HOUSE FINANCE COMMITTEE
April 27, 2017
3:44 p.m.

3:44:49 PM

CALL TO ORDER

Co-Chair Foster called the House Finance Committee meeting to order at 3:44 p.m.

MEMBERS PRESENT

Representative Neal Foster, Co-Chair
Representative Paul Seaton, Co-Chair
Representative Les Gara, Vice-Chair
Representative Jason Grenn
Representative David Guttenberg
Representative Scott Kawasaki
Representative Dan Ortiz
Representative Lance Pruitt
Representative Steve Thompson
Representative Cathy Tilton
Representative Tammie Wilson

MEMBERS ABSENT

None

ALSO PRESENT

Dr. Jay Butler, Chief Medical Officer and Director of Public Health, Department of Health and Social Services

SUMMARY

HB 25 INSURANCE COVERAGE FOR CONTRACEPTIVES

HB 25 was SCHEDULED but not HEARD.

HB 159 OPIOIDS;PRESCRIPTIONS;DATABASE;LICENSES

HB 159 was HEARD and HELD in committee for further consideration.

3:45:07 PM

Co-Chair Foster reviewed the meeting agenda.

#hb159
HOUSE BILL NO. 159

> "An Act relating to the prescription of opioids; establishing the Voluntary Nonopioid Directive Act; relating to the controlled substance prescription database; relating to the practice of dentistry; relating to the practice of medicine; relating to the practice of podiatry; relating to the practice of osteopathy; relating to the practice of nursing; relating to the practice of optometry; relating to the practice of veterinary medicine; related to the duties of the Board of Pharmacy; and providing for an effective date."

3:46:08 PM

DR. JAY BUTLER, CHIEF MEDICAL OFFICER AND DIRECTOR OF PUBLIC HEALTH, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, introduced the bill and read from prepared remarks:

> I think everyone is aware that the opioid epidemic continues. In 2016, over 90 of our fellow Alaskans died of an opioid overdose. That's nearly three times the number of Alaskans who died of AIDS at the peak of the HIV epidemic. This represents nearly 1 in every 40 deaths that occurred in Alaska last year and often times these deaths occur among our young people. Two-thirds of these deaths involved a prescription opioid painkiller and the majority of people who use heroin or synthetic opioids report that they started and became hooked using prescription opioids, often times taken on the advice of a trusted healthcare provider and a well-meaning healthcare provider.
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> But Alaska is responding through community coalitions and even through state government. SB 91 passed by the legislature and signed into law by Governor Walker on March 21 [2016] authorized increased access to the lifesaving drug naloxone and with federal funds it made possible for us to be able to provide these rescue kits. We've now distributed nearly 5,000 of these around the state. I'm very pleased to say that now in the public health centers, we have staff that

have received the trainer information so they could also be able to distribute the kits locally to people and save lives. We have a number of reports of people who have been able to be revived using the kits. While the kits can save a life, they really don't solve the problem. They do not support people in recovery who desperately want to continue to live in sobriety and they don't address the underlying drivers that increase the risk of opioid misuse and addiction. HB 159 adds to the state's multifaceted approach to addressing the epidemic and it aligns with many of the recommendations of the CDC (Centers for Disease Control and Prevention) as well as the recent report from the U.S. Surgeon General and a number of medical professional societies and with some of the best practices developed and adopted through the VA [Veterans Affairs] system.

3:48:54 PM

Mr. Butler provided an overview of the legislation with prepared remarks:

HB 159 can be viewed as addressing three areas. As a mnemonic I think of it as the three "P"s: patients, providers, and the prescription drug monitoring program (PDMP). Regarding patients, there's two aspects. First, the bill provides for an opioid advanced directive as a communication tool between patients and a provider that can be included in the medical record. The directive makes it clear that a patient does not wish to receive opioid medications. The directive is purely voluntary and is revocable. As a provider, I might not have thought this was necessary, but as I've talked to a number of people in recovery, as well as their families, they have expressed concern that too many providers don’t fully understand the destructive effects of opioids for some people. For some, they're the wrong drug at any time at any dose.

