Legislative History for Connecticut Act

PA 19-191

HB7159

Transcripts from the Joint Standing Committee Public Hearing(s)
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7654-8447

Chamber.

DEPUTY SPEAKER CANDELARIA (95TH):

Have all members voted? Please check the board to ensure that your vote has been properly cast. If all members have voted, the machine will be locked and the Clerk will take a tally.

Will the Clerk please announce the tally?

CLERK:

House Bill No. 7179 as Amended by House "A"

Total Number Voting	145
Necessary for Passage	73
Those voting Yea	127
Those voting Nay	18
Absent not voting	6

DEPUTY SPEAKER CANDELARIA (95TH):

The Bill as amended passes [Gavel]. Will the Clerk please call Calendar No. 307?

CLERK:

On Page 66, House Calendar 307, Substitute House Bill No 1759 AN ACT ADDRESSING OPIOID USE. Favorable Report of the Joint Standing Committee on

Public Health.

DEPUTY SPEAKER CANDELARIA (95TH):

Representative Steinberg, you have the floor, sir.

REP. STEINBERG (136TH):

Thank you, Mr. Speaker. I move for Acceptance of the Joint Committee's Favorable Report and Passage of the Bill.

DEPUTY SPEAKER CANDELARIA (95TH):

The question is on Acceptance of the Joint Committee's Favorable Report and Passage of the Bill. Representative Steinberg you have the floor.

REP. STEINBERG (136TH):

Thank you, Mr. Speaker. We must be going on a half dozen years now that we have tried legislatively to address the many problems of the opioid epidemic has created here in the State of Connecticut. Each year we bring forward a Bill which is the result of the good efforts of many people, stakeholders across the spectrum and this is particularly important because the insidious aspect

of opioid addiction affects us in so many ways. We are inclined to look at various ways in which we can address the problem from identification, prescription, education, intervention, law enforcement and then ultimately treatment and recovery and support services. We recognize that there is no one solution to addressing the opioid epidemic. We seem to have maybe leveled off in terms of the number of fatalities here in the State of Connecticut but we know there is much more for us to do. So we've convened a working group. I also want to thank the involvement of the Governor's Office has put forward a very aggressive agenda. I want to thank the good Chair of the Insurance Committee, Representative Scanlon, my Ranking Member Representative Petit and a variety of members from both sides of the aisle and from the Senate who have participated in an ongoing working group to identify new ideas that we can peruse in this context. Mr. Speaker, the Clerk is in possession of an Amendment LCO 10686. I ask that the Clerk please call the

Amendment and I be granted leave of the Chamber to summarize.

DEPUTY SPEAKER CANDELARIA (95TH):

Will the Clerk please call LCO No. 10686 which will be designated House Amendment "A".

CLERK:

House Amendment Schedule "A" LCO No. 10686

offered by Representative Steinberg, Senator Daughtery-Abrams.

DEPUTY SPEAKER CANDELARIA (95TH):

The Representative seeks leave of the Chamber to summarize the Amendment. Are there any objections to summarization? Hearing none, Representative Steinberg, you have the floor, sir.

REP. STEINBERG (136TH):

Thank you, Mr. Speaker. As I just mentioned, our goal each year is to see a variety of different ways in which we can help ameliorate the problem that has been created by the introduction of opioids into our society. So what we have before us is an extensive Bill covering some 16 sections.

DEPUTY SPEAKER CANDELARIA (95TH):

[Gavel] [Gavel] Please proceed, sir.

REP. STEINBERG (136TH):

Thank you, Mr. Speaker. So each of these Section touches on a somewhat different area. I'm gonna just quickly run through some of the areas of interest for people and then we will open it up for questions. The first sections require pharmacists and pharmacy employees to offer advice and counseling to a patient when they are filling their use of an order and to keep records of these consultations. Section three designates trained pharmacy technicians to consult the Connecticut Prescription Monitoring and Reporting System before filling a prescription to make sure the person receiving the prescription is the appropriate person and there is no pattern of abuse.

Section four deals with drug manufactures and wholesalers requiring them to report to the Department of Consumer Protection decisions they make to terminate or refuse an order to, from a

pharmacy or a prescribing practitioner. Again intended to head-off abuse of over prescribing.

Section five deals with insurance companies, prohibiting life insurance or annuity policies from excluding coverage solely based on an individual having received a prescription for naloxone or a biosimilar. Once again we want to solve the problem and not this is one way we're gonna do it.

Section six deals with chronic opioid prescriptions of more that 12 weeks which requires prescribing practitioners for anybody for more than 12 weeks supply to establish a treatment agreement with the patient. This is obviously the exception to the rule, somebody who has a long-term need for opioids we are going to be even more explicit about the need for an explicit plan for those people.

Section seven deals with how we address the potential of using Narcan in facilities in higher learning. It requires higher educational institutions by January of 2020 to provide and maintain a supply of opioid antagonists and they

must adopt policies generally requiring the institutions to maintain supplies of the product and to notify EMS or 911 should an event occur on their premises.

Section eight requires DMAS in collaboration with DSS and DPH to review literature on the efficacy of licensed substance use disorder treatment service provided in the homebased treatment setting. There are examples in other states the homebased approach being a very effective and efficient way to deal with people in the Committee and help them with their opioid issues.

Section nine requires treatment programs to, that provide treatment or detox services to educate them on the use of opioid antagonists and issue a prescription for or deliver to the patient at least one does of an opioid antagonist to prepare them for that prospect.

Almost done, Section ten requires EMS personnel to complete mental health first aid training. We ask a lot of our first responders and in this case

they are often the first ones on the spot. Giving them some training in mental health may make all the difference in having them make good decisions and helping people who maybe have overdosed on opioids.

Section 11, requires hospitals to administer a mental health screening or assessment if a patient is treated for a nonfatal opioid drug overdose. Again there is an opportunity at the hospitals to intervene and to help somebody get a mental health screening to hopefully avoid repeated use of opioids.

Section 12 clarifies language which allows behavioral health providers not just mental health providers to serve a counselors.

Section 13 is a more controversial section where we are asking DMAS in collaboration with DHP to study the protocol for the police detaining people who they suspect of having experienced an opioid overdose and the implication of involuntarily transporting them who have overdosed to a safe setting, a hospital or to, in contact with a

recovery coach. I think that's good for now. Thank you, Mr. Speaker. I move adoption.

DEPUTY SPEAKER CANDELARIA (95TH):

Question before this Chamber is on adoption? Will you remark? Representative Candelora? Representative Scanlon? Representative Petit.

REP. PETIT (22ND):

Thank you, Mr. Speaker. I was going to reserve comments to the Bill but as this Amendment is the entire Bill, I can make some comments right now. I think it was a great group effort. I thank the Good Chairman for his leadership. I would also thank our Senate colleagues, Senators Somers and Abrams for their participation. We had people from a wide array of services. People on the frontlines, first responders, those involved with chronic substance abuse, rehab people from the university system, people from the medical society, nursing associations, APRNs etc. so it was a very well-rounded working group. I think it is a well thought out, it's really been in evolution since January

until today. I would point out that I think Section four on the diversion and trying to stop diversion when it is going on in large levels is an important part of it. Section five was something I never thought of before if you are a parent or you are someone who wants to have narcotic antagonist and you want to have it so you can save a friend, save a child, that you are not denied the ability to obtain insurance just because you've obtained a prescription for naloxone. We had great discussions with university system in terms of what they needed to do to make sure that naloxone and narcotic antagonists were available throughout the campus and I think the good Chairman spoke to the issue of diversion. I would not that there was probably three or four folks from the Democrat side of the aisle and three or four folks from the Republican side who submitted variation of Bills to the Committee about attempting to take care of people who had been treated in the field that is someone who overdoes near death, receives Narcan, wakes up

and tells the first responders hey, I'm great just drop me off or let me go back home and they go and overdoes again and sometimes die. We had many poignant testimony from parents and friends of people who were not transported who ended up eventually dying. It is a controversial issue in terms of civil rights and whatnot so I think studying this further and it is an issue we are going to take up in earnest next year.

I think all in all it is a great effort for the people of Connecticut. There is still more work to do in terms of this crisis and I urge all my colleagues to support the Amendment and then the final amended Bill. Thank you, Mr. Speaker.

DEPUTY SPEAKER CANDELARIA (95TH):

Thank you, sir. Will you care to remark further? Representative Hall. You have the floor, ma'am.

REP. HALL (7TH):

Thank you, Mr. Speaker. I rise in support of this Amendment particularly the last item that the

good Representative Petit commented on. I came before the Health Committee to discuss the protective custody statute. Massachusetts and all our surrounding states do transport overdosed patients that have been narcaned directly to the ERs and there is a limited amount of time that they can be held in the ERs. The families appreciate this because there is no real way to get their loved one the help they need if they can't be transported to the hospital because I think if you talk to any law enforcement once a patient is narcaned their first inkling is to get up and leave. There is a very rare circumstance where any patient or person who overdoses askes to be transported to the hospital, they go back, they overdose again. So I for one, am thrilled to see this in the Amendment that we're going to take a look at this closer over the course of this coming year. I think if we study our surrounding states that already do this, Massachusetts in particular has had some really great success in their opioid programs. So I

applaud the Health Committee for the work on this opioid Bill. I truly, truly know it is going to make a difference in a lot of patients' lives and I thank you and I stand in support of the Amendment. Thank you, Mr. Speaker.

DEPUTY SPEAKER CANDELARIA (95TH):

Thank you, madam. Will you care to remark further on the Amendment? Representative Scanlon you have the floor, sir.

REP. SCANLON (98TH):

Thank you very much, Mr. Speaker. About two hours ago the Hartford Police Department had a press conference and at that press conference they said that in the last 15 hours five people have fatally overdosed from an opioid overdose within one mile of where we are all sitting here today. Five people in 15 hours all of them are dead. This story is not unique to Hartford. This is happening according to the statistics in 159 of the 169 towns in our State. You guys do the math. That means that only ten communities in the last year did not suffer a fatal

overdose. That is devastating. That is an epidemic and that is why we are doing this. As the Chairman reference earlier this is the sixth year, I believe, that we have done a comprehensive bipartisan package but it will never be enough. There is never enough that we can do to declare victory on this. We had 1,000 people in our State die from this last year. More people have died in one-year, last year than in the entire Vietnam wars, 60,000 Americans lost their life to this and so I just want to get up and give that context that this is not a problem we've solved. We have made progress and I am deeply grateful to the Chairman, the Ranking Member and the other members of the working group that we worked on this. But we can never, even accept this fact that five people, five human beings, five loved one, died just in the span of 15 hours, not far where we are standing right now and those people, and those who are suffering and those who deserve treatment are the people that we have to always remember, every single day and I am glad that we are doing that now

by addressing this Bill. I thank the Chairman and I hope all my colleagues will support this on both sides of the aisle. Thank you.

DEPUTY SPEAKER CANDELARIA (95TH):

Thank you, sir. Will you care to remark further on the Amendment? Do you care to remark further on the Amendment before us? If not, I will try your minds. All those in favor please signify by saying, aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER CANDELARIA (95TH):

Those opposed, nay. The aye's have it, the Amendment [Gavel] is adopted. Will you remark further on the Bill as Amended? Representative Steinberg. You have the floor, sir.

REP. STEINBERG (136TH):

Thank you. I just wanted to thank Representative Scanlon for not only his collaboration on the legislation we see before us but for all of his hard work over the past half-

dozen years. He has been a leader in this legislature in trying to address the opioid epidemic in so many different ways and it has been a wonderful partnership between the Insurance Committee and the Public Health Committee as we've been moving this forward. And just to reiterate what he and Representative Petit have said, this has been bipartisan, this has been in collaboration with not only the Senate, explicitly with the Governor's Office that feels very strongly about this and if I recall has put close to $5 million dollars into the budget to look into medication assisted treatment options in the prison system which is another important aspect of this initiative. I should also add that the working group that came up with a bunch of ideas, not all of which we could act on this year, and I think it should be encouraging to everybody we have a bunch of good ideas for the next session, some of which will require further study and public hearings and involvement of various other experts but there is never a shortage of things we

can do and you have the commitment of this Committee that we'll continue to do so. Thank you, Mr. Speaker.

DEPUTY SPEAKER CANDELARIA (95TH):

Thank you, sir. Will you care to remark further on the Bill as amended? Representative O'Dea, you have the floor, sir.

REP. O'DEA (125TH):

Thank you very much, Mr. Speaker. I just want to briefly stand up and thank the good Chair for his work on this and the Ranking Member. This was back, you know, when I first got elected, Representative Jerry Fox and I had worked on adding the application of Narcan in giving people who use it immunity and that has saved a number of lives and this is obviously taking another step further. You may all remember we actually also passed a Bill allowing municipalities or giving them immunity if they put the Narcan in where defibrillators are throughout. So I do encourage my colleagues to support this. This opioid epidemic is spreading through the

country and impacting our, frankly our cities more so but even also affecting every municipality in our State. And at the risk of alienating some on the other side I am very happy that we did not, or have not, I guess we still have 24 about 28 hours left but we are not proceeding with marijuana which I am glad to see. So with that I would encourage my colleagues to support this Bill. Thank you very much.

DEPUTY SPEAKER CANDELARIA (95TH):

Representative Petit you have the floor, sir.

REP. PETIT (22ND):

Thank you, Mr. Speaker. Just very quickly to follow up on the good Chairman. The Governor's Office as fabulous in putting these ideas together. I think I left him out of my comments but they worked very hard, they helped us make a lot of changes to the Bill so I really appreciate the way they really dug into the Bill and worked hard on this and with a comment added, this is not a good Bill it is an excellent Bill and it definitely

should pass and we need to move forward with the further ideas the working group has going forward. But thank you, Mr. Speaker.

DEPUTY SPEAKER CANDELARIA (95TH):

Thank you, sir. Will you care to remark further? Representative Carney you have the floor, sir.

REP. CARNEY (23RD):

Thank you very much, Mr. Speaker. I just wanted to arise for a comment. I appreciate the good Chairman of Public Health for his work on this as well as Representative Scanlon and all my colleagues. I just wanted to say though when we think about the opioid issue we do need to think about the addicts and making sure that we can save lives but we also need to make sure that we think about the family members of those addicts. When folks bury a loved one because they are a drug addict, it's horrible, it's absolutely horrible. I've seen it in my community, loving families that have had to deal with a family member that has a

opioid addiction and then that day comes when they get that phone call and I know because since I've been a State Rep a very close family member of mine has passed away from this. So I do think that this is a wonderful Bill and we do need to continue to fight this epidemic as much as we can, not just for the addicts but also for the families. So, thank you very much, Mr. Speaker.

DEPUTY SPEAKER CANDELARIA (95TH):

Thank you, sir. Will you care to remark further? Representative MacLachlan. You have the floor, sir.

REP. MAC LACHLAN (35TH):

Thank you, Mr. Speaker. Just a brief comment on the Bill.

DEPUTY SPEAKER CANDELARIA (95TH):

Please proceed, sir.

REP. MAC LACHLAN (35TH):

Thank you, sir. I just wanted to thank the good Chairman Public Health Committee, good Ranking Member, the good Chairman of the Insurance Committee

as well, the Ranking Member of the Insurance Committee. I've learned over the last four-and-a-half years of representing the 35th District that this is an epidemic that affects every community and requires participation and cooperation, efforts from State matched with the efforts of local individuals who give of their time and I just want to take a minute to recognize the organizations in my district that have really stepped up particularly in the Town of Clinton, Partner's in Community as a advocacy organization for youth prevention of drug abuse, the Clinton Police Department that recently won an award for Committee policing has done a great job of outreach in the community as well as our Youth and Family Services. I just want to thank the members of this House for continuing to push the envelope on addressing this epidemic that stretches across the State. Thank you, Mr. Speaker.

