**House Finance Subcommittee on Health and Human Services**
**Thursday, November 17, 2016**

**Testimony of**
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Chairman Sprague, Ranking Member Sykes and members of the House Finance Subcommittee, on behalf of the Ohio Association of Health Plans (OAHP), thank you for the opportunity to testify today on Senate Bill 319. I am Miranda Motter, President and CEO of OAHP.

The Ohio Association of Health Plans (OAHP) is the leading state trade association representing the health insurance industry. OAHP members provide health benefits to more than 9 million Ohioans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare, Medicaid and the Health Insurance Exchange marketplace. Our members offer a broad range of health insurance products to Ohioans in the commercial marketplace and are committed partners in public programs.

Like all parties who have come before this panel to testify on Senate Bill 319, OAHP recognizes that communities and families across Ohio are now at the forefront of a national dialogue about the tragedy that comes with opiate dependency.

I would like to commend and thank the bill's sponsor, Senator Eklund, for his leadership on this effort. Senate Bill 319 introduces several reforms that will assist Ohio in its continued fight against opiate abuse. While the bill's provisions certainly point Ohio in the right direction, the Ohio Association of Health Plans, in fact, believes there is opportunity to take even a few more steps forward.

I am testifying because OAHP believes SB 319 provides the Ohio General Assembly an opportunity to significantly reform and improve prescribing practices as they relate to the purchase, distribution, and delivery of opioid medications for the treatment of both chronic and acute pain.

As this panel continues to consider the provisions contained in SB 319, OAHP asks that you also consider the Center for Disease Control's (CDC) 2016 Guidelines for Prescribing Opioids for Chronic Pain. OAHP believes that these recently released guidelines can serve as an effective framework in achieving many of the overall goals of SB 319. Broadly, there are 12 recommendations in the guidelines with the three following principles key to improving patient care:

1) Nonopioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care.

2) When opioids are used, the lowest possible effective dosage should be prescribed to reduce risks of opioid use disorder and overdose.

Providers should always exercise caution when prescribing opioids and monitor all patients closely.

Long-term opioid use can often be traced back to the treatment of acute pain. Because of this, the CDC guidelines also provide prescribing guidance specific for acute pain. Recommendation #6 of the guidelines states, that "when opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed."

Full details about the guidelines can be found at www.cdc.gov.

We believe that the CDC guidelines are a "game-changer." However, today in Ohio, they are not actually guidelines; rather, they are just – recommendations. We know there has been a significant amount of work done to date in Ohio relative to prescribing; yet, Ohio continues to be several steps behind the new, comprehensive national standards, as well as the prescribing limits being adopted in states such as Arizona, Connecticut, and New York. With that said, OAHP strongly recommends that Ohio follow suit and codify the CDC prescribing guidelines, which represent an aggressive, evidence-based approach to combating our opioid problem.

Additionally, for several months, word circulated that House Bill 248, or provisions contained in it, may be amended into SB 319. House Bill 248 would require health insurers to provide access to opioids with abuse deterrent formulas (ADFs) and impose restrictions on the utilization tools insurers use to ensure appropriateness and safe prescribing. In short, such an approach attempts to combat opioid addiction by prescribing a different type of highly addictive drug.

ADFs do not prevent abuse or addiction and may lead to a series of unintended harmful consequences. Moreover, any attempts to limit or restrict the use of pharmacy benefit tools – such as prior authorization and step therapy – must be carefully considered, as these tools are in place to help combat opioid misuse.

Amending HB 248 into the legislation pending before this Subcommittee would be counterintuitive to the overall goal that is shared by SB 319, the CDC in introducing their evidence-based guidelines, and other state frameworks being implemented across the country. Again, because of that, OAHP would be opposed to seeing House Bill 248 rolled into Senate Bill 319.

On behalf of OAHP, again, I would like to thank you for the opportunity to testify on Senate Bill 319, and we appreciate your commitment to combatting the opiate crisis that is affecting so many families and communities across our state. We stand ready to partner with policymakers on this very important issue.

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**CDC Guidelines for Prescribing Opioids for Chronic Pain – 2016**

http://www.cdc.gov/media/dpk/2016/dpk-opioid-prescription-guidelines.html

*Determining When to Initiate or Continue Opioids for Chronic Pain*

1. Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. Opioid therapy should only be considered when the expected benefits for both pain and function are anticipated to outweigh risks to the patient. When opioids are used, however, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy.

2. Before opioid therapy for chronic pain begins, clinicians should establish treatment goals with all patients. Such goals should be realistic in addressing pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before and throughout opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy. Both patient and clinician responsibilities for managing therapy should be addressed.

*Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation*

4. At the beginning stage of opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids rather that extended-release/long-acting (ER/LA) opioids.

5. When opioid therapy begins, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day

6. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids. Clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Additional evaluations for continued therapy should occur every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

*Assessing Risk and Addressing Harms of Opioid Use*

8. Both before starting and then throughout continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose are present. Such factors include histories of overdose or substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use.

9. Clinicians should utilize state prescription drug monitoring program (PDMP) data to review a patient's history of controlled substance prescriptions. This will assist clinicians in determining whether a patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. PDMP data should be reviewed when starting opioid therapy for chronic pain and periodically throughout the duration of opioid therapy.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy. Clinicians are also encouraged to use urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment for patients with opioid use disorder. Often times, this is medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies.