

2021 House Bill No. 1139
Testimony before the House Industry, Business and Labor Committee
Presented by Tim Wahlin
Workforce Safety and Insurance
January 18, 2021

Mr. Chairman and Members of the Committee:

My name is Tim Wahlin, Chief of Injury Services at WSI. I am here today to provide testimony regarding House Bill No. 1139. The WSI Board supports this bill.

House Bill 1139 creates controls over two types of medications commonly prescribed to injured employees following a work-related injury. Each of these medications, given long-term, present significant problems including dependency, an increasing likelihood of addiction, increased sedation and respiratory depression, especially when used concurrently.

This bill was developed and heard in the 2019 Legislative Assembly. It was amended in Committee and then failed in the House by a narrow margin. The bill before you is the amended bill from the 2019 Legislative Assembly.

The 2019 bill was developed after numerous consultations with North Dakota physicians.

Currently the United States is in the midst of an opioid epidemic. Deaths from overdose have exceeded deaths related to traffic accidents. Opioids are not the only medications that are plagued with misuse and abuse and this legislation addresses others as well. Collectively, we are discovering in order to meaningfully address this issue, there needs to be changes.

WSI has taken steps to control and limit the widespread, long-term use of opioids in particular, but this legislation will continue to advance that mission and hopefully limit the devastating consequences dependency brings to our injured employees.

The basis of this legislation was a recommendation from the 2018 Performance Evaluation of North Dakota Workforce Safety & Insurance, performed by Sedgwick. The report recommended opioid caps, not only on the initial fill during the acute phase of treatment, but also on the continued use of opioid medications into the chronic phase of treatment. The Interim Workers' Compensation Review Committee received Sedgwick's report in 2018, and directed legislation be drafted.

The first medication the bill addresses is opioid and opioid-like medications. The legislation follows medical evidence that challenges the efficacy of long-term opioid use for the treatment of chronic pain and recognizes the increasing likelihood of dependency and the devastating consequences that can entail as well as the alarming rise in opioid-related deaths. The bill will limit the maximum day supply which can be obtained in the first thirty days of therapy to 7 days of medication at a time. This limit will minimize opioid medications in circulation and keep unnecessary prescriptions from being distributed. The seven day fill is also consistent with the fill programs for Medicaid administered by the N.D. Department of Human Services.

In addition, the bill establishes a cap on the strength of the opioids prescribed. Because opioid medications vary widely in potency, in order to accurately compare medications, each has to be

compared to an existing drug, in this case morphine. The industry has created measures of “morphine milligram equivalents.” Each medication has a conversion factor. As an example, 1mg of oxycodone is equivalent to 1.5mg of morphine. This bill sets a cap for an amount not to exceed 90 milligrams morphine equivalents per day. This level was chosen based upon the Sedgwick evaluation. After reviewing the literature, Sedgwick determined that dosing above 90 mg daily morphine equivalents constitutes high dosages and significantly increases the risk or likelihood of potentially fatal adverse effects. This practice matches similar dosing limits throughout the healthcare industry. In fact our state employee health coverage has similar provisions and in fact more stringent limitations on short term dosing.

The proposed legislation specifically exempts certain applications where the risk of overdose or dependency is muted. For example, applications when there is direct supervision of the administration or the likelihood dependency is not an issue, such as end of life care.

The second medication the bill addresses is benzodiazepine therapy extending beyond a cumulative duration of four weeks. Like opioid therapies, benzodiazepine therapies cause mood alteration and can lead to habituation and dependence, and in most circumstances lose effectiveness in a relatively short period of time. Studies have shown that in the United States there is a high likelihood of abuse and misuse potential for these medications. Medical science likewise recognizes the very challenging, and often long-term process of recovery to reverse this course. In rare circumstances, long-term therapies of benzodiazepine for treating certain types of anxiety disorders may be appropriate and this is recognized in the legislation.

The final proposed regulation addresses when the two substances are used in combination. When used in combination the chance for a fatal overdose increases dramatically. In combination they will not only sedate but will also depress respiration, an obviously dangerous combination.

Finally, the bill allows for the organization to depart from these limits “upon a showing of medical necessity.” This review system is described at NDCC 65-02-20, WSI’s managed care statute. This will create flexibility to accommodate cases that present special medical circumstances where the statute would otherwise deny the therapy drug.

Section 2 is the application portion of the bill. The application is different for injured employees receiving any therapy exceeding the therapy limits. The application directs all injured employees to be in compliance by July 1, 2022. This will give both providers and injured employees notice and over a year to reach compliance.

This concludes my testimony and I will be happy to answer any questions you may have.