DEPUTY SPEAKER CANDELARIA (95TH):

Thank you, sir. Will you care to remark further? Representative Klarides-Ditria, you have

the floor, madam.

REP. KLARIDES-DITRIA (105TH):

Thank you, Mr. Speaker. I would like to make a comment, I would like to thank the Chair of the Public Health Committee for your hard work on this Bill, the Ranking Member of Public Health. As we know the opioid addiction problem is not getting any better in our country so anything we can do to help with this issue I thoroughly support and encourage all my members to support this Bill. It is a good Bill, ought to pass. Thank you.

DEPUTY SPEAKER CANDELARIA (95TH):

Thank you, madam. Representative Smith, you have the floor, sir.

REP. SMITH (108TH):

Mr. Speaker, thank you. On Sunday we all had the day off after a long week being up here in the Chamber. Sunday night my wife and myself stood in line for an hour-and-a-half at a wake and the wake was for a young gentleman, about age 30 who lost his life. He lost his life due to this epidemic and

when Representative Currey talked about how it affects the families, and how it affects the communities really, because our community came out in full force to support this family that lost their child to this drug and it bring tears to your eyes, Mr. Speaker. So it just doesn't play favorites, it's not just in the cities, it's not just where you think it might be, it's everywhere. And everywhere was Sunday in New Fairfield. So I'm getting a little choked-up cause I remember, I recall just giving my daughter who is very, very good friends with this young man, you know that tight hug that, tight hug you want to give your children, we just don't do it enough because you never know, you know, you just never know. So I know this Bill will pass and I wanted to thank the Chairman for bringin it out and the Ranking Member for helpin, and for this legislature for this Chamber for pursuing this cause really to help your youngsters fight, fight, fight this addiction because it's taken over and it's winning and we need to fight hard and continue to

fight every year, so God bless the family, the families that have lost their children and let us continue to do the right thing. Thank you, Mr. Speaker.

DEPUTY SPEAKER CANDELARIA (95TH):

Thank you, sir. Will you care to remark further on the Bill as amended? Will you care to remark further on the Bill as amended? If not will Staff and guests please come to the Well of the House. Members please take your seats; the machine will be open. [Ringing]

CLERK:

The House of Representatives is voting by roll, Members to the Chamber. The House of Representatives is voting by roll, Members to the Chamber.

DEPUTY SPEAKER CANDELARIA (95TH):

Have all members voted? Please check the board to ensure that your vote has been properly cast. If all members have voted, the machine will be locked and the Clerk will take a tally.

Will the Clerk please announce the tally?

CLERK:

House Bill No. 7159 as Amended by House "A"

Total Number Voting	148
Necessary for Passage	75
Those voting Yea	148
Those voting Nay	0
Absent not voting	3

DEPUTY SPEAKER CANDELARIA (95TH):

The Bill as amended passes [Gavel] Would the Clerk please call Calendar No. 568.

CLERK:

On Page 41, House Calendar 568 Substitute Senate Bill No. 964, AN ACT CONCERNING COURT OPERATIONS. Favorable Report of the Joint Standing Committee on Judiciary.

DEPUTY SPEAKER CANDELARIA (95TH):

Representative Blumenthal you have the floor, sir.

REP. BLUMENTHAL (147):

Thank you, Mr. Speaker. I move for Acceptance

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welcome your daughter as well, a future leader. And with that Mr. Clerk -- Senator Duff.

SENATOR DUFF (25TH):

Thank you, Madam President. Madam President would the Clerk now please call Calendar Page 60 -- I'm sorry, mark it go. Calendar Page 60, Calendar 681, House Bill 7159, if the Clerk would mark that as go and the next order of business, please.

THE CHAIR:

Mr. Clerk.

CLERK:

Page 60, Calendar No. 618, Substitute for House Bill No. 7159, AN ACT ADDRESSING OPIOID USE, as amended by House Amendment Schedule "A", LCO No. 10686.

THE CHAIR:

Good afternoon, Senator Abrams.

SENATOR ABRAMS (13TH):

Thank you, Madam President. I move acceptance of the Joint Committee's Favorable Report and passage of the Bill in concurrence with the House.

THE CHAIR:

And the question is on acceptance. Will you remark?

SENATOR ABRAMS (13TH):

Thank you, Madam President. Over the past six years, from 2012 to 2018, we've had a steady increase of opioid deaths among Connecticut residents. In -- in 2016, Connecticut ranked 11th among states in the highest rates of overdoses. However, these statistics are extremely frightening, but we must always remember that each of these numbers represent someone special, a loved one, a friend, a family member, a neighbor. Therefore, we owe it to everyone in Connecticut to fight this surge of opioids because every life is worth saving.

It is with that intention that this Bill comes out as a culmination of the tremendous efforts of many people, from the Governor, to our leadership in both the House and the Senate, to elected officials on the state level and the municipal level, from agencies, particularly the Department of Mental Health and Addiction Services, the Department of Public Health, and the Department of Social Services.

We've spoken to constituents to business communities, both private and public, and they've all come together. And I think that -- that is reflected in the Bill before us. In this Bill, it requires that pharmacists and pharmacy employees, with certain exceptions, offer counseling to patients about drugs and it's uses. And it requires pharmacists to keep records for three years on this counseling, and the patient's refusal or inability to accept the counseling. It allows pharmacists to designate trained pharmacy technicians in consultation with the Connecticut Prescription Monitoring Reporting system to keep track of the drugs that are -- the controlled substances prescriptions that are dispensed.

It requires drug manufacturers and wholesalers to report to the Department of Consumer Protections any decisions to terminate or refuse an order from an pharmacy or prescription practitioner for a Schedule II to V controlled substance. This applies when the manufactural wholesale -- wholesaler has concerns of potential diversion. And it allows the Department of Consumer Protection to designation an electronic system for reporting.

It prohibits life insurance and annuity policies from excluding coverage solely on the basis of an individual having received a prescription for Narcan or -- or bio simulator or generic of the same kind. It's prescribing -- it asks prescribing practitioners who prescribe opioid drugs for more a 12-week supply, to establish a treatment agreement with the patient and discuss the clear -- a care plan for chronic opioid drug use which includes non-opioid treatment options. It also requires higher education institutes, by January 1st, 2020, to provide and maintain a supply of opioid antagonists that are accessible to students and employees, and to adopt policies generally requiring institutions to notify EMS providers after an opioid antagonist has been used.

It requires the Department of Mental Health and Addictive Services in collaborations with the Department of Social Services and the Department of Public Health to review literature on the efficacy of life and substance use disorder treatment service providers, providing homebased treatment and recovery services to individuals with opioid use disorder. And the report is to -- to be -- the outcome of the report is to be sent to the Public

Health and Human Services Committees by January 1st, 2020.

It also requires treatment programs that provide treatment and detox services to individuals with opioid use disorder to educate them on opioid antagonist and their use and to offer education to patient's relatives and significant others. And -- and issue a prescription for and delivery to the patient at least one dose of an opioid antagonist if a program affiliated prescribing practitioner thinks he or she will benefit from this access.

It requires EMS personnel to complete mental health and first aid training. It requires hospitals starting January 1st, 2020 to administer mental health screening or assessment on a patient it treats for a non-fatal opioid drug overdose and it must provide the results of the screening or assessment as medically appropriate to the patient or the patient's parent, guardian or legal representative as applicable.

It clarifies -- it makes a clarifying change to the laws on supervision, certification for alcohol and drug counselors, specifying that behavioral health may supervise -- behavioral health providers may supervise them.

It requires the Department of Mental Health and Addiction Services, in collaboration with the Department of Public Health and other relevant entities, to study a protocol for police detaining people whom they suspect having experiences of an opioid overdose and the implications that involuntary transporting people who overdose to ERs and referring them to recovery coaches. It requires

that DMHAS report to the Public Health Committee with this information by January 1st, 2020. As you can see, this Bill is quite comprehensive, and I think it needs to be, because this is a serious epidemic in our state and in our country and it needs to be dealt with on many levels. And I thank all of the people, including the members of the Public Health Committee who came together to work with the stakeholders and find the best ways to intervene. Thank you.

THE CHAIR:

Thank you, Senator Abrams. Will you remark further? Senator Somers.

SENATOR SOMERS (18TH):

Yes. Thank you, Madam President. And I rise in support of this Bill. This is a Bill that is a culmination of work out of the Governor's Office and the Public Health Committee combined into one Bill. And as many of you know, we have passed some significant and very powerful opiate legislation in the past. I think that you will end up seeing each year, a new attempt to create legislation to help us curtail the opiate epidemic that we're experiencing in Connecticut and across the country.

Some of our cities and towns are experiencing a very acute, I'll say symptoms of opiate disorder problems. And as, you know, just yesterday in Hartford, we had a situation where we had 15 people overdose, and five fatalities. But that was fentanyl. And that is something that the Public Health Committee will be looking at going forward. It was interesting, when the Public Health Committee

got together a subcommittee on opiates. We had law enforcement. We had mental health workers. We had clinicians. And one of the things that came to our attention was, not only how dangerous the opiate epidemic is, but it is dangerous for those who care for those who have this addiction. And just the police officer obtaining or touching someone who has had a -- a mixture of perhaps opiates laced with fentanyl can get sick from the fentanyl from just touching some of the remnants of the drugs that may be left behind.

So, I think that each year you will be seeing a new version. This Bill is comprehensive. It touches on many different areas, one of the most -- I think, really out of the box areas that I wanted to highlight was an idea that we are going to be studying what it's like to have a homecare based opiate disorder treatment plan and that's based on a visiting nurse model where you would have a behavioral health nurse, who is trained in mental health and addiction, actually go into the addict's home to check on them, to make sure that their nutrition is proper and that their home is in order, that they are complying with the life skills that they would need to be able not only help with their addiction but to move on to bigger and better things. And it has had success in other states.

This is something that I think the Public Health Committee would love to explore, of course we'd have to figure out how we're going to pay for it. But if we can measure the outcomes in a quantitative effort that show positive outcomes, I think we would be really be ahead of the curb in that respect, because we do know that treatment is difficult, it's long, it's expensive, and it's not always successful. So,

I would like to highlight that in this Bill.

And also, I would like to thank everyone who contributed to this. There was a lot of great input from folks on the Public Health Committee, also outside of the Public Health Committee, obviously the Hospital Association, the Medical Society, those trained in mental health. We had EMS providers. We had police chiefs. And everybody is all onboard -- excuse me -- to do whatever we can here in the state of Connecticut to try to curb this epidemic.

And I'm hoping, at some point, we won't have to have an opiate Bill and we would be able to focus on other areas. But until that time, I ask the -- the Circle to join us in supporting this Bill. Thank you.

THE CHAIR:

Thank you, Senator Somers. Will you remark further? Senator Anwar.

SENATOR ANWAR (3RD):

Thank you, Madam President. I rise in support of this Bill, strong support. This is personal to essentially everyone around the Circle because we may know within one or two people that within our -- your community, you will know people who have died. This is very real. Just about yesterday, there were about five people who died literally minutes away from where we are right now. And this was all opioid-related. This is preventable and this is going to require literally all hands-on deck.

This Bill is a starting point to try and address the

various weak links, if you will, which are in the system which would allow us to strengthen our capacity to fix this. I could speak on this for hours because I have lost people in the Intensive Care Unit literally one every month from opioid-related deaths. But in the interest of time and to cover more Bills today, I'm just going to say that, I would urge each and every one of us to please vote for this and -- and move forward so we can start to save some lives. Thank you, Madam President.

THE CHAIR:

Thank you, Senator Anwar. Will you remark further? Senator Witkos.

SENATOR WITKOS (8TH):

Thank you. Thank you, Madam President. This Bill was certainly a topic of -- of a lot of discussion and the recipient of a lot of Bill titles by a lot of members of a General Assembly. In fact, there was a Bill in the General Law Committee that basically almost did the exact same thing and it's a mirror of this Bill, except this Bill has a few more extra pieces into it. It was well received at -- at the public hearing, was passionate for the folks that came in and testified. And I think this Bill encompasses all the things that we'd like to do to move the state forward to addressing some of the opioid crisis. So, I urge adoption of the Bill. Thank you, Madam President. Thanks to all those on the other committees that worked on such things -- similar legislation.

THE CHAIR:

Thank you, Senator Witkos. Will you remark further on the Bill before the Chamber? Good afternoon, Senator Martin, to be followed by Senator Champagne.

SENATOR MARTIN (31ST):

Thank you, Madam President. I rise for a few questions to the proponent of the Bill.

THE CHAIR:

Please proceed, sir. Senator Abrams, prepare yourself.

SENATOR MARTIN (31ST):

Thank you, Madam President. Through you, Madam President. Has the -- since we've -- the public in particular, has been made aware of the opioid epidemic, how has -- has there been significant gains in dealing with the -- with the opioid epidemic itself? Through you, Madam --

THE CHAIR:

Senator --

SENATOR MARTIN (31ST):

-- President.

THE CHAIR:

-- Abrams.

SENATOR ABRAMS (13TH):

Yes, there have been.

THE CHAIR:

Senator Martin.

SENATOR MARTIN (31ST):

What -- what is there still to do, in your opinion? Through you, Madam President.

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

I'm sorry could you repeat that?

SENATOR MARTIN (31ST):

In your opinion, what do you feel we still need to do? Through you, Madam President.

THE CHAIR:

Senator Martin, thank you. Senator Abrams.

SENATOR ABRAMS (13TH):

I think this Bill carefully spells out all of the things that would be the next step.

THE CHAIR:

And Senator Martin.
SENATOR MARTIN (31ST):

Thank you, Madam President. And do you think that this -- this Bill, in itself, and maybe you could elaborate a little bit regarding how it will impact what we need to deal with. Through you, Madam President.

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

Through you, Madam President. This Bill, I think is very comprehensive and it's understanding of the problem of opioid uses disorder, bringing together a lot of different agencies and trying to look at it from everywhere from higher education and what they can be doing, to EMS workers, to hospitals, to pharmacists, to the agencies themselves, looking at what literature is out there and what programs are out there to report back to Public Health for the next session, so that we can continue to move forward. Through you, Madam President.

THE CHAIR:

Senator Martin.

SENATOR MARTIN (31ST):

Thank you, Madam President. And I have no further questions for the good Senator from the 13th. And I'd like to ask a few questions from the Senator from the 18th, please.

THE CHAIR:

That's fine. Senator Somers, prepare yourself. Please proceed, sir.

SENATOR MARTIN (31ST):

Thank you. Through you, Madam President. I believe you mentioned something regarding in-house or in-home behavioral health program. Can you describe a little bit about that program and how it would work to address the opioid disorder? Through you, Madam President.

THE CHAIR:

Senator Somers.

SENATOR SOMERS (18TH):

Yes. Thank you. Through you, Madam President. The -- this is an idea that came to the Public Health Committee during our subcommittee that we had focused just on this particular Bill. And it is a new idea. It is done in some other states. I believe Colorado is a state, if I'm remembering correctly. And what it does -- probably the easiest way to describe it is, it takes the idea of a visiting nurse model where they go into the home to change a wound or to make sure that somebody is looked after surgery, or if they're elderly. And it brings that model to the idea of someone who is already through detox. But instead of having somebody go into a facility or having to go someplace every day to get treatment, both for, you know, their mental health but also their addiction, the -- the nurse who is an advanced practice nurse who has a specialty in mental health and addiction,

would go into the person's home or where they're living.

And the value to it is, just like a visiting nurse, if the behavioral home nurse -- we haven't really come up with a title yet what it would be called, would go into the person's living condition, they could check on them, maybe three times a week. They could make sure that they are complying with their medication routine. They could also -- being in someone's home or the place that they live, gives a really intimate view as to what's going on, rather than having that person come to you, you're able to look at the living conditions, making sure there's the appropriate food in the refrigerator. You also have an opportunity to see, you know, if there's anything sitting around on the table that shouldn't be, you know, the whole picture is much more clear when you're in somebody's personal space, so to speak.

