely and at a greater frequency than any other opioid or opioid preparation ever known.
3. Opioid Drug Dependency is a disease state; but not an addiction.
4. Addiction rates increase with Opioid Drug Dependency.

# What's been the response?

- We screen and monitor:
  - Urine drug screens, prescription drug monitoring programs.
- We react:
  - Distribute narcan, clean needles, treatment programs for addiction (ex. Suboxone), pill confiscation/collection drives.

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#These initiatives are fine but will not solve the problem. If analogous to motor vehicle accidents they are the equivalent of hiring wreckers and ambulances. We need to address the problem; Making cars that don't wreck. Ex. Antilock breaks, traction control, speed limits, public awareness not to drink and drive etc..

# Pain Management Societies

- American society of Pain Management and The American Academy of Pain Management Opioid Treatment Guidelines (Journal Pain Mgt., Vol. 10 no. 2 (February) 2009).
- “Theoretically opioids have no maximum or ceiling dose, but there is little evidence to guide safe and effective prescribing at higher doses and there is no standard definition for what constitutes a “high” dose. By panel consciences, a reasonable definition for high dose opioid is > 200 meq morphine per day.”
- #This is 4 times the recommended CDC dose. The paper also recommends use of long acting or sustained release opioids.

# Interesting Update

- On September 22, 2016 the “American Academy of Pain Management” officially became the “Academy of Integrative Pain Management”. Lawsuit avoidance? Are Board certified pain doctors by the American Academy of Pain Management still boarded?
- First time in the history of American Medicine that an “established” medical specialty or subspecialty has had a fundamental medical concept in direct contradiction to the Centers for Disease Control.

# CDC Guidelines 2016

- Potential to move the curve! Best ideas of the 12 recommendations:
  - #2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients and should consider how opioid will be discontinued.
  - #4. Prescribe immediate release opioids instead of extended release.
  - #5. Clinicians should use caution when prescribing opioids at any dosage. Should carefully reassess increasing dosage > 50 meq morphine per day, and avoid dosages > 90 meq morphine per day.
  - #7. If benefits of opioid therapy do not outweigh harms clinicians work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
  - #11. clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

# The problems of CDC vs. Pain Management

- The vast majority of pain medicine doctors have bought into the shallow science and educational marketing of large pharmaceutical companies over the last 20 years.
- We have millions of American citizens stuck in a state of opioid dependency; many under the false idea that their medications are necessary to treat their pain problem. They were told by their doctors that this what they should do. Patients trust their doctors.
- The medical doctors in pain management sincerely believe they have been acting in their patients best interest and it will be hard for a practicing physician to accept CDC guidelines that blatantly refutes an entire medical career of how to prescribing pain medications.
- It will place pharmacy recommendations in contrast to the pain medicine community. The Arkansas pain physicians submitted a consensus recommendation Thursday, August 4, 2016 to the Arkansas State Medical Board recommending a 200 meq of morphine per day upper limit as excessive. This contrasts the CDC limit of 50 meq morphine per day. The Arkansas State Medical Board rejected endorsement of their proposal.

# The Challenges of Implementing CDC Prescribing Guidelines

- Physicians and patients are poorly equipped to effectively taper patients off opioids. It is like going on a diet to lose 100 pounds. Treating opioid dependency in the face of a chronic pain problem is not an easy task.
- Understanding that physical dependency is not addiction.
- Understanding chronic non-cancer pain. It's complicated.
- A mandated and sudden removal of opioids en masse will lead to a flood of emergency room visits for these patients going into drug withdrawal and will lead to an increased use of the black market to obtain opioids including a rise in heroin use.
- Physician pain practices are mostly set up on a business model of prescribing opioids.
- Physicians who have sincerely practiced what was taught to them by “pain management” experts and the sub-specialty boards of pain management will by nature struggle to change course.