The bill provides for a waiver of civil liability if an opioid is withheld when a directive is in place and also if an opioid is inadvertently administered when a directive is in place. As might occur during an emergency situation. The second aspect for patients: the bill provides in state statute the authority for a

patient to be able to request a partial fill of an opioid prescription if they wish to receive a smaller number of pills and it reinforces the authority of the pharmacist to be able to honor the partial fill request without immediately voiding the remaining portion of the prescriptions. This matches with a federal authority under the Comprehensive Addiction and Recovery Act of 2016. The bill does two things relating to providers to advance patient safety and improve care for persons with addiction or who are in recovery. First, an analysis of data that was released earlier this year shows that persons who receive larger first time supplies of opioids are more likely to be chronic opioid users and at greater risk of dependency and addiction a year later. This risk increases particularly for first time prescriptions that are more than about 5 to 7 days in length.

3:51:11 PM

Mr. Butler continued to read from prepared remarks:

Recently we reviewed the Alaska Medicaid claims from last year and found that roughly half of all first time opioid prescriptions were for supplies of 15 days or longer. Even if the drugs are not used they can become a source of diversion and misuse in the community. Another review published this month in the Annals of Surgery showed that nearly three-fourths of all the opioids prescribed to patients being discharged from a hospital at the time of surgery go unused. Therefore, HB 159 proposes that first time prescriptions for acute pain be limited to no more than a 7-day supply to define a safer standard of care. This aligns with the CDC recommendations for pain management, which recommends in general a 3-day or less supply be prescribed, but points out that more than 7 days is really an unusual indication. Recognizing that opioids are appropriate for treatment of some conditions, the limit is waived for severe acute pain, chronic pain, cancer pain, palliative care, or situations where travel logistics would make it difficult to potentially get a refill or to see a provider.

The reason for dispensing more than a 7-day supply would be documented in the medical record. There's no

intention of limiting the access to care, but this does provide a stop-check for the provider to consider how much of the medication is really needed for a given patient and have it documented in the medical record.

Mr. Butler shared that he continued to hear stories from Alaskans and provided detail about one case that had caught his attention about a month back related to a school nurse who had described how one of her students had undergone a fairly minor orthopedic procedure. The student had come to school the next day and as was required turned in his prescription medications and had 120 Vicodin. He stressed that there really was no indication for that. He hoped the bill would encourage providers to stop and consider whether a patient really needed that many pills. He continued to read from prepared remarks:

> The second provision for providers is the bill authorizes the professional boards to require part of the currently required continuing education credit be designated to education in pain management or basics of addiction medicine. For example, as a physician every time I renew my medical license every other year I have to provide documentation that I have received 40 hours of continuing medical education credit and the bill would require that at least 2 of those hours be dedicated to either pain management or addiction medicine. It's important to recognize that even though this is part of an opioid bill, the challenges with substance misuse and addiction are much larger. There's a similar number of Alaskans who have a substance use disorder as the number of Alaskans who have diabetes. It's important that all providers understand the basic fundamentals of both of these common chronic conditions, yet many more understand diabetes than are aware of the special needs of persons in recovery or how to approach the patient who's struggling with addiction or a substance use disorder.

3:54:50 PM

Mr. Butler continued to read from prepared remarks:

> The science of treating substance use dependency and addiction is evolving fast and this had been an area

> of medicine that too many of us have ignored, and I'll be among the first to say that I certainly ignored it for a number of years, despite the fact that as an infectious disease provider I was taking care of a number of self-injection drug users. There's plenty of good, free online continuing medical education [CME] courses available. For example, the American Medical Association has produced a fabulous CME module that's entitled "A Primer on Opioid Mortality and Morbidity: What Every Prescriber Needs to Know."

Mr. Butler added that the CME module did not only apply to what every physician needs to know, what every ER doctor needs to know, what "the other guy" needs to know, but what every prescriber needs to know. He continued to address prepared remarks:

> The CDC has also produced a number of materials in collaboration with the UW [University of Washington] pain clinic that is also available online and includes some of the questions that I hear from providers that are most challenging. Such as - what do I do with the patient who has chronic pain and has been on opioids for years, it's not controlling the pain, they want increasing doses, and I really worry about this patient's safety?
>
> Some of the CME modules even provide specialty maintenance of certification credit, making the training a two-for. They were really, I believe, underused. We'd stress again that many of the options that are available are free.
>
> The third "p" is the Prescription Drug Monitoring Program. As I said to this committee last year, the PDMP is not a panacea, but it can be a useful clinical tool. Although, it’s a tool that only does the job if it's actually used. I have to admit I'm not a natural fan to PDMP, it's another step in the process of patient care, but I've been impressed as I've talked to some of my colleagues who've begun to use it - that they have learned things that they did not know about how to best take care of their patients. There's also emerging data showing that in states that have had the required mandate to use the PDMP, there's been about a 10 percent decline in Medicaid expenditures related to opioid medications.