I know that when I used to take of wounds, when I would into somebody's house, I would always make sure that they -- look in their fridge, make sure they're eating properly.

And it just gives you another level of an assessment. It has been very successful, because these individuals are trained in that specialty, they form a -- a relationship with the patient who is going through the -- the process of becoming some who will always be an addict, but is coming through the process of coming off opiates. And it has shown to be -- as I said before, successful.

We would love to be able to pilot that. We talked about that. We just -- we're not able to locate a

grant that would fund it. But I think, if we could find pilot money or find grant money to be able to establish this type of system, it's new, it's cutting edge, we could really measure the outcomes as far as when somebody's gone through the process, is it a 30-day program where the -- the nurse goes in. What are the outcomes? Does someone move on from there? Are they able to, you know, be all out more independent without this type of medical supervision? Because sometimes the outcomes are not great for somebody going through rehab so to speak, for 30 days, is just not enough. So, we have to look at that. That -- that person also could be the key to help that individual hook up with the services they may need going forward. And I think it's definitely a value to look at something different than what we are doing, because what we're doing does not necessarily work for every individual.

So, thank you for that question. I'm hoping that maybe next year we'll come back with a defined model. But this at least gives us an opportunity to study it. Thank you. Does that answer your question?

THE CHAIR:

Senator Martin.

SENATOR MARTIN (31ST):

Thank you, Madam President. Somewhat. It sounds like it's not in the Bill what you're describing. But it's sort of an idea for something that we could address in the future, the program that you just described. Through you, Madam President.

THE CHAIR:

Senator Somers.

SENATOR SOMERS (18TH):

Yes, that's correct. It is just a study right now to look at it. But it is something that we would like to advance in the future.

THE CHAIR:

Thank you, Senator. Senator Martin.

SENATOR MARTIN (31ST):

Thank you, Madam President. It seems like the industry itself is -- is going towards homecare. And it sounds like the model would be in-line with what we are trying to achieve, particularly in cost savings in going to -- to homes rather than having the individual go to an -- to a facility itself. And I would think, in that program, and I'll just ask this, for something that you may want to consider when you start talking about such a program is, if that individual, I don't know if it's a nurse -- I'm assuming it will be an nurse or a --

SENATOR SOMERS (18TH):

Uh-huh.

SENATOR MARTIN (31ST):

-- qualified nurse or regardless if it's in behavioral health, specifically, but should that

individual go to a home and there is some type of abuse, child abuse, having sat on the Children's Committee for a few years and having dealt with someone who -- who died -- a child who died in one -- in my district, there was a reporting that was done and, unfortunately, because of the systems that we had in place, the flags that -- myself being a layman now, I haven't read the report, I realize that geez, here's a flag. Here's a flag. Here's a flag. But yet, that child was allowed to drop through the cracks. So, my question is -- my question is would that be part of the program that the whoever that person is visiting, noticing something within the household would be required -- and -- and if some type of child abuse, as an example, would it be mandatory reporting that would be required? Through you, Madam President.

THE CHAIR:

Thank you, Senator Martin. Senator Somers.

SENATOR SOMERS (18TH):

Yes. Thank you. Through you, Madam President. All clinical workers, whether a nurse, a doctor, you are a mandated reporter. So, if they saw something that you've described in the house that they were visiting, if this -- something like this were to come to fruition, then absolutely, they would have to report it.

And just to go over the -- what's written in the Bill, just so we can be clear, is that this is the review concerns providing medical assisted treatment -- and these are Medicaid recipients who visit an emergency room due to a -- a suspected

overdose and they -- with a primary or secondary opiate use disorder diagnosis, they'd have to be obviously diagnosed with a disorder and an emergency room doctor or other physician determines that this patient has a moderate to severe risk of relapse, that would sort of be the criteria for this type of program to go forward.

So, the idea is to provide consistency and support and -- and medical background to be able to help that individual not relapse, not go back to using opiates. And I think it's something that we should definitely explore.

THE CHAIR:

Senator Martin.

SENATOR MARTIN (31ST):

Thank you, Madam President. I was informed that I should -- should've asked the good Senator from the 13th to yield to -- to the -- Senator Somers. But I am at the end of my question -- questions. So, thank you so much. I appreciate the answer from both of you.

THE CHAIR:

Thank you, Senator Martin. Will you remark further? Senator Champagne.

SENATOR CHAMPAGNE (35TH):

Thank you, Madam President. I have a question for the proponent of the Bill.
THE CHAIR:

Senator Abrams, prepare yourself. Proceed, sir.

SENATOR CHAMPAGNE (35TH):

Through you, Madam President. I have a question about line 35 in the Bill. It talks about the pharmacist -- the pharmacist having to counsel the patient or somebody coming in to -- for the drugs that are on their prescription. Is this -- what -- what kind of drugs are we talking here?

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

Through you, Madam President. They would be -- it's for any drug that would be an opioid-based drug.

SENATOR CHAMPAGNE (35TH):

Okay.

THE CHAIR:

Senator Champagne.

SENATOR CHAMPAGNE (35TH):

Thank you, Madam President. And -- and I looked under Section -- through you, Madam President. I looked under Section B of -- of this and -- and I didn't see it said opioid. I may have missed it, though. I guess my question is, is how -- how long does this counselling have to last? Through you,

Madam President.

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

First of all, I just want to make a clarification that they are to offer the counselling, it's not required. A -- a person can refuse to participate in that. And the counselling is -- is just to discuss with them the -- the -- the drug itself and the use of it.

THE CHAIR:

Senator Champagne.

SENATOR CHAMPAGNE (35TH):

Thank you, Madam President. Thank you for that answer. And I -- and I can see that they can refuse it. I -- I guess, it also says that if I refuse, they're going to keep a log of this along with the prescription. So, I -- I -- I didn't know if this was -- how long you're going to keep this or -- or -- or what the purpose of keeping that log is for? Through you --

THE CHAIR:

Senator Abrams.

SENATOR CHAMPAGNE (35TH):

-- Madam President.

SENATOR ABRAMS (13TH):

Through you, Madam President. It would be three years.

THE CHAIR:

Senator Champagne.

SENATOR CHAMPAGNE (35TH):

Thank you, Madam President. And through you again, and -- and the purpose of having to keep it?

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

I believe the purpose is to maintain a record so that we can see if people were being appropriately informed about the drug and it's use and the consequences of it. Through you, Madam President.

THE CHAIR:

Senator Champagne.

SENATOR CHAMPAGNE (35TH):

Thank you, Madam President. And I guess that leads to my next question, even though we -- we keep track of this, how do we know what they're asking? What they're counselling? Are we giving out a form to tell them what to say? Through you,

Madam President.

THE CHAIR:
Senator Abrams.

SENATOR ABRAMS (13TH):

There -- through you, Madam President. There is a recording that's made, I believe it is, through a form of some kind. Through you, Madam President.

THE CHAIR:

Senator Champagne.

SENATOR CHAMPAGNE (35TH):

Thank you, Madam President. Okay. Thank you very much. And -- and -- and I guess that was -- that was one of my concerns. And -- and I guess, the other concern is, have we talked to the pharmacists or -- or the small businesses that -- owners of the pharmacies about what kind of time limits this is going to take up and if it will hurt their businesses? Through you, Madam President.

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

Not to my knowledge, Madam President.

THE CHAIR:

Senator Champagne.

SENATOR CHAMPAGNE (35TH):

Thank you, Madam President. I am for anything that will stop the opioid problem that we have. Again, we lost five here. This -- this year, we've lost several -- several people in my area in -- in -- in the 35th district, in fact, Stafford has been hit quite hard. And in fact, the -- the good Senator that sat in my seat for 26 years lost his grandson this year and a very sad situation.

I just want to make sure when we do this, that we do want to make sure that the pharmacists are onboard, that they're going to have enough time to -- to -- to counsel and -- and -- and it's not going to hurt the businesses. You know, it'd be great if we had a -- a -- the -- the form typed out, so if somebody refuses, we could just either put it on the paperwork that they take with them or provide 'em with the form. But I'm -- I'm going to support this Bill anything, like I said, to help with this problem. But I -- I -- I wish we did reach out to those small businesses. Thank you, Madam -- Madam President.

THE CHAIR:

Thank you, Senator Champagne. Will you remark further on the legislation that is before us? Senator Kissel.

SENATOR KISSEL (7TH):

Thank you very much, Madam President. First of all, I want to commend Senator Abrams for her hard work in putting together quite a large Bill, Public

Health Committee, as well Ranking Member Senator Somers. I clearly want to touch bases on a lot of different areas. But I have a couple specific questions, through you, Madam President.

THE CHAIR:

Certainly. Please proceed. Senator Abrams, prepare yourself.

SENATOR KISSEL (7TH):

I was going to accompany Representative Carol Hall and two other folks from the town of Enfield to the public hearing, but had General Law at the exact same time and we're voting on marijuana legislation, so I haven't figured out how to clone myself in this building or the LOB yet.

But it was a -- she was going up there with our current Enfield Police Chief, Alaric Fox who used to be Colonel in the State Police, and former beloved Police Chief Carl Sferrazza. And one of the things that Representative Hall and myself had spoken of about with Chief Fox, and as a concern is that, when the police actually go and get someone that has this problem and they bring them to an emergency room, quite often, they'll just turn around and walk right back out.

And there may be some nuance in Massachusetts law where, somehow they can be detained for a certain period of time. And -- and especially when it's young people, a lot of times their loved ones, could be a spouse, could be parents, go to the police and they say, can't you just hold them overnight, so that they don't hurt themselves, again? And in

speaking to the -- the good Police Chiefs, they have said it's not uncommon that they'll go out, pick someone up, detox them, you know, with the pen or however, they do it and bring them to the emergency room, and then a couple hours later, they're back at the scene.

And so, through you, Madam President, is there anything in this Bill that addresses that conundrum that seems to be facing loved ones and law enforcement out there regarding this opioid addiction crisis? Through you, Madam President.

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

Through you, Madam President. I do remember their testimony actually at the public hearing. And -- and we've heard from a lot of different groups who have split -- who have expressed the same concerns. At this point, we felt the best way to go with that was to create a study, a short-term study that will be available before our next session, so that we would have an opportunity to act on it, to hear more information about it involuntarily transfers and involuntarily commitments, even for a short period of time, for people who are overdosing. Through you, Madam President.

THE CHAIR:

Thank you, Senator. Senator Kissel.

SENATOR KISSEL (7TH):

Thank you very much, Madam President. And thank the good Senator for her response. And through you, Madam President. I apologize you may have stated this when you did your excellent recapitulation as to what's in the Bill, but who are the members of the study group? Through you, Madam President.

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

The study group is going to be do -- done through the Department of Mental Health and Addiction Services along with the Department of Public Health and any other relevant entities. It would be a working group again, like we've done before. And the members of the Public Health Committee would be involved, too, to pull that together. Through you, Madam President.

THE CHAIR:

Senator Kissel.

SENATOR KISSEL (7TH):

Thank you very much. And through you, Madam President. So, the -- the two Police Chiefs, former Chief Sferrazza, current Chief Alaric Fox, if they wanted to have input to this, could they submit testimony or would there be public meetings? Is there any opportunity for folks that aren't official members of the study group to offer input and ideas? Through you, Madam President

THE CHAIR:

Thank you, Senator Kissel. Senator Abrams.

SENATOR ABRAMS (13TH):

Through you, Madam President. Absolutely. In our last working group we had local law enforcement members as a part of it, and their input is incredibly helpful. Thank you. Through you, Madam President.

THE CHAIR:

Senator Kissel.

SENATOR KISSEL (7TH):

Thank you very much. I have no further questions. I think that's an excellent approach. The Lieutenant Governor is probably going to be familiar. Actually -- when you were -- when Lieutenant Governor was marching in our Memorial Day Parade, I pointed out the street that I live on, which basically goes from Pearl Street up to Enfield Street, and it's pretty quiet neighborhood, except when it's morning rush hour or people are going back home like 5:00 o'clock to 6:00 o'clock, and that's just road traffic. But people familiar with that part of town, just in the last, I'd say year, maybe a little more than a year, all of a sudden there were like a ton of police cars and firetrucks at the bottom of my street which is a one-way street. You can -- you can take the Enfield, Suffield, Veteran's Bridge from Suffield across, go across Pearl Street up through Terrace to Enfield Street. And so, it

was down at the base, just about a block from the Carnegie Library and -- which is at the bottom of Franklin, which is the other one way direction, and there was a dead body there.

And -- so obviously, you know, I have a 23-year old and 15-year-old, there's a lot of other families that have younger children in the neighborhood. There's not a lot of crime, knock on wood. So, it was sort of shocking and it was like a Sunday morning, what's a -- a dead person doing just at the bottom of our street. And ultimately, it was determined that this person was wandering or stumbling from the Thompsonville section of town and, apparently, was under the influence of an opioid and -- and died there. It was not foul play or anything else like that. That really brings it home as to how close this is geographically and as far as our community goes.

It's also not unusual to hear stories. I mean how heartbreaking. I have heard this a couple of months ago that Senator Guglielmo, nicest guy in the world, and, you know, being in this Chamber for 26 years and then until I decided to seek this term, he was always ahead of me because he got in at the regular beginning of the session 26 years ago and I have to go through a special election, just the nicest guy and what heartbreak for that good Senator to lose his grandson to an opioid overdose, someone that we love and care about and served with for many, many years.

So, this is insidious. I -- it -- it -- it crept into our society quietly and doctors were making these prescriptions. And I don't think anybody was acutely aware as to how addictive these drugs are.

And now, you know, there's almost the sense of anger that we are turning back to these drug manufacturers to come up with a remedy. And some people sort of lay the blame at their feet. But we, as a society, embrace this. You know, we often think about miracle drugs and pain killers and just think that, you know, advances in this field are the way to go. And Connecticut is a state that had many of these manufacturers.

So, one of the things that was stated in our Judiciary Committee, because we indeed had Bills regarding opiates, as well, was that every single year in Connecticut, more people die of opioid overdoses than Connecticut lost in the entirety of the Vietnam war. And that's just a staggering thought. There are places you go throughout the state of Connecticut -- I was at a -- a camp called Workcoeman on a volunteer project, helping spruce up the camp, and the cabins were actually named after fallen Vietnam war veterans, sort of brought it home. But think of how many young men and women we lost in that war and how it tore the state apart. And people were acutely aware of those losses. Yet, it's almost like we're inured to the opioid epidemic. It's almost like, you know, it's on the back of page seven.

I was shocked when I read in the Journal Inquirer this week, that someone had given someone, it was either fentanyl or an opioid and the other individual died. And so, the dealer was sentenced to two years, just two years. But I'm not so sure that harsh penalties on the dealers, while I think in some instances would be completely appropriate, but this is a multiprong issue that we have to approach.

As the good Senator indicated, Senator Abrams, that there's, you know, coaches out there -- recovery coaches, that if the individual does not want to turn their life around or at least make the first few steps, there's very little you can do, you can't really force them. It doesn't work. I mean you could probably force them to stay in the emergency room area for a certain number of hours. But that doesn't mean the problem is going to be solved. It just means that this individual is sort of segregated from the rest of society until they go back into the cycle.

So, I don't want to belabor it. I know that time is fleeting on our final day here in the regular session of our 2019 long-term legislative session. But I do want to commend, Senator Abrams, Senator Somers, and all the other hardworking people on the Public Health Committee. This is as much as Judiciary took up these Bills, and we have some proposals and we voted on one this afternoon. It's really inherently your bailiwick. It's a -- it's a matter of public health. And I'm really, really hopeful that the study group can come up with some great recommendations. And to the extend you can keep us apprised, myself apprised as to the progress and -- and when's an appropriate for my constituents get to offer input, that would be much appreciated. I'm so happy to stand in strong support of the Bill. Thank you, Madam President.