# Blue Coat Pain Project

- This is a first world problem; a uniquely American problem. This is not malaria or yellow fever.
- This is a movement of independence. A declaration of opioid independence. Opioid dependency is a disease state and should be treated accordingly.
- Chronic Pain patients deserve better. They are our friends and neighbors, they have become crippled by disease and massive trauma.
  - They have a right to opioid independence. They have a lot to offer and should not be marginalized into a drugged stupor, and/or state of drug dependency.
  - They have right to return to work. Their medical treatment should improve those possibilities. Modern pain medicine should lower disability rates not facilitate it.
  - They have a right to multimodal treatments to include surgery, interventional treatments, physical therapy, and other non-narcotic treatments.
  - They have a right to deny any treatment or procedure without fear of reprisal from the treating doctor.
  - They have a right to be believed. Any complaint of pain should be properly worked up.
  - They have a right to addiction treatments that acknowledges iatrogenic opioid addiction in the course of chronic pain; they deserve treatment of both.
  - They have the right to proper access to opioids if indicated.
  - They have a right to treatment of circumstantial depression as expected from chronic pain.
  - They have right to understand their disease and prognosis.
  - They have a right to fair assessment of their disability and ability.

# How do we move forward

- Public awareness is as key as physician awareness/education. It may be easier to educate the public than change the practice pattern of current physician pain management practices.
- Physician/nurse education and training certification. To include endocrinology of endorphins, treating opioid dependency, addiction awareness.
- Website.
- An App: a self-contained program or piece of software designed to fulfill a particular purpose; an application, especially as downloaded by a user to a mobile device. There is a prototype.
- A documentary film. These patients have an untold story and deserve to be heard.
- Educational materials in medical offices.
- Staffed educators. Using same model that got us into this mess. Send educators out like drug representatives.
- A foundation dedicated to proper treatment of chronic pain patients will do more to affect the opioid prescription problem than any other venture. It would cost a fraction of other ideas, create jobs, and solve the problem from its source: the practice of pain management.
- CDC guidelines make this possible. Arkansas should lead.

# Economic Impact

- Reduce 1 million sustained release prescriptions: \$1,200 per month x 12 months=\$14,400 per year x 1,000,000=14 billion dollars. Just 1000 fewer prescriptions 14 million dollars.
- Included polypharmacy reduction, work loss, lower addiction rates. It will save billions more.
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# Pain Medicine must change.

- American Cancer Society: **Estimated New Female Breast Cancer Cases and Deaths by Age, US, 2013\*** total of 39,620 deaths.
- American Society of addiction medicine: Drug overdose is the leading cause of accidental death in the US, with 47,055 lethal drug overdoses in 2014. Opioid addiction is driving this epidemic, with 18,893 overdose deaths related to prescription pain relievers, and 10,574 overdose deaths related to heroin in 2014.

# Effective Tapering of Opioids

## Very complicated, no real complicated

- When opioids are reduced or discontinued, a taper slow enough to minimize symptoms and signs of opioid withdrawal (e.g., drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, diaphoresis, mydriasis, tremor, tachycardia, or piloerection) should be used. A decrease of 10% of the original dose per week is a reasonable starting point; experts agreed that tapering plans may be individualized based on patient goals and concerns. Experts noted that at times, tapers might have to be paused and restarted again when the patient is ready and might have to be slowed once patients reach low dosages. Tapers may be considered successful as long as the patient is making progress. (CDC 2016 Guidelines for prescribing opioids for chronic pain.)

# Current Problems:

- Dependence
- Both tolerance and physical dependence can develop during chronic opioid therapy.
- OPANA<sup>®</sup> ER should not be abruptly discontinued. If OPANA<sup>®</sup> ER is abruptly discontinued in a physically-dependent patient, an abstinence syndrome may occur.
- Infants born to mothers physically dependent on opioids will also be physically dependent and may exhibit respiratory difficulties and withdrawal symptoms.

# Drug Company Taper

- Discontinuation of OPANA<sup>®</sup> ER
- When a patient no longer requires therapy with OPANA<sup>®</sup> ER, use a gradual downward titration of the dose every two to four days, to prevent signs and symptoms of withdrawal in the physically-dependent patient. Do not abruptly discontinue OPANA<sup>®</sup> ER.