3:57:21 PM

Mr. Butler spoke to the three aspects of the PDMP with prepared remarks:

> It authorizes the Department of Commerce, Community and Economic Development to issue regular, unsolicited reports to prescribers, sometimes called report cards. These would be issued to all providers registered in the PDMP and it would simply provide a non-punitive feedback source for each provider on his or her prescribing practices for opioids and how that compares to that of their peers. In talking with colleagues and thinking about what are some of the things that we need to do to address opioids, this is a concept that was actually suggested to me by some providers as a way to use the PDMP as an educational tool and a self-check. Not unlike what's been done in some healthcare organizations to provide feedback on prescribing of antimicrobial drugs to be able to limit unnecessary use of those drugs that can lead to antimicrobial resistance. Roughly ten states have instituted similar programs.
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> The second aspect of the PDMP - the PDMP depends on timely data. Under SB 74 the reporting interval for pharmacies went from monthly to weekly. HB 159 proposes to further increase the reporting interval to daily as is already done in 25 other states. We do recognize that this is an administrative burden for some of our valued rural pharmacies who may not be as automated and are still preparing for the advanced weekly updates. The draft you have of HB 159 has an implementation date in mid-2018 for advancement to the daily updates to be able to give pharmacies time to be able to get up to speed.
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> Finally, HB 159 clarifies a point that was discussed during the SB 74 hearings last year and clearly defines the role of veterinarians with active DEA numbers and who have legal authority to prescribe opioids, requiring them to register in the PDMP. While I do not know how prevalent the problem is, perhaps you've heard some of the reports from the Lower 48 of people who've actually injured animals as a way to go to the veterinarian and try to obtain opioid

medications for personal use or for diversion. The goal of this portion of the bill is to help vets from becoming the go-to for opioids to be misused or diverted.

In closing, addressing the opioid epidemic in Alaska is going to take all of us. I'm not here to blame anybody and I think it's important that we don't go down that road - we all have to own the problem and address it. Congressman Hal Rogers from Kentucky, Chair of the House Appropriations Committee is a lawmaker that really has struggled with this and said it well when he said "no silver bullet exists to stem the tide of prescription drug abuse in America, the lack of an easy solution requires all of us to treat the opioid crisis as a nonpartisan issue and adopt an all-hands-on-deck approach." I believe HB 159 is part of Alaska's call for all-hands-on-deck to help support our fellow Alaskans living in recovery and reduce the number of persons who become newly dependent on these medications, while protecting the care of those who truly need them.

4:00:51 PM

Co-Chair Seaton referred to CDC recommendations distributed by his office (copy on file). He was concerned about the seven-day time limit language in the bill. He explained that the CDC specified that three days or less was often sufficient for acute pain and that more than seven days would rarely be needed. He wondered how Dr. Butler would feel about intent language in the legislation detailing that although there was a seven-day maximum that it should not be considered a standard and that prescribers should err on the side of the lower limit if it appeared sufficient.

Mr. Butler believed the idea was very reasonable because it would not define the limitation prescriptively, but it would reiterate the intent of the bill to keep the dose low and the amount of pills as small as possible to meet the clinical needs. The language would also provide the flexibility for the professional judgement of the provider.

Representative Wilson thought it appeared government was trying to play doctor with the legislation. She surmised prescriptions of 120 pills at a time should already be

against the rules and that a bill should not be needed. She thought the bill insinuated that controlling the amounts a doctor could prescribe would solve the whole issue and that the only place people were getting the drug was from doctors. She asked if her understanding was accurate.