THE CHAIR:

Thank you, Senator Kissel. Will you remark further on the legislation that is before the Chamber? Senator Hwang.

SENATOR HWANG (28TH):

Thank you, Madam President. I rise in support of this Bill. We've heard enough about the tragedies that have been caused by opiate use. Through you, to the proponent of the Bill, some questions.

THE CHAIR:

Please prepare yourself, Senator Abrams. Please proceed, sir.

SENATOR HWANG (28TH):

Thank you, Madam President. I think -- believe, in section as it relates to the pharmacy's notification. Is it permissive? And if not, what is the requirement for the pharmacist to provide counselling and in what form? Through you, Madam President.

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

Just a moment. Thank you, Madam President. It states, beginning on line 47, that nothing in this section shall be construed to require a pharmacist to provide counselling to a patient. Through you, Madam President.

THE CHAIR:

Senator Hwang.

SENATOR HWANG (28TH):

Through you, Madam President. Is that part of the amended change to make that change? I believe the original underlaying message did have that and -- and was the change as the result of feedback from pharmacists in -- in regard to that requirement? Through you, Madam President.

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

Through you, Madam President. I do not know.

THE CHAIR:

Senator Hwang.

SENATOR HWANG (28TH):

Thank you. Okay. With that said, are there minimum requirements -- I believe there was a -- a 12-day prescription limit, could the good proponent of this Bill explain what the process is beyond the 12-day limit and what this Bill would do to -- to manage the possible abuses of -- of opiate usage? Through you, Madam President.

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

Through you, Madam President. It's actually a 12-week supply that once the physician prescribes to that level, that they are asked to come with a care plan for chronic opioid drug use. We do acknowledge that there are some people who do need this medication and rely on it to control their pain. And we -- we're looking to have the patient discuss with their doctor a plan about pain management that would also include non-opioid treatment options. Through you, Madam President.

THE CHAIR:

Thank you, Senator. Senator Hwang.

SENATOR HWANG (28TH):

Thank you very much. I want to thank the proponent for the clarification that is indeed very helpful. We -- we also made some changes in this Bill in regards to how EMS, as well as law enforcement and fire, would be able to raise awareness, retain or detain individuals under the suspicion of an opiate overdose. Could the good proponent of this Bill, elaborate a little bit more what this Bill does in regards to an additional level of -- of detainment or precautionary care? Through you, Madam President.

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

Through you, Madam President. In this Bill, we

decided to make that a study until the next session. The -- the results of the study would be due January 1st, 2020. It would be a study that would be run through the Department of Mental Health and Addiction Services in collaboration with the Department of Public Health and any other entities that would be involved with the group, to look at whether or not detaining people who are suspected of having experience in opioid overdose what would be the implications of the involuntarily transport or an involuntarily commitment to -- even to a hospital for a few days. Through you, Madam President.

THE CHAIR:

Senator Hwang.

SENATOR HWANG (28TH):

Thank you, Madam President. I want to thank the proponent for that clarification. Is there a deadline for the study to be submitted to the Committee for review? Through you, Madam President.

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

January 1st, 2020. Through you, Madam President.

THE CHAIR:

Senator Hwang.

SENATOR HWANG (28TH):

Thank you. The proponent does know the Bill. I want to compliment her. That being said, I think we also changed some stipulations in regards to hospital detainment and procedures related to that. Is that part of the study or is it a separate component of compliance? Through you, Madam President.

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

Through you, Madam President. Yes, it would be part of the study.

THE CHAIR:

Senator Hwang.

SENATOR HWANG (28TH):

Thank you very much. It -- would there be any consideration to the study in -- in regards to testing of the personnels within EMS, fire, police, and hospitals because, there are incidences, we've heard, where individuals with easy access to the possible opiates are, themselves, subject to potential addiction? Are there any implications or directions within the study to explore the possibility of assessing whether proponents of this -- individuals that we cited earlier, first responders and hospital personnel that are administering this, be considered from a standpoint of testing, evaluation, and the possible addiction

services? Through you, Madam President.

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

No. There is not anything of that nature in this Bill. Through you --

THE CHAIR:

Senator Hwang.

SENATOR ABRAMS (13TH):

-- Madam President.

THE CHAIR:

Senator Hwang.

SENATOR HWANG (28TH):

Through you, Madam President. Just in getting ahead of the study, would that be a possible consideration of the study group? And -- and are there any other area in regards to the broad area of possible consideration that this study has been entasked with? Through you, Madam President.

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

Through you, Madam President. Everything that could help in this situation is -- is willing to be looked at by the Public Health Committee. So, certainly that could be something that could be brought up. Although it is not -- would not be in this particular study. Through you, Madam President.

THE CHAIR:

Senator Hwang.

SENATOR HWANG (28TH):

Through you, Madam President. I -- I just want to get clarification. I -- I do agree that we should do everything within our own powers to -- to evaluate and understand the prevention of addiction to opiates. Why would this study not encompass those type of comprehensive points of study? Through you, Madam President.

THE CHAIR:

Senator Abrams.

SENATOR ABRAMS (13TH):

Through you, Madam President. The purpose of the study was to keep it concise, so that it could be looked in a -- in a precise manner and reported back in a short period of time, particularly about the detaining and the transferring of people involuntarily. Through you, Madam President.

THE CHAIR:

Senator Hwang.

SENATOR HWANG (28TH):

Thank you. I want to thank the proponent for her answer and -- and my appreciations. And I want to compliment the advocates of the Committee for raising this Bill, even though it is significantly narrow in its study focus, it is at least one small step forward to addressing the opiate epidemic in our society. And I urge support of this. Thank you.

THE CHAIR:

Thank you, Senator Hwang. Will you remark further? Senator McCrory.

SENATOR MCCRORY (2ND):

Thank you, Madam President. Madam President, just a couple words. I am proud to support this Bill. It goes a long way of helping so many people in the state of Connecticut who are dealing with opioid epidemic -- epidemic that's been going for a while now. The fact that we're going to provide counselling, the fact that we're going to provide mental health evaluations for individuals who are suffering from this or may or may not be suffering, but I don't want to take up too much time. But I'm just -- the reason why I'm so happy to support this, because there was a time, not long ago, when we had other crises of substance in our -- in our -- in our state, throughout our country, in the 80s and early 90s, so many people were dealing with substance abuse issues at that time.
And at that time, we didn't have the forward

thinking, like we have now, to provide those individuals who were suffering from drug addiction and -- and -- and all the things that come along with -- with that behavior. I'm glad that now we see it as a -- a -- a health issue.

Unfortunately, back then we saw it as a criminal issue. And -- and we what we did then, instead of providing the mental health support, the counselling and all the other support and changing legislation, we locked people up. And once we locked people up, that changed the conversation, not only for that individual, but for that family and that -- that neighborhood and that community. And it put a stigma -- they put a stigma on all those entities that I just said, that individual, that family, that neighborhood, that community. And we created new terminologies that we used to describe individuals who were having substance abuse problems. We called them crackheads. We called them addicts. We said all these -- all these negative, derogatory things for -- to 'em.

Good thing that we're not going to be able to do that as we move forward with this new epidemic. Because there may be the support. The families might get the support. The doctors will be able to -- to treat them. Even EMTs would have experience, and all the personnels will be involved from the beginning to the end.

But I just want to remind us, we still suffering those communities, those families, those neighborhoods, those people, still suffering today because they never, never, never became healed. They never became healed because those supports that we put in place today were not there then and it's

sad.

THE CHAIR:

Senator, I -- I hate to interrupt you, I just wanted to welcome our guests in the gallery to the Chamber. And I would just like to ask them to respect our rules. Our rules, while they allow you to listen to the debate and watch the debate, it is against the Senate rules to take photos or videos. So, again, we welcome you. And we do ask you to respect our rules. And we thank you for coming and watching our process. And Senator McCrory, please do -- please do continue, sir.

SENATOR MCCRORY (2ND):

No, I -- I believe the individual -- they -- they probably understand what I'm talking about because some people, you know, they understand where I'm coming from. Some -- some people who have been dealing with for a number of years, so I'm not worried about those individuals because they lived it. So, I would just summarize now, President, that thank you and thank the kind Co-Chair -- I mean Chair of the Public Health Committee for doing this. It's a look forward but we never forget where we -- from which we came. Thank you, Madam President.

THE CHAIR:

Thank you so much, Senator McCrory. Senator Fasano.

SENATOR FASANO (34TH):

Thank you, Madam. I rise for a point of personal privilege.

THE CHAIR:

Please do proceed, sir.

SENATOR FASANO (34TH):

Thank you. Madam President, we have three special guests in our Chamber today, of one family. We have former State Senator Art Linares, his son, Teddy for next state Senator of the District [laughter], and Representative Caroline Simmons, who's well, I guess Linares; right? I should make those corrections. I'm not sure to be politically correct, but we want to welcome them to the Chamber and Teddy's first visit to the Chamber. Congratulations. You guys got a great family and we look forward to seeing you -- for the next years in the Senate. Thank you. [Applause]

THE CHAIR:

And the Representative Simmons and Art Linares, may I just say that that is one very cute baby. [laughter] Thanks for visiting us today. Will you remark further on the legislation that is before the Chamber? Will you remark further on the legislation? Senator Duff.

SENATOR DUFF (25TH):

Thank you, Madam President. I have a feeling I've been overshadowed here by a little cute baby --

THE CHAIR:

Upstaged.

SENATOR DUFF (25TH):

-- which is totally fine.

THE CHAIR:

Absolutely.

SENATOR DUFF (25TH):

Totally upstaged, and that's totally fine. Just very briefly, I wanted to thank, Representative -- Senator Abrams and Senator Somers and the House leadership of the Public Health Committee and our staff for the work that they did, Senator Anwar as well, for his work on this Bill. And I appreciate all their -- their help on this crisis. I know it's the Governor's Bill, as well, so thank the administration as well as you, Madam President, for your efforts on this. It's a good Bill. And we should be voting for it unanimously. Thank you.

THE CHAIR:

Thank you very much, Senator Duff. Will you remark further on the legislation that's before the Chamber? Will you remark further? Senator Abrams.

SENATOR ABRAMS (13TH):

Madam President, if there's no objection, I would ask that this be placed on the Consent Calendar.

THE CHAIR:

Seeing no objection, so ordered. Mr. -- Senator

Duff.

SENATOR DUFF (25TH):

Thank you, Madam President. Madam President, if we can now have a -- if the Clerk can now call the items on Consent Calendar, followed by a vote of Consent Calendar, please?

THE CHAIR:

Mr. Clerk. Mr. Clerk.

CLERK:

Consent Calendar No. 1. Page 5, Calendar 128, Senate Bill 394. Page 7, Calendar 169, Senate Bill 906. Page 20, Calendar 372, Senate Bill 920. Page 25, Calendar 417, House Bill 7126. Page 39, Calendar 547, Senate Bill 1018. And Page 60, Calendar 681, House Bill 7159.

THE CHAIR:

Thank you, Mr. Clerk. Would you kindly call the vote? The machine will be opened.

CLERK:

Immediate Roll Call Vote has been ordered in the Senate on Consent Calendar No. 1. Immediate Roll Call Vote in the Senate, Consent Calendar No. 1. Immediate Roll Call Vote in the Senate on Consent Calendar No. 1.

Immediate Roll Call Vote has been ordered in the Senate. Immediate Roll Call Vote has been ordered

in the Senate. Immediate Roll Call Vote in the Senate.

THE CHAIR:

Have all the Senators voted? Have all the Senators voted? The machine will be locked. Mr. Clerk, please call the tally on the Consent Calendar.

CLERK:

Consent Calendar No. 1.

Total number voting	36
Those voting Yea	36
Those voting Nay	0
Absent and not voting	0

THE CHAIR:

[Gavel] The Consent Calendar is adopted. Senator Duff.

SENATOR DUFF (25TH):

Thank you, Madam President. Madam President, I move all items needing further action to the House of Representatives to be immediately transmitted please.

THE CHAIR:

So ordered, sir.

SENATOR DUFF (25TH):

Thank you, Madam President. Madam President, the

JOINT
STANDING
COMMITTEE
HEARINGS

GENERAL LAW

Part 2
755-1545

2019

CHAIRPERSON:	Representative Michael D'Agostino
SENATORS:	Fonfara, Leone, Witkos
REPRESENTATIVES:	D'Agostino, Gibson, Cheeseman, Ackert, Allie-Brennan, Altobello Arconti, Candelora, D-Amelio, Luxenberg, Orange, Rutigliano

REP. D'AGOSTINO (91ST): All right. We'll call the general public hearing to order, here on Tuesday, March 12 at 10:00 AM. We have a handful of Bills to review today and several very distinguished speakers to speak on them. So we will get right to our agenda, if that's all right with everybody. And our first is Representative or -- nope. She's not here. Okay. All right. Rudy Marconi of Ridgefield representing COST. There's Mr. Marconi. A familiar face around these parts.

MR. MARCONI: Good Morning.

REP. D'AGOSTINO (91ST): Good morning.

MR. MARCONI: Thank you, Representative D'Agostino, members of General Law for allowing me this time to speak this morning. I'm speaking in support of Governor's Bill H.B. 7159 AN ACT ADDRESSING OPIOID USE. I know the CHA as well as the Orthopedic Association has submitted some concerns in their testimony and I just wanted to take advantage of the time here today to talk about the opioid crisis, specifically this Bill and its guidelines for

prescription writing. But more importantly, the believe that many of us share that we need to implement the MAT model, the medically assisted treatment model in all of our rehab centers throughout Connecticut.

It has been proven to have a much greater affect to reduce the recidivism rate that we've seen across our state. This is an issue that we all know. Most of us, if we haven't been affected directly, we know someone who has been impacted by this issue. And I think it's just critically important, as does my good friend, Dr. Peter Rostenberg, who is a Suboxone certified doctor, that the MAT Model is critical to addressing this issue. So I ask that you give that some consideration. Thank you.

I also represent today not just COST, but CCM and both organizations have, in fact, submitted testimony and I'm President of COST and a member of their Board of Directors of CCM. Thank you.

REP. D'AGOSTINO (91ST): That's what I was going to ask you. So CCM and COST are unified in this position?

MR. MARCONI: Absolutely and that's why I'm here representing both organizations.

REP. D'AGOSTINO (91ST): Thank you. Questions from the committee? Thank you, Mr. Marconi.

MR. MARCONI: Thank you.

REP. D'AGOSTINO (91ST): Is the Commissioner here? Yep, there you are Commissioner. Good morning Commissioner.

COMMISSIONER MICHELLE SEAGULL: Good morning, Senator Witkos, Representative D'Agostino, Representative Cheeseman, other honorable members of the General Law Committee. Thank you for giving me the opportunity this morning to testify in support of several of the bills on your agenda today. You already have my written testimony so I'm not going to repeat it in its entirety here, but I do want to touch on some high points and then definitely be happy to answer any questions you may have. SB 1006 SB 1007 HB 7291 HB 7300

So first I'd like to testify in support and we strongly support HB 7159. This is the Governor's opioid bill. It does a number of things within DCP statute which we think are good ideas and will be helpful in addressing the opioid crisis. Among them would require pharmacists to offer counseling to patients regarding their prescriptions. Right now, this is something that's already required for Medicaid patients and we think it's a good idea to do for all patients and so we support that. Also, while right now pharmacists, some of them are voluntarily accessing the PNP to kind of look at the drug use by the patients they're dispensing medication to. To make that easier for those who are choosing to do that, we want to allow an agent to the pharmacist to do that. It would require drug manufacturers and wholesalers to let DCP know when it's terminating or declining to do business with a pharmacy, and this would allow us to catch issues earlier. That would be a good red flag for us. And it would require a diagnostic code to be used for opioid prescriptions and finally require a treatment agreement between a patient and their prescriber if there's going to be a prescription for more than 12 weeks of opioid treatment for pain. So, those are

among the things within the Governor's opioid bill that impact DCP statutes and we are in supportive of all of that.

We also have a number of DCP statutes so first, thank you for giving consideration to those and giving us an opportunity to have a hearing on that. We know some industries or others have flagged some issues with these various groups so there may be some substitute language to compromise on some of those [Inaudible-00:02:14] that what we're doing [Inaudible-00:02:10] But really quickly we have SB 1006. This is the revisions to the pharmacy and drug control statutes. Kind of three big things it's doing is further strengthening and helping us to stay on top of sterile compounding which has a huge issue and really on the forefront of our minds since the incident happened back in 2012 where over 60 people died because of the sterile compounding pharmacy that wasn't doing things properly in Massachusetts. It would require in state pharmacies to report if they're subject to legal action and this is something that compounding or out of state pharmacies must do. And it would finally help us make sure that our controlled substance designations are staying in sync with federal law. SB 1007 just makes some technical changes to our statutes. Some are because of recommendations from federal law leaders to create some internal consistencies with our law and then just clarify a few areas where there either has been or we see the potential for confusion.

HB 7291 makes some changes to our enforcement statutes. Primarily it aims to give us more flexibility in how we do enforcement. Sometimes we can only revoke or suspend a license which is a

REP. D'AGOSTINO (91ST): Thank you Representative. Any other questions for the commissioner? Thank you, Commissioner. We went easy on you today.

COMMISSIONER MICHELLE SEAGULL: Okay Thank you.

REP. D'AGOSTINO (91ST): Representative Pat Miller? She's around. She seems to be caught up right now so we'll see if she can come down. Commissioner Mais.

COMMISSIONER MAIS: Good morning, Committee Chairs, Vice Chairs, ranking members, and members of the General Law Committee. I am Insurance Commissioner designee Andrew Mais and on behalf of the Insurance Department I do appreciate the opportunity to testify today in strong support of the Governor's House Bill No. 7159, an act addressing opioid use. Governor Lamont's bill would create meaningful public policies to continue to combat the opioid crisis. The insurance department has been a partner in working with all stake holders including consumer groups, legislatures, legislators such as yourselves, other executive branch agencies, the insurance carriers and others to create sound public policy to combat this opioid epidemic and we are an active member of the Alcohol and Drug Policy Council.

Now generally this bill makes changes to reduce the misuse of prescription opioids. It strengthens oversight of prescription opioids and facilitates the use of the state's prescription drug monitoring program. It also enhances communication among healthcare practitioners and patients regarding the use of opioids. Section five of this bill would prohibit life insurance carriers from excluding coverage to individuals who have fulfilled

prescriptions for life saving opioid antagonist. Now you've got our written testimony and while the department supports the entire bill, I would like to provide the committee with particular insight into section five. This new section would prohibit life insurance and annuity policies from excluding coverage solely on the basis of receipt of a prescription for an opioid antagonist, such as Naloxone something they use to save people's lives.

And when an individual applies for life insurance the carrier may undertake a formal underwriting process which could investigate the applicant and their health history and that may include filled prescriptions and medical treatment among other things and it has been found during this process, individuals have been denied coverage due to a history that included either filling or using an opioid antagonist. Governor Lamont's bill would prohibit this practice and the department strongly supports the Governor in pursuing this important consumer protection.

In fact, this is what I heard on NPR a few months ago. It was widely reported that a nurse in Massachusetts was denied life insurance because she had previously purchased Naloxone, not for herself but this was to help others. It was a prescription she filled as a good Samaritan in case she came across anyone experiencing an overdose. It is important to protect people who have decided to carry an opioid antagonist to treat potential unexpected opioid overdoses and save a life of a friend, a family member, or perhaps somebody they don't know. The law makes it clear that these good Samaritans should not and will not be denied coverage of a life insurance or a new policy solely

for having filled a prescription for an opioid antagonist. I ask that you take affirmative action on this important bill proposed by Governor Lamont. Thank you for the opportunity to testify on this important piece of legislation. I and my colleagues have the insurance department standing ready to assist you and to work with our fellow agencies on this important topic. I am happy to take any questions you may have.

REP. D'AGOSTINO (91ST): Thank you, Commissioner. My apologies for getting your last name wrong and good luck in the nomination. Questions for the commissioner designee. Senator.

SENATOR WITKOS (8TH): Thank you, Mr. Chairman. Good morning, Commissioner. Just a question. It's section four of the bill. I don't know if you have it there in front of you.

COMMISSIONER MAIS: I do not have it in front of me but if you do have a question, I can get back to you.

SENATOR WITKOS (8TH): It's in section two and maybe it just needs clarification on my part, but it talks about a registered manufacture wholesaler of drugs that ceases or declines distribution of a scheduled drugs or controlled substance to an individual in the state of Connecticut shall report the name of the individual, etc. But I wasn't aware that a manufacturer or wholesaler could go directly to an individual in the state. What scenario would allow that to happen if you didn't go through a pharmacist or a doctor? Is the individual in this paragraph here really a business entity?

COMMISSIONER MAIS: Senator, I just got through my first week on the job so let me get back to you on that one in the next day or two.

SENATOR WITKOS (8TH): Just for your notes it's lines 326 through 333 in the bill. Thank you. I appreciate it.

REP. D'AGOSTINO (91ST): Representative Rutigliano.

REP. RUTIGLIANO (123RD): Thank you, Mr. Chairman. Good Afternoon, Commissioner. I really couldn't agree with the Governor more on that issue, but I wanted to point you to a bill on the insurance committee, 6087. We've already had a public hearing on it that completely addresses this issue and I would invite you to support it. It prevents people from using prior claims history for Narcan from denying them insurance or life insurance, or disability insurance or anything so I would appreciate your support considering it was my bill. [laughter] We could use it.

REP. D'AGOSTINO (91ST): Senator I just want to make sure what lines you were inquiring about.

REP. RUTIGLIANO (123RD): Yeah lines 326-333. It speaks of manufacture wholesaler that declines to distribute the scheduled drugs to the individual, but I've never heard where a manufacturer can go to an individual unless they went to a pharmacy or a doctor and I'm just wondering if the term individual may mean a business entity.

REP. D'AGOSTINO (91ST): That's a good question. I think we should also just ask for the record ask DCP as well and try to get an answer to that question.

REP. D'AGOSTINO (91ST): Fair enough. You're trying to avoid liability when you haven't done any work which I think as a practical matter makes sense but I think we do have to correct the language.

Other questions from committee members? Thank you. I appreciate it Representative Miller.

REP. MILLER (145TH): Thank you.

REP. D'AGOSTINO (91st): And just a note for our drafting staff that we need to make sure the language is clear. The clause in 3b that would void those provisions only applies if the snow contractor is instructed not to perform services. Thank you. Dr. Katz, Dr. Andrews?

We're transitioning to our public hearing since you guys were on the legislator list, but your legislator didn't show we'll have you guys go first and then we'll transition to the next list.

DR. MARILYN KATZ: Distinguished members of the General Law Committee, thank you for allowing us to testify on HB 7159 an act adjusting opioid use. My name is Marilyn Katz. I am joined here today by my colleague, Rebecca Andrews. We are both primary care physicians from Yukon Health and we are here representing the opioid task force at Yukon Health for which we co-chair. The opioid task force is a multidisciplinary committee that is charged with developing policies around opioid prescriptions and opioid prescribing for Yukon Health. As clinicians, educators, and researchers who work daily with the issues of opioid prescribing, we commend the Governor and committee on its renewed commitment to reducing the impact of the opioid epidemic and would like to help HB 7159 best achieve its goals.

In that vein, we have a couple of recommendations in both sections six and seven that instead of requiring documentation on a prescription or in a medication agreement that key elements of the decisions to use opioids be documented in the patient charge and/or in the patient plan. We believe that requiring this documentation strategy will minimize additional paperwork and allow for providers to focus their time on the shared decision-making process involved with prescribing a potentially lethal medication to a patient. One of the goals of the bill is to facilitate the use of the state's PDMP can be achieved through a single click integration of the database with electronic medical records.

The medication reconciliation and polypharmacy work crew legislatively formed under the Health Information Technology Advisory Council has identified that this is technically feasible. We would strongly encourage prioritizing and fiscally supporting the implementation of this as a state sponsored service of the emerging health information exchange. Not all prescriptions are currently reported to the PDMP for controlled substances. Currently Methadone is not reported if it isn't prescribed for opioid abuse disorder or detoxification from opioids. Historically this was to protect patients and reduce stigma for patients with opioid use disorders. However, we have multiple options for treating opioid use disorders which are reported to the PDMP including Methadone and the PDMP should be considered for patient safety particularly in the reality that other controlled substances used for treatment are already reported. Unfortunately, one of the unintentional consequences

of the enhanced regulation in the overstate of opioids has been the attrition of providers willing to prescribe.

Chronic pain affects hundreds of thousands of patients across the country. While we all agree that the current state of affairs is truly a crisis and support the oversight of prescribing practices, caution has to be taken to not unintentionally reduce healthcare access for an already stigmatized patient cohort. Streamlining oversite mandates the focus on some really impact long-term outcomes while carefully avoiding additional administrative burden should be a primary goal of this and future legislation.

In conclusion, we applaud the Governor and committee for raising HB 7159 and for its efforts to address the opioid crisis in Connecticut. As part of the state's only public academic medical center, we are ready and willing to discuss our working recommendations and to assist you in any way. Thank you for your consideration. We are happy to answer any questions the committee may have.

REP. D'AGOSTINO (91ST): Did I hear you say you want changes to sections six and seven. Just walk me through what you want.

DR. KATZ: We submitted this in our written testimony but it's longer than three minutes. So, in section six, the recommendation is that there is documentation of the diagnosis on the prescription. And the justification and the summary of the bill was that patients and providers will have a more meaningful discussions with their patients about why they're using an opioid, what it's for but that doesn't necessarily make sense. Prescriptions are

often written at the very end of the visit so if you really want that discussion to take place, just putting a diagnosis code on a prescription at the end is not going to get you to your goal of having that discussion with patients.

DR. ANDREWS: The language also talks about using the ICD codes that are used by physicians so other prescribers such as dental providers would be completely left out of that component. If it was in interest of having acute versus chronic pain, that would be maybe a different topic but having it in the chart which protects patient privacy as well would stimulate the conversation in the shared decision making about the risks and benefits of the medication.

DR. KATZ: And section seven talks about the use of a medication agreement and that's something that we actually do, however we just want to point out that this is not based on evidence-based medicine. It's in response to the opioid crisis and our literature is constantly changing so rather than enforcing medication agreement itself takes a component of medication agreement and require that to be documented directly in the patient's chart. It would still allow you to go through that shared decision-making process with the patient.

REP. D'AGOSTINO (91ST): Not to put too much a burden on you but do you have suggested language for those sections that you could send to us?

DR. ANDREWS: Yeah, we could send it to you. Actually, the language is very impressive. It's very accurate and meets what we do as best practices. It was just because we don't know yet if medication agreements actually reduce overdoses, theft, and

other negative outcomes so we didn't want to be tied to that and then have the literature suggest something different, but we can send that forward if you would like it.

REP. D'AGOSTINO (91ST): Thank you. I know you mentioned that Methadone is not reported to the PDMP.

DR. KATZ: Correct. So often times Methadone is dispensed at a free-standing Methadone clinic so there's not a prescription that is written. They go to the Methadone clinic. They talk to their clinician who's there and they get their dose for the day or for a couple of days or for a week depending on the schedule that they're on. Methadone clinics don't go through a pharmacy and they don't report to the database. Again, there's a lot of history behind this and trying to protect these patients who are seeking appropriate treatment, but as more and more things are noted on the database, we feel like this is kind of a big thing that's missing.

DR. ANDREWS: The risk of respiratory depression and accidental overdose and death if someone is on Methadone and me unknowingly or another clinician prescribes is actually pretty high. Methadone when use for chronic pain is reported but just in this one area when it's used for opioid use disorders and they're going to the center and they're able to get their dose it's not reported.

REP. D'AGOSTINO (91ST): I can see the tension between what you're suggesting now and the clinics. I wanted to make sure that the access is available. I'm wondering if you may know what the burden is on

those clinics to actually install and have a PDMP system.

DR. KATZ: I don't know the answer to that but one of the kinds of similar situations is currently for medical marijuana. When someone registers for medical marijuana it's not every single time, they go to the dispensary but there's a line that says they are a holder of medical marijuana card so at least it lets me know that this is something they will also have access to. So, it doesn't necessarily need to be every single time they get dispensed but some sort of alert so you can make the clinicians aware.

REP. D'AGOSTINO (91ST): Thank you. Questions from committee members? Representative Cheeseman.

REP. CHEESEMAN (37TH): Yes, your comments about the medication agreement entered into by patient. I am not familiar with these. How are they structured? As you say there is no real research that it shows it makes a difference. Is it a contract I hereby understand why I'm taking this and I better not misuse it, that sort of thing?

DR. KATZ: It's actually pretty comprehensive. The idea is to reduce the risk but not deny access to patients with chronic pain who want to take a high-risk medication. It's a reminder to the prescriber and the patient what needs to happen to do this safely so one of the first things it does is list the reason you're taking it. So, if you're taking it for knee osteoarthritis and you get a knee replacement and that's better, we don't just keep prescribing it. It goes over expected behaviors so to reduce tolerate and addiction we use additional medications in conjunction with opioids. It talks

about appropriate behaviors on both parts so there may be something that happens like maybe the patient is using an elicit street drug and that makes it unsafe to continue to prescribe, they know going into this agreement that, that would be an indication that we would stop prescribing. And then it goes into the risks and benefits including things like respiratory depression, the risks of addiction and tolerance with opioids. It talks about some of the other medical causes that are such as unable to urinate and issues you might run through and you talk through that together so at the end the patient knows fully what they're getting into. Some patients, honestly at the end of that will make the decision not to prescribe and the other thing is to removes stigma so if you do every patient who is on chronic opioids nobody feels like they were singled out to be scrutinized or any other manner.

REP. CHEESEMAN (37TH): So, you are in favor of these being included? You're not? Or it would be up to the doctor to make the decision because my understanding is that the legislation would mandate the use of these.

DR. KATZ: So, it's really the mandate of the use that we have an objection to because the medical literature changes all the time and again, we're using these in response to a crisis because everybody kind of agrees that this is a reasonable kind of step to take. It's similar to informed consent that we use in a lot of like before you go into surgery, there's a risks/benefits/alternatives conversation that you have with the surgeon. This is very similar to that but again we don't have any

literature saying this is the best way. It's recommended by the CDC guidelines, but we just don't know for outcome.

REP. CHEESEMAN (37TH): And how would this apply where you're prescribing for palliative care, end stage cancer where the patient's concern is not becoming addicted nor is it the patient's family. It's to relieve that intractable, intolerable pain when you know the end is in sight. Would that give you then, we don't have to have this conversation or it's going to be a different conversation as opposed to a strict mandate. Is that the sort of relief you're looking for?

DR. KATZ: So, at Yukon Health we actually use some of both indications because you have to walk through the unintended side affects that may occur and that's just good care, so we use them. Again, the problem is really with the mandate so the components and language that is in the bill is excellent. It talks about all the components of the medication agreement but we may find three years down the road that there's a better way to accomplish this that works to achieve those same goals and if it's mandated in the legislation then we would still have to do this and that might be burdensome to physicians and patients further down the road if a better technique is discovered.

REP. CHEESEMAN (37TH): How would their enforcement in this? Would this now be in the electronic medical records that would have to take place that you had presented the medication agreement to the patient, it had been discussed, and you had to check yet another electronic box. It's all very well mandated but how do you then track it?

DR. KATZ: I'm not sure how they're planning on overseeing the medication agreement component of it but my understanding from sitting on the medical board is that when something happens, when there's a complaint or when there's an adverse outcome then someone would be going in and looking at the charts and seeing if it was documented appropriately. Were these steps taken?