Mr. Butler answered "no, absolutely not." He did not believe it was government's role to dictate how medicine is practiced. However, he believed there was a role for government to define some parameters, which sometimes may require definition in statute to have the ability to address the challenge of the large numbers of pills that were sometimes dispensed. He referred to the current medical, nursing, and pharmacy boards that issued licenses and oversaw the quality of care. He detailed there were times the state needed to help redefine and direct the standard of care. He noted that medicine was certainly practiced differently than it had been 100 years earlier. Additionally, "where we are in 2017 is a little different place than we were in 1997." He continued that there clearly needed to be some sort of check, particularly when it came to pain management. From about 1995 to 2010 the nation started prescribing four-fold the number of opioids, which had been accompanied by a four-fold increase in overdose deaths; however, there was no evidence there had been a decline in chronic pain. The nation had been "doing something with the goal of an outcome that we didn't achieve, with clearly adverse effects."

4:05:12 PM

Representative Wilson did not have a problem with a standard of care. Her issue was with government identifying the standard of care. She specified that physicians attended school for a significant amount of time and were required to have a certain number of continuing education. She surmised the bill was trying to control doctors who were prescribing too much; however, it would also regulate doctors already using best practices. She wondered why the medical board would not set the regulations and do its own monitoring. She thought the board already had the tools to handle the issue if a physician was overprescribing.

Mr. Butler responded by quoting a colleague who had objected vociferously to some of the measures in SB 74 [Medicaid reform legislation passed in 2016] that "it seems like just putting out clinical guidelines isn't changing

things fast enough." He underscored that the bill would not make everything go away, but it was part of the way to address the problem. He believed there were two aspects in the practice of medicine where "we're not doing everything we should." The first was addressing how pain is managed and understanding that opioids are like a third level. He referred to the recent guidelines from the American College of Physicians and explained there was much more emphasis on nonsteroidal anti-inflammatories, but also some alternative pain management strategies including massage and physical therapy. However, too often opioids were the first thing that were used.

Representative Wilson did not understand why government was managing doctors and why doctors were not managing themselves. She wondered if the committee would hear expert testimony from physicians about how practices had changed. She did not think it was so simple that the problem would be solved if government merely told doctors what to do or how to prescribe.

Co-Chair Foster replied that his office would work with Representative Wilson's office on her request.

4:08:29 PM

Vice-Chair Gara wanted to get at least a partial solution out as soon as possible. He agreed that he did not see a full solution in the legislation; however, he did not want to slow down a partial solution just because no one had a full solution at present. He shared he had experienced pain from broken ribs and back surgery, but in his "limited pain experiences" he had never wanted more than three days' worth of a pain prescription. He wondered why there would not be a three-day limit for certain types of pain and the requirement for a doctor to explain in a patient's chart the reason for needing to prescribe more than the three-day limit (five to seven days).

Mr. Butler responded that he was unsure where the "sweet spot" was. He believed the idea was to provide as much opportunity for the professional judgement of the provider to be able to determine the appropriate amount and to define some guidelines and guardrails (that did not currently exist) because some very large amounts of opioids were sometimes dispensed. Additionally, the goal was to call attention to the seven-day limit by requiring

documentation in the record. He had often heard physicians prescribe something "just in case you need it." He believed the strategy was probably not a good indication for opioids, particularly if a prescription included 30 to 50 tablets. He shared that he had been surprised to find a prescription of that amount in his medicine cabinet when his daughter had recently had some dental work done.

Vice-Chair Gara agreed that the doctor would know best. He reasoned discretion would still be given to the doctor if there was a three-day limit with the option for a physician to provide an explanation that a patient needed more. He asked what happened when an individual did not live in a location with a drugstore in rural Alaska. He asked how the patient would receive a renewal in time if needed.

Mr. Butler answered that it was an aspect of the bill that was fairly unique compared to the language in some other states and compared to language in Senator John McCain's bill introduced in the U.S. Senate. He detailed that HB 159 specifically called out the situation of the rural resident who may have logistical or travel challenges being able to get to a pharmacy as a valid waiver to the seven-day limit.

Co-Chair Foster requested to hear from Mr. Butler via teleconference during the next HB 159 bill hearing.

HB 159 was HEARD and HELD in committee for further consideration.

Co-Chair Foster addressed the schedule for the following day.

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ADJOURNMENT

4:14:01 PM

The meeting was adjourned at 4:14 p.m.