REP. CHEESEMAN (37TH): Okay so in some ways from a CYA point of view it might be useful to have these. Not to be rude but if there were an adverse -- I mean I suppose I'm loathed to knowing the demands on particularly primary care physicians with how you're tasked, and you have to see a certain number of patients in a certain period of time. The extensive nature of electronics. I can understand the aversion to having another mandate. On the other hand, I can understand you're obviously excellent clinicians and doing a good job for your patients but to ensure that those doctors who might be less scrupulous or you know more concerned that this conversation is taking place.

DR. KATZ: Unfortunately I think you're going to see more and more people just walking away completely from prescribing and while that seems like a good thing to have fewer people prescribing to fewer patients, that's when patients feel abandonment and that's when they do turn to more elicit drugs and that's why we do see this increase in Heroin use and the Fentanyl overdoses that you hear about all the time. Also is that patients are going to continue that drug seeking pattern of not getting that continuity of care that they need. Patients get the best care when they're at one location with one person over a prolonged period of time so that we

can address, not just their pain but also their diabetes and their uncontrolled blood pressure so I think there's a balance and I think by requiring the elements but not completing the agreement you'll see a lot more people being able to accomplish these and continue prescribing in a safe way.

DR. ANDREWS: As primary care physicians we appreciate your concern because we do click a lot of boxes. And this is something that falls to primary care. There are only four chronic pain specialists for every 100,000 patients with chronic pain, so this is a primary care problem of immense proportions. I think Dr. Katz, what she is mentioning is a real concern. I hear all the time from patients who come to us from established care that they have left a practice that was unwilling to continue to prescribe because of the risks involved. Medication agreements are tools that provide physicians and patients the right way and to the best of our knowledge really good best practices. It's just that mandating it might be the one thing that tips these providers from continuing to do it and provide the service to their patients.

REP. CHEESEMAN (37TH): Okay thank you. Thank you very much, Mr. Chair.

REP. D'AGOSTINO (91ST): Representative Rutigliano.

REP. RUTIGLIANO (123RD): Thank you, Mr. Chairman. I'll be brief. This is more of a statement than a question, but I may have one question. I fully support the reporting of Methadone into the Prescription Monitoring Program. I think it's a great idea. We've been talking about it for quite some time. Mr. Chairman, I have got to be honest. I'm having a hard time with six and seven. I read

them a few times. I've been reading legislation for a while and I kind of don't understand. I don't even know where they're going. I don't know if you and I could have a question and answer conversation to do that but as a committee member I think we're going to have to.

REP. D'AGOSTINO (91ST): I think just to follow up. Have you expressed your concern about six and seven to the Governor's office through the committee or individually?

DR. KATZ: I know that our written testimony was submitted directly to them, but we haven't had a conversation.

REP. D'AGOSTINO (91ST): And you're both from the -- I'm sorry, what's the task force?

DR. KATZ: The Opioid Task Force.

REP. D'AGOSTINO (91ST): Could the task force, through you or through your offices, and we could help get in touch with someone at the Governor's office with respect I think might be worth having the conversation because you're raising a lot of issues that at least make sense to our uneducated ear, I think. And we're not sure where this came from, from the governor's office so it might be worth you all having that conversation with them and then reporting back to us. Representative Rutigliano.

REP. RUTIGLIANO (123RD): I appreciate that. That would be very helpful. Thank you. I won't ask anymore questions because I would need more information on six and seven so thank you.

REP. D'AGOSTINO (91ST): Thank you, sir. Senator Altobello?

SENATOR ALTOBELLO (82ND): Along those lines, perhaps you could have a conversation with a representative from the Department of Consumer Protection as well. I think I see one in the room and when someone suggested additional conversations, I believe she was nodding in a sense so you guys could, after your testimony maybe coordinate that. Thank you.

DR. KATZ: Thank you.

REP. D'AGOSTINO (91ST): Other questions from committee members? Other questions? Thank you doctors. Thank you for your testimony.

DR. KATZ: Thank you.

REP. D'AGOSTINO (91ST): And moving on with our speaker list for the general public, Roger Nelson, Connecticut Fire Marshals.

ROGER NELSON: Good morning Representative D'Agostino, Senator Witkos, Senator Cheeseman, distinguished members of the Law Committee. My name is Roger Nelson. I'm the Fire Marshal for the Bloomfield Center Fire District and I sit on the Board of Directors on the Connecticut Fire Marshal's Association. Connecticut Fire Marshall's Association is in opposition of section four of House Bill 7299 and that concerning making changes to Department of Consumer Protection enforcement statutes. The Department of Consumer Protection brought this proposal forward last year and the committee decided to remove it at that time as the proposal moved forward. The CFMA testified against

talking about something that we've not seen yet in this state. SO instead of going to the gas station to get gasoline a truck or a van loaded with gasoline is going to come out and bring fuel to you so that truck may be able to hold a few hundred gallons. It's not the kind of truck you see going down 84 or 91. It's not one of those 9,000- or 10,000-gallon trucks. This is a small van that would dispense fuel. So, it's the latest innovation of the gig economy. The gig economy doesn't have a lot of rules, so we recommend that if you decide to go forward you put some kind of rule in and then consider whether you want to have local officials have a say in this. We have a statewide code that's adopted if you want to have local officials have a say in it. That's where we will conclude our testimony and we thank you for taking it.

REP. CHEESEMAN (37TH): Thank you. Are there any questions from the committee members? No? Thank you for your testimony. And my apologies Representative Miller. You weren't here when we called you before. Did you have a question? So, could you please come up. You did testify? That's what I thought. Yeah. She's confusing me. Making trouble. Yes. I guess, of course you did. It was on

Next, we have Nathan Tinker.

NATHAN TINKER: Good morning Chairman D'Agostino and Fonfara, Senator Witkos, Representative Cheeseman, and a special Good Morning to my own personal representative from the great town of Trumbull, Representative Rutigliano. Thank you for being here. HB 7159

My name is Nathan Tinker and I'm chief executive of the Connecticut Pharmacist Association which represents over 1000 pharmacists, technicians, students, and others in every pharmacy setting across the state. I'm here to talk a bit about HB 7159. You already have my written testimony, so I just want to expand on that a little bit.

Pharmacists play an important role in helping people on their path to better health by improving access to care and lowering costs for patients. They are educated and experienced in pharmacology and drug effects, side effects, and interactions and by law they must complete many hours of continued education to maintain their licenses. And importantly pharmacists are daily on the front lines of the opioid crisis and therefore have the opportunity to do much more in this fight than just fill prescriptions. One of the pharmacists most important roles is to provide medication counseling to help patients better understand their prescription medications and to ensure that a patient's medication regimen including the use of opioids is appropriate.

Furthering enabling pharmacy technicians to better support pharmacists by creating pathway to qualify technicians to access the Electronic Prescription Monitoring Program can help to create time and opportunity for pharmacists to commit these other engagements. The Connecticut Pharmacists Association already manages pharmacy technician training programs across Connecticut and if HB 7159 is passed we will work with relevant parties and agencies to develop and deploy an appropriate training and certification program. And finally, while we do have some concerns about the potential

impact requiring pharmacists to potentially gatekeep prescribers who forgot to note diagnoses codes on their prescriptions, we appreciate the opportunity to discuss these concerns with DCP in more detail. Perhaps including a way to educate prescribers about writing better prescriptions. HB 7159 offers a number of passed addressing the opioid problem and we believe pharmacists play an important part. We support the bill's goals and we will work close with you and DCP to make it as successful as possible.

REP. CHEESEMAN (37TH): Thank you. Questions from committee members? Representative Rutigliano?

REP. RUTIGLIANO (123RD): Thank you. Good morning. We didn't get a printed copy of this particular testimony so that's what I was looking for. Are there any sections of the bill -- you're generally supportive of the bill is what you're saying? Are there any sections that you think where wording needs to be changed or can make maybe the pharmacists more supportive?

NATHAN TINKER: Well, we are very supportive particularly of the expanding the opportunity for our pharmacy technicians to have access to the PMP in certain cases to help support pharmacists do their job better. That I think is a really important piece that will make the entire experience of the pharmacist and the ability to track opioids in the system that much easier.

REP. RUTIGLIANO: (123RD): Is the pharmacist ultimately responsible if his assistant -- the PMP is basically the assistant. It's still their responsibility to oversee that entire operation but you're saying that it would be helpful if the tech

or the assistant can make the notations in the Prescription Monitoring Program.

NATHAN TINKER: Exactly. And the way it's written it specifically notes that the pharmacist is the responsible party at the end of the day and could be held responsible including penalties for the technician's misuse or accidents in the program.

REP. RUTIGLIANO (123RD): Okay, thank you.

REP. CHEESEMAN (37TH): Any other questions from committee members? Seeing none. All right, thank you very much for your testimony today.

REP. A'AGOSTINO (91ST): Thank you very much Representative Cheeseman. Chris Herb, CEMA.

CHRIS HERB: Hello, my name is Chris Herb. I'm the president of the Connecticut Energy Marketer's Association. Our members own and operate gas stations in Connecticut. We own, operate, and supply about 1,000 of them. We are here today in opposition to Section four of House Bill 7299 regarding the mobile on demand fueling. You're heard previous testimonies and I've submitted written comments, so I'll just cut to our three major concerns on this. The first one being, the decades worth of development of consumer protection laws to be able to disclose to consumers. You've all been to gas stations where you've seen all the disclosure requirements that occur at the point of purchase.

They require us to talk about the price of the fuel, any cash discounts that might be provided, bank holder credit/debit purchases, meter inspection

pumps and valves and stuff our brothers, the fitters install this stuff, but we rebuild them, replace them, and we inspect them with motors and stuff with alignments so that's kind of a quick 25 cent information on what a millwright is. If you have any questions, feel free to ask them please.

REP. D'AGOSTINO (91ST): Questions from committee members? No questions? Representative Altobello.

REP. ALTOBELLO (82ND): Thank you for coming today. Good morning. You said you had not yet submitted written testimonies.

TIM MORIARITY: No, we will be.

REP. ALTOBELLO (82ND): Okay and who's the we you're representing.

TIM MORIARITY: Millwrights Local 1121.

REP. ALTOBELLO (82ND): Thank you very much.

REP. D'AGOSTINO (91ST): Other questions? Thank you.

Dr. Joanne Santiago.

DR. JOANNE SANTIAGO: Good morning, Mr. Chair and representatives of this committee. My name is Dr. Joanne Santiago and I am president of the Connecticut Chiropractic Association. We do commend you and Governor Lamont for remaining diligent in this time of opioids crisis and pursuing ways to reduce the use of opioids and their abuse. This bill, HB 7159 revised as the general statutes for opioid prescription and control to help combat the opioid crisis. The revision suggested should help alleviate the crisis and they are reasonable.

While we focus on alleviating the opioid crisis through pharmaceutical treatment and control of prescriptions, we must also realize that there are affective non-pharmaceutical methods of care that can alleviate the need for current opioid use and abuse, especially preventing the initiation of opioid use for those with various acute and chronic condition. We submit that it is essential this bill include the disclosure and possible use of non-pharmaceutical care for those receiving opioid prescriptions specifically as recommended by the work group of the Connecticut Alcohol and Drug Policy Council. The report to the legislation recommended that physical therapy, acupuncture, massage, and chiropractic care should be part of the response to chronic pain.

This recommendation is consistent with recommendations from many reputable government and non-profit healthcare organizations as was given in my written testimony to you. There's substantial scientific evidence that firmly supports the use of chiropractic care on the front lines of health care for conditions that may lead to opioid use and abuse. Unfortunately, these benefits are all often suppressed due to various healthcare policies which we submit are a contributing factor to this opioid crisis. Disclosing to the patients of chiropractic and other non-pharmaceutical methods of treatment prior to prescribing this opioid medical will bring a reduced use and abuse of this prescription. In closing, I would like to say that I am second generation chiropractic physician and my daughter Joelle is now the third generation in my family as doctor. We are now six chiropractors in my family tree. My parents mastered this healing art and

brought great health and well being to their patients without the use of drugs. I've seen many patients achieve health excellence without the use of drugs, especially opioids in all my years of practice. One of my brothers was a chiropractic physician for the Olympics. There they triage and use natural healthcare when indicated.

My daughter will see greater and greater numbers and will have more opportunity to prevent her patients from getting started in the first place with the opioid medications, as the chiropractic profession does help alleviate this terrible crisis. Please, we are asking you as an association to amend this bill to include the experts in the natural and non-drug health base healthcare for chronic pain conditions as recommended in my report. Patients are first and foremost and must have this knowledge of the non-drug approaches to chronic care treatments when they see their physicians. Please add chiropractic to this important position for our citizens in Connecticut seeking healthcare. Thank you.

REP. D'AGOSTINO (91ST): Thank you doctor. Questions from committee members? Thank you very much. Joyce Wojtas.

JOYCE WOJTAS: Good morning, Mr. Chairman, members of the General Law Committee. My name is Joyce Wojtas and I'm here on behalf of the Mechanical Contractors Association of Connecticut and with me is Cam Champlain who the lobbyist for the Local 777 Plumbers and Pipefitters Union. We're here to strongly support House Bill 7299, especially section 11 which includes inspection and testing as defined in subsections 24, 25, and 26 of the Bill to various

JOSEPH VALLANO: It won't explode. It will catch fire because it's flammable. That's why we have vapor recovery systems on our trucks is to alleviate any vapors getting into the atmosphere.

SENATOR LEONE (27TH): Thank you. Thank you, Mr. Chairman.

REP. D'AGOSTINO (91ST): Any other questions from committee members. Thank you very much. Appreciate it. Glad we got to hear from you on that. That's the remainder of our list of people that's signed up. If there's anybody else that could testify please come up. State your name and let us know what you're testifying about.

MR. TRUMAN: I am Mr. Truman and I've testified here many times on the opioid. You're talking about federal law about vaping and everything else which is a narcotic and under DEA law that we are not enforcing you combine do opioid is Pot. You have more regulations on gasoline than you do on opioids. See on the racketeering laws -- HB 7159

REP. D'AGOSTINO (91ST): I'm sorry. Which bill are --MR. TRUMAN: The opioids.

REP. D'AGOSTINO (91ST): The Governor's bill?

MR. TRUMAN: Yes, the Governor's bill. When you run for state office you take an oath to protect the public from itself. When you're opening up a drug war just like the cartel in New York went to jail for federal felony which our state is now liable for because under the Rico Act, under Public Safety Act. I've done a lot of hearings on federal law and under Federal Banking Commission law you cannot transmit an opioid because its gang activity because the

state cannot regulate and open up a drug fest because that's why you got elected because of the drugs. You didn't get re-elected under your personal attitude you got elected under the Drug Enforcement Act because you want to legalize Pot. Then you have legalizing opioids. Opioids is liquor, tobacco is an opioid. But we have an opioid addiction in tobacco and alcohol which causes liver and cancer, but we do not want to go back to prohibition, but you have more regulations on gas than you do on basically them. You're opening up a drug fest because you have children and you have schools that are going to be exposed to opioids. They already are. You go down to St. Patty's Day and they were smoking Pot on the side of the road. They had an open beer. So, what happens is 1920 the prohibition laws they said we want to save our youth from the exposure, so they enforced the Prohibition Act which New York and Rhode Island still have because they were tired of all the arrests and having all these people laying all over the street. And so, you're having your anti-police because the police are trying to bust everybody and put them in prison and -- It's under the Rico Act.

REP. D'AGOSTINO (91ST): Thank you. I think we got what you're saying.

MR. TRUMAN: Basically, when you get voted in, you're supposed to protect the public and that little child going to school but you don't because instead of drug enforcing the police bust so then the state says –

REP. D'AGOSTINO (91ST): Thank you. It thinks we got it.

MR. TRUMAN: Yeah that's why 22 Republicans got voted out – because of the Rico Act.

REP. D'AGOSTINO (91ST): I think we got it. Thank you very much. I appreciate your testimony. Is there anybody else that would like to testify about the matters before us today? All right, that will finish the public hearing. Thank you.

Joint Testimony of the American Council of Life Insurers
and the Insurance Association of Connecticut
before the Joint Committee General Law
Tuesday, March 12th, 2019

House Bill 7159 – An Act Addressing Opioid Use - Support

Chair Fonfara, Chair D'Agostino, and members of the Joint Committee on General Law, the American Council of Life Insurers (ACLI) and the Insurance Association of Connecticut (IAC) appreciate the opportunity to offer the following statement of support on House Bill 7159, which would prohibit life insurance or annuity policies from excluding coverage solely on the basis of receipt of a prescription for naloxone. ACLI and IAC members are the leading writers of life insurance, annuities, disability income and long-term care insurance and supplemental benefit insurance here in Connecticut and across the country.

As an industry dedicated to promoting long, healthy lives, the staggering loss of life resulting from the opioid epidemic strikes at the nation's overall well-being and the core of our industry. Life insurers laud the families and medical professionals at the forefront of combating this crisis.

Life insurers support the efforts of "good Samaritans" to prevent loss of life due to opioid overdose. We also support the use of "Standing Orders" that make the anti-overdose drug naloxone more accessible to prevent loss of life.

The opioid epidemic has raised questions about good Samaritans who have prescriptions for naloxone and how that may impact their ability to obtain life insurance coverage. The clearer the picture life insurers have of applicants' medical situations, the more accessible and affordable coverage is for all.

While life insurers fully support the use of naloxone by good Samaritans, information on an applicant's medical record or prescription history report about a prescription for naloxone may prompt additional questions and a deeper review of the request for coverage and reason for the prescription. Indeed, a life insurer would not be doing its job of assessing the risks it assumes on behalf of current and future policyholders if it did not notice and evaluate such a prescription. That is why life insurers ask applicants to provide all medically relevant information when seeking coverage.

Life insurers' risk-assessment process, called underwriting, is governed by state laws barring unfair trade practices. Companies must underwrite based upon sound actuarial principles and reasonably anticipated loss experience. That means that insured people with similar characteristics should pay the same premiums for the same coverage. Life insurers rely on a variety of factors when determining whether to provide coverage to an applicant and what to charge for premiums. These factors generally include an applicant's age, height and weight, blood pressure, cholesterol, blood sugar, smoking status and medical history, among other factors.

Any person denied coverage for any reason should know that America's life insurers are in the business of providing people the financial protection they want and need and seek ways to offer coverage to as many people as possible. Indeed, the life insurance industry is very competitive, with more than 700 life insurers in the United States working to serve consumers' financial needs. Establishing their own underwriting criteria in accordance with relevant state laws is one way individual companies can differentiate themselves from their competitors. As a result, insurers might evaluate the same applicant differently and, therefore, make different decisions on issuance and pricing. We recommend that applicants shop around to find the best policy for them.

Life insurers want to help those on the front lines of the opioid crisis and all Americans address their financial protection and retirement security needs.

In its current form, we believe the bill helps those on the front lines of the opioid crisis while allowing life insurers to ask applicants medically relevant information when seeking coverage. The ACLI and the IAC support the language used in the bill.

We encourage the committee to consider passing the legislation.

We appreciate the opportunity to provide our comments on H.B. 7159.

UCONN HEALTH

Testimony of
The UConn Health Opioid Task Force

By: UConn Health Opioid Task Force Co-Chairs
Dr. Rebecca Andrews
Dr. Marilyn Katz

General Law Committee
March 12, 2019

HB 7159 – An Act Addressing Opioid Use

Distinguished Members of the General Law Committee, thank you for allowing us, as Co-Chairs and representatives of the Opioid Task Force at UConn Health, to testify on HB 7159, An Act Addressing Opioid Use.

The Opioid Task Force at UConn Health is an interdisciplinary group of clinicians, educators and researchers at UConn Health collaborating (1) to develop policies pertaining to opioid prescriptions for chronic non-malignant pain, (2) to identify resources for alternative pain treatments, (3) to make recommendations for acute pain treatment protocols based on literature and evidence-based guidelines; and (4) to serve as an advisory council on issues pertaining to opioid use. Our membership includes doctors and other health care practitioners and experts practicing in primary care/internal medicine, orthopedic surgery, emergency medicine, pharmacy, psychiatry/addiction medicine, dentistry, hematology/oncology, poison control, neurology, and health care quality.

The members of the Opioid Task Force commend the Governor and this Committee for putting forth HB 7159. The goals of this legislation are laudable, and it is critical that we as providers and you as policy-makers continue to look at ways to address opioid misuse.

As clinicians, educators and researchers who work daily with the issue of opioid prescribing, and with developing and instituting best practices in this area, we would

like to work with the Governor and the Committee to help HB 7159 best achieve its goals.

Specifically, we have some concern that Sections 6 and 7 of the bill, as currently written, may not achieve their stated goals. We believe that there are changes that can be made that will be more effective and have more real impact.

Section 6 would require prescribers to specify a patient's diagnosis and ICD code on opioid prescriptions, with the intention of making providers think twice before prescribing opioids. However, we do not believe this additional work will be useful to either the patient or the provider, nor will it limit opioid prescribing. We respectfully submit that documenting the indication for use clearly in the patient's chart would be a more meaningful use of documentation. Additionally, if a patient plan is used by the prescriber, indication information could be written there.

Section 7 of the bill would require a medication agreement if an opioid is prescribed to a patient for longer than 12 weeks. This is a recommendation from the 2016 CDC guidelines, and in fact, UConn Health already does have a policy that requires a medication agreement for chronic opioid prescribing. However, there is not a lot of literature on medication agreements and whether or not they actually improve outcomes. We have concerns about putting such a requirement into state statute, since that will not allow the ease of change and modification as new literature emerges. Similar to our recommendation for Section 6, we believe that encouraging that this key information (treatment goals, risk of opioids, etc.) be incorporated into the progress note and/or patient plan would be a better requirement than mandating a medication agreement.

Our Opioid Task Force has some other recommendations to promote safe prescribing that we believe are achievable. For example, facilitating the use of the state's prescription drug monitoring program (PDMP) by ensuring single-click integration of the PDMP with prescribers' Electronic Medical Record systems (EMRs) would go a long way. Currently, most providers across the state need to leave the patient chart, open up the PDMP website, use a separate username and password to log on and then enter in the patient first and last name and their date of birth to access the report. Each of these steps are cumbersome and unnecessary, and discourages prescribers' use of the PDMP.

Last year, the legislature created a Medication Reconciliation and Polypharmacy Workgroup under the Health Information Technology Advisory Council, and this group has concluded that it is technically feasible to integrate a PDMP link directly into a state-wide Health Information Exchange (HIE) with a single click within the patient's chart, pulling up the patient's controlled substance prescription history. We believe that this functionality should be supported and expedited by the State as it develops its HIE.

Another recommendation of our Opioid Task Force where we believe legislation can make a real difference is in ensuring that all prescription controlled substances are reported to the PDMP. Currently methadone is not reported if it is being prescribed for Medication Assisted Treatment (MAT) of Opioid Use Disorder (OUD) or for detoxification from opioids. Historically, this was due to protect patients and reduce stigma for patients with opioid use disorders. However, we now have multiple options for treating OUD, including buprenorphine (suboxone), and those are reported to the PDMP. Additionally, methadone is reported if it is prescribed for chronic pain and dispensed through a pharmacy. Not having access to methadone prescription history puts patients at a high risk of overdose if prescribed an opioid in addition to their methadone, placing providers in a challenging position, particularly in an acute prescribing situation. Adding all methadone to the PDMP would provide the clinician with a more accurate morphine milligram equivalent (MME) and would enhance opioid prescribing safety. There are challenges to include methadone reporting in the PDMP, including the fact that Methadone for MAT and OUD is dispensed at a clinic and not a pharmacy. However, steps to include methadone in the PDMP should be considered for patient safety, particularly because other medications used for MAT are already reported.

In conclusion, we applaud the Governor and the Committee for raising HB 7159 and for its efforts to address the opioid crisis in Connecticut. As part of the State's only public academic medical center, we are ready and willing to talk with you further about our work and our recommendations and to assist you in any way.

We believe it is critical to get legislation like this right – to ensure that we achieve the goals of reducing abuse, but also to ensure that we do not create any unintended consequences. One of the unintended consequences of enhanced regulation and oversight of opioids has been the attrition of providers who are willing to prescribe these medications. Chronic pain affects hundreds of thousands of patients across the country. While we all agree that the current state of affairs is a true crisis and support the oversight of prescribing practices, we believe it is important to be careful to not unintentionally reduce healthcare access for an already stigmatized patient population. We respectfully submit that focusing on what really will impact long term outcomes, and being careful to avoid additional administrative burdens on prescribers that do not add value, should be primary goals of this and future legislation.

Thank you for your consideration and we are happy to answer any questions that the Committee may have.

CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
GENERAL LAW COMMITTEE
Tuesday, March 12, 2019

HB 7159, An Act Addressing Opioid Use

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **HB 7159, An Act Addressing Opioid Use**. CHA supports the bill as a component of an ongoing comprehensive statewide strategy to combat the opioid epidemic in Connecticut. We have concerns about certain sections of the bill, specifically Sections 1, 2, 6, and 7.

Before commenting on the bill, it is important to point out that Connecticut hospitals and health systems provide high quality care for everyone, regardless of their ability to pay. They do more than treat illness and injury. They build a healthier Connecticut by improving community health, managing chronic illness, expanding access to primary care, preparing for emergencies, and addressing social determinants of health. By investing in the future of Connecticut's hospitals, we will strengthen our healthcare system and our economy, put communities to work, and deliver affordable care that Connecticut families deserve.

Connecticut hospitals and health systems have been engaged for years in efforts to reduce inappropriate opioid use while ensuring patients have appropriate pain medication. The adoption of voluntary opioid prescribing guidelines in January of 2015 helped Emergency Department (ED) staff treat patients with chronic pain conditions. Developed by ED directors in collaboration with other prescribers and the Department of Public Health (DPH), these guidelines were updated in 2018 in light of new laws developed with input from hospitals and other healthcare providers.

For several years, CHA has collaborated with other professional societies and DPH to sponsor continuing education programs for prescribers on the topic of controlled substances. Representatives of Connecticut hospitals have served on a variety of task forces and working groups in furtherance of the state's efforts to reduce the potential for people to become addicted to opioid medications.

Other measures taken by hospitals and health systems to combat the opioid epidemic include:

- Deploying recovery coaches in EDs
- Hosting evening intensive outpatient programs for patients recovering from drug addiction
- Supplying naloxone kits to first responders, as well as to patients and their loved ones

- Incorporating opioid awareness into clinical integrated care programs
- Sponsoring community awareness and education programs
- Screening and enrolling patients in buprenorphine/naloxone treatment programs for opioid dependence
- Establishing a statewide collaborative to assess and treat babies born with neonatal abstinence syndrome (NAS)
- Initiating the NAS Comprehensive Education and Needs Training (NASCENT) project, which educates providers on best practices for opioid prescribing and NAS treatment, as well as identifying substance use disorders in women of childbearing age
- Partnering with the Connecticut Perinatal Quality Collaborative to improve the health, equity, and quality of care for mothers and infants, including those affected by opioid use disorder

We look forward to continuing to work with the state and with our continuum of care partners to resolve this crisis.

HB 7159 proposes to strengthen oversight of prescriptions for opioids, facilitate the use of the state's Prescription Drug Monitoring Program (PDMP), prohibit discrimination against individuals who use life-saving opioid antagonists, and enhance communication between healthcare practitioners and patients regarding opioid use. As mentioned above, CHA has concerns about the following four sections of the bill.

Sections 1 and 2 propose to expand the current statutory requirement that pharmacists offer counseling to patients regarding their prescriptions. CHA asks that you amend this section of the bill to allow telepharmacy in addition to in-person counseling. Such a change would acknowledge situations in which a patient may be bedridden. A telepharmacy option would better accommodate both patient and prescriber in these situations.

Section 6 of the bill would require a prescriber to include ICD codes for every "prescription" of opioid drugs. We have two concerns about Section 6. First, it will take some time for all prescribers to adapt their e-prescribing systems, understand the new rule, and ensure that they are able to comply. To reduce the risk of impeding patient care, we ask you to change the effective date of this section from October 1, 2019 to January 1, 2020.

Second, it is unclear whether this section will apply to hospital orders that are for drugs administered to patients at a hospital. It would appear from the phrase "who was issued the prescription" (lines 349-350) that the section would apply only to prescriptions given to patients or sent to community and retail pharmacies for patients' self-use. We recommend that you clarify the language of this section by adding the following sentence: "This Section 6 shall not apply to opioid drugs ordered for a patient that are to be administered to the patient at a hospital."

Section 7 requires a pain contract between a prescriber and a patient for prescriptions with a duration greater than twelve weeks. As drafted, the bill implies that each pain contract must include, at a minimum, a discussion of treatment goals, risks of using opioids, urine drug screens, discontinuation of opioids, and expectations for continued treatment of pain with opioids.

We argue that each of these listed elements will not always be appropriate to include in every pain contract, and will depend on the particular circumstances of the patient, (e.g., a cancer patient with four months to live does not need urine drug screens). We must rely on each prescriber to incorporate the appropriate elements into a pain contract, using their medical judgment as applied to the particular circumstance of the patient.

CHA asks the Committee to substitute the word "address" for the word "include" at line 359 of the bill.

CHA and Connecticut hospitals are proud to renew our pledge to continue working with the state to address this epidemic. We thank you for considering our proposed revisions to **HB 7159**.

For additional information, contact CHA Government Relations at (203) 294-7310.

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

A Healthcare Service Agency

NED LAMONT
GOVERNOR

MIRIAM DELPHIN-RITTMON, PH.D.
COMMISSIONER

To: General Law Committee

From: Miriam E. Delphin-Rittmon Ph.D., Commissioner

Date: March 12, 2019

Re: Written Testimony regarding HB 7159

Please accept this written testimony from the Department of Mental Health and Addiction Services (DMHAS) in support of Proposed House Bill 7159 AN ACT ADDRESSING OPIOID USE.

DMHAS has been actively addressing Connecticut's opioid crisis and will continue to provide treatment and recovery services to those struggling with opioid use disorder. DMHAS is the lead state agency for substance use and misuse prevention across the lifespan. DMHAS, in collaboration with state and community stakeholders, works to implement evidence based prevention strategies addressing the opioid crisis. HB 7159 aligns with evidence based strategies that include monitoring access to opioids and educating individuals who have obtained an opioid prescription.

While DMHAS is not directly impacted by HB 7159 the agency supports this bill due to the anticipated positive impact of reducing unnecessary or uninformed opioid use. Thisbill proposes to utilize the expertise of pharmacists to educate consumers during the course of routine transactions. The bill also provides an opportunity for pharmacy technicians to have a role in addressing the opioid crisis by allowing them access to the electronic prescription drug monitoring program, providing yet another opportunity to flag risky opioid use. DMHAS is especially supportive of the provision that ensures individuals who have received naloxone cannot be denied insurance, an annuity policy or contract based on having a naloxone prescription. DMHAS would also like to emphasize the importance of developing treatment agreements if pain medication is prescribed for longer than twelve weeks.

Thank you for the opportunity to testify on this bill.

CTChiro
Connecticut Chiropractic Association Inc.

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CTChiro.com

March 12, 2019

Re: HB 7159 An Act Addressing Opioid Use.

Senator Fonfara, Senator Witkos, Representative Cheeseman and members of the General Law Committee

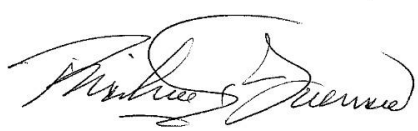
My name is Dr. Richard Duenas and I am the Government Relations Chairperson of the Connecticut Chiropractic Association. We commend you and Governor Lamont for remaining diligent on this opioid crisis to reduce the use and abuse of opioids. This bill revises the general statutes for opioid prescription and control, and should help alleviate the crisis. We also commend the work done by the Workgroup of the Connecticut Alcohol and Drug Policy Council and its recommendation to utilize non-drug care to help alleviate chronic pain and the opioid crisis:

> "Physical therapy, acupuncture, massage, and chiropractic care should be part of the response to chronic pain. Based on available literature regarding alternative opioid treatment therapies, we recommend, as a first phase, targeting changes in access to these four interventions for two types of chronic pain: low back pain and neck pain. Given experience and results of phase one, additional types of chronic pain could be added."

There is more than sufficient science and clinical based evidence that firmly supports the use of chiropractic care on the front lines of health care for conditions that may lead to opioid use and abuse. Unfortunately, these chiropractic benefits may be suppressed due to various health care policies within the health insurance, workers compensation, and public healthcare systems which may contribute to the opioid crisis. Disclosing to patients the benefits of chiropractic and other non-pharmaceutical treatment prior to prescribing opioid medication for chronic pain will help reduce the use and abuse of opioid medication.

We suggest amending HB7159 to include the recommendation from the Workgroup of the Connecticut Alcohol and Drug Policy Council as attached to this testimony.

Respectfully,



Richard Duenas, D.C.
Government Relations Chairperson

Connecticut Chiropractic Association
Proposal on Treating Chronic Pain without Opioids
March 2019

H.B. No. 7159 'AN ACT ADDRESSING OPIOID USE', to implement the Governor's budget recommendations

As part of Section 7 of HB 7159:
Sec. 7. (NEW) (Effective October 1, 2019) A prescribing practitioner, as defined in section 20-14c of the general statutes, who prescribes an opioid drug, as defined in section 20-14o of the general statutes, for the treatment of pain for a patient for a duration greater than twelve weeks shall establish a treatment agreement with the patient. The treatment agreement shall, at a minimum, include treatment goals, risks of using opioids, urine drug screens, discontinuation of opioids and expectations regarding the continuing treatment of pain with opioids.

CCA recommends:
(a) before starting a patient on an opioid when such patient seeks treatment for chronic pain, a health care practitioner shall inform, refer or prescribe to the patient any of the following non-pharmacological treatment alternatives, based on the practitioner's clinical judgment and the availability of the treatment:

- chiropractic services by a chiropractor licensed under chapter 372,
- acupuncture by an acupuncturist licensed under chapter 384c,
- physical therapy by a physical therapist licensed under chapter 376,
- massage therapy by a massage therapist licensed under chapter 384a.

(b) nothing in this section should be construed to require that one or more of the treatment alternatives set forth in subsection (a) are required to be exhausted prior to the patient receiving a prescription for an opioid.

(c) nothing in this section shall preclude a practitioner from simultaneously prescribing an opioid.

(d) the commissioner shall

- recommend guidelines for the use of evidence-based, non-pharmaceutical interventional therapies to treat chronic pain that include, but are not limited to, chiropractic treatment and services, acupuncture, physical therapy and massage therapy
- prepare with representatives from the chiropractic and acupuncture professions, a document that informs patients of the benefits derived from non-pharmacological treatment of any condition that causes chronic pain to be distributed to patients by prescribers when a prescription for opioid medication is made

(e) the commissioner shall conduct an outreach and marketing campaign to the public and healthcare consumers about the methods available for treating chronic pain that do not involve the use of an opioid drug.

Connecticut ORTHOPAEDIC Society

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860-690-1146

Written Testimony of the
Connecticut Orthopaedic Society
HB 7159 AA Addressing Opioid Use – Tuesday, March 12, 2019

Senator Fonfara, Senator Witkos , Representative Cheeseman and distinguished Members of the General Law Committee, on behalf of the more than 230 orthopaedic surgeons of the Connecticut Orthopaedic Society, we appreciate the opportunity to submit written testimony on HB 7159, AA Addressing Opioid Use.

Opioid abuse continues to be a serious public health matter and an addiction epidemic unlike others. Since 2016, the State of Connecticut and Legislature has enacted numerous policies seeking to reduce and prevent opioid drug overuse and abuse all in an effort to help our patients, protect the public and stop this epidemic that has claimed many lives and destroyed many families.

The Connecticut Orthopaedic Society appreciates the Legislature's continued commitment to addressing the ongoing public health epidemic. As orthopaedic surgeons, we prescribe controlled substances for legitimate medical purposes and are very cautious and cognizant in our prescribing practices to all our patients and most of our practices are equipped with Electronic Medical Records (EMR) that document the diagnosis code as well as drugs prescribed to the patient in their electronic medical record. However, some EMR systems may not be able to handle this propose requirement and there are practices that do not use EMR systems, both these situations would make this provision in HB 7159, Sec. 6, a cumbersome addition to the practicing physician. Most importantly, we do not know why this new requirement is necessary or what it will achieve and improve in opioid drug prescribing as a pharmacist does not need to know what the diagnosis is for the opioid drug prescribed.

Furthermore, our Society members are concerned that while the language notes that the diagnosis code is not required to be on the label; it does not prohibit the pharmacist from doing so after consultation with the prescribing physician which could lead to public awareness of a patient's confidential, HIPPA protected medical information by not only the pharmacist but also any staff associated with the retail pharmacy stores.

We believe that HB 7159, Sec. 6, not only jeopardizes our patient's medical information and could lead to serious HIPAA violations but also would require that their health diagnosis be reported to the pharmacist without justification as to the need for the pharmacist to have the confidential information.

In closing, we appreciate this Committee's work to continue to stem the opioid epidemic and we ask you to protect the medical information of all our patients by removing the proposed language found in HB 7159, Sec.

6. We are proud that the orthopaedic community is working diligently to battle against opioid addiction and abuse, on the national level, as a state society, and within our own practices to ensure the safety of our patients and would like to serve as a resource to this Committee and the Legislature as we all continue on a path to eliminate opioid overuse and abuse. Thank you.

Respectfully submitted,
Mariam Hakim-Zargar, MD, MPH
President
Torrington, CT

Ned Lamont
GOVERNOR
STATE OF CONNECTICUT

March 12, 2019

Sen. John Fonfara
Rep. Michael D'Agostino
Sen. Kevin Witkos
Rep. Holly Cheeseman

General Law Committee
Legislative Office Building, Room 3500
Hartford, CT 06106

Re: Testimony from Governor Ned Lamont in support of HB 7159: An Act Addressing Opioid Use

Thank you for the opportunity to offer written testimony in support of House Bill No. 7159, An Act Addressing Opioid Use, and thank you to the Committee for raising this bill at my request.

As I traveled throughout Connecticut last year, I witnessed firsthand the toll that opioid use disorder takes on individuals, families, and their communities. On a visit to New London's Homeless Hospitality Center, I met with first responders, treatment providers, non-profit leaders involved with certifying and operating sober homes, recovery navigators, and individuals in recovery from opioid use disorder. New London's Opioid Action Team brings together the diverse areas of expertise needed to combat the opioid crisis in a collaborative way. The Opioid Action Team has helped blunt the impact of the opioid crisis in southeast Connecticut, but more must be done there and across the state. No community of ours has remained unscathed from the opioid epidemic.

Over the past several years, Connecticut has been at the forefront of public health efforts to confront the opioid crisis, but our state's residents are still struggling with addiction, and it is incumbent upon us to help. New data from the latter part of 2018 suggest the state's opioid overdose epidemic is stabilizing as a result of local and statewide drug overdose prevention strategies. While this is positive news for the state, Connecticut's opioid overdose emergency department rate remains approximately 1.7 times higher than the national rate. This is simply unacceptable. We need to do more to help our friends, neighbors, and family members. The stabilization in overdoses does not mean we have halted addiction, abated its consequences, or sufficiently aided those who have received treatment and are trying to move forward with their lives. This crisis requires our attention and best efforts.

I recognize that addiction is an illness and not a moral failing, and the only way to address the opioid epidemic is to treat it as what it is: a true public health emergency. I look forward to collaborating with all stakeholders as we continue to improve our state's response to the opioid epidemic. Individuals with opioid use disorder, advocates, academics, public health officials, health providers, and insurance carriers, along with members of this committee and the legislature at large, are among the stakeholders and experts that my

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administration will work with in responding to the opioid crisis. This year, we have new opportunities to address the opioid crisis due to new funds made available from recent federal legislation, and my administration is already working on ways to access those funds.

My strategy to address the opioid epidemic includes $8 million in my biennial budget to expand medication-assisted treatment (MAT) for individuals with opioid use disorder in our state's correctional facilities. MAT is shown to be clinically effective in fighting opioid withdrawal and helping reduce relapse. Fifty-two percent of people in Connecticut who died of a drug overdose had at one point been in a correctional facility. Yet most incarcerated people today do not have access to evidence-based treatment. In neighboring Rhode Island, a comprehensive MAT program reduced deaths by 60% among recently incarcerated people in its first six months of operation. Similar results in Connecticut would mean 100-150 saved lives every year. This investment will help promote both a safer environment for corrections officers and greater recovery among people in prison with opioid use disorders. Treatment saves lives, saves money, and reduces crime.

My commitment to addressing the opioid epidemic exemplifies my broader interest in improving our state's public health. As part of my budget, I proposed to raise the age to twenty-one for purchase of tobacco and vaping products, reduce the use of vaping and consumption of sugary beverages by increasing the cost, enhance screening of newborns for treatable diseases, expand childhood immunization, and ensure safe drinking water for years to come.

The statutory changes in this proposal will help continue to drive down opioid use in Connecticut. This proposal makes changes to reduce the misuse of prescription opioids, strengthen oversight of prescriptions for opioids, facilitate use of the state's Prescription Drug Monitoring Program (PDMP), prohibit discrimination against individuals who use life-saving opioid antagonists, and enhance communication between health care practitioners and patients regarding opioid use.

Sections 1 and 2 require pharmacists to offer counseling to patients regarding their prescriptions. Currently, C.G.S. §20-620 requires pharmacists to offer such counseling to Medicaid patients. Expanding that requirement will enhance communication between pharmacists and patients and reduce the likelihood of misuse of prescription opioids.

Section 3 facilitates use of the state's Prescription Drug Monitoring Program (PDMP) by allowing pharmacists to designate an authorized pharmacy technician and clarifies statutes regarding disclosure of controlled substance prescription information to the Department of Social Services (DSS). Prescription drug monitoring programs continue to be among the most promising state-level interventions to improve opioid prescribing, inform clinical practice, and protect patients at risk. Evaluations of prescription drug monitoring programs at the national level have illustrated changes in prescribing behaviors, reduced use of multiple providers by patients, and decreased substance use disorder treatment admissions.

This proposal will make Connecticut's PDMP easier to use for pharmacists. This section also clarifies that prescribers can disclose PDMP controlled substance prescription information to DSS for the purpose of administering the Medicaid program. DSS has experienced a few recent situations in which Medicaid providers refused to give PDMP information to the department, citing confidentiality requirements under C.G.S. § 21a-254(j)(7). Not receiving this information has hampered DSS' ability to make meaningful decisions regarding the authorization of opiates and other dependency-producing drugs. This proposal will clarify that prescribers can share controlled substance prescription information with DSS. The information DSS could obtain through the PDMP would be specifically for the purposes of conducting prior authorization reviews of prescription drugs covered under any of the medical assistance programs

administered by DSS. DSS requires prescription prior authorization review and approval for controlled substances, with the majority of such reviews specifically for opioid-related prescriptions. This proposal is consistent with recommendations provided by the federal Centers for Medicare and Medicaid Services. Its January 28, 2016 Informational Bulletin, "Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction," identifies access to a state's PDMP as an effective tool for the Medicaid agency to "identify potential inappropriate prescribing and use of controlled prescription drugs, such as opioids."

Section 4 requires manufacturers and wholesalers to report to the Department of Consumer Protection when they terminate or decline distribution of controlled substances to a pharmacy. In 2018, legislation codified in C.G.S. §21a-70(i) required manufacturers and wholesalers to report suspicious orders of controlled substances. This new provision would strengthen investigatory tools and allow the department to identify potential problems more rapidly.

Section 5 prohibits discrimination against substance users and their families, friends, and good Samaritans who carry naloxone and other opioid antagonists designed to treat opioid overdoses and save lives. Specifically, the provision prohibits denial of life insurance to an individual solely on the basis of a prescription for an opioid antagonist.

Section 6 requires prescribers to specify diagnosis on opioid prescriptions. By specifying the medical condition being treated, this requirement provides an opportunity for the prescriber to fully consider and discuss the most appropriate options with the patient. The provision does not require the diagnosis information to be included on the label of the prescription or prevent the pharmacist from adding the information after consultation with the prescribing practitioner. This new provision excludes prescriptions for animals.

Section 7 requires a pain contract between prescriber and patient. Under the provision, a prescribing practitioner who prescribes an opioid drug for the treatment of pain for a patient for a duration greater than twelve weeks must establish a treatment agreement with the patient. The treatment agreement must, at minimum, discuss treatment goals, risks of using opioids, urine drug screens, discontinuation of opioids, and expectations for continued treatment of pain with opioids.

This problem requires a multi-faceted response from nearly everyone in this state, and we need to do what we can to leverage state resources and maximize opportunities under state law. There are many opioid-related proposals before the legislature this year, and I welcome further conversation on how we can best do that.

In conclusion, I request that the committee act favorably on H.B. 7159. Thank you for the opportunity to present this written testimony on such an important issue.

Ned Lamont

Ned Lamont
Governor

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Testimony
Rudy Marconi
First Selectman, Town of Ridgefield
On Behalf of the
Connecticut Council of Small Towns
General Law Committee
March 12, 2019

RE: SUPPORT - HB- 7159 - AN ACT ADDRESSING OPIOID USE.

My name is Rudy Marconi, First Selectman of the Town of Ridgefield and President of the Connecticut Council of Small Towns (COST), which represents 110 smaller communities throughout Connecticut.

COST applauds Governor Ned Lamont's proposal to strengthen the state's efforts to address the opioid crisis by calling for changes to reduce the misuse of prescription opioids and enhance communication between health care providers and patients. HB-7159 builds on drug overdose and prevention initiatives adopted in previous years, which have helped our communities respond to this public health crisis.

According to the state's Chief Medical Examiner, there has been a 2% decrease in fatal drug overdoses in 2018 compared to 2017 and fewer overdose-related emergency room visits. However, rates for opioid overdoses and emergency room visits are still approximately 1.7 times higher than the national rate.

As a state, we must do more to address this crisis, which has devastated individuals and their families in every town in Connecticut.

COST stands ready to work with Governor Lamont and lawmakers to support efforts to confront Connecticut's opioid crisis head on.

Connecticut Council of Small Towns
1245 Farmington Ave., 101 West Hartford, CT 06107
Tel. 860-676-0770; www.ctcost.org

GENERAL LAW COMMITTEE

March 12, 2019

The Connecticut Conference of Municipalities (CCM) is Connecticut's statewide association of towns and cities and the voice of local government - your partners in governing Connecticut. Our members represent over 96% of Connecticut's population. We appreciate the opportunity to testify on bills of interest to towns and cities.

HB 7159 "An Act Addressing Opioid Use"

HB 7159, the Governor's proposal to combat the opioid crisis, makes changes to reduce the misuse of prescription opioids, strengthens oversight of prescriptions for opioids, facilitates the use of the state's Prescription Drug Monitoring Program (PDMP), prohibits discrimination against individuals who use life-saving opioid antagonists and enhances communication between health care practitioners and patients regarding opioid use[i].

Local leaders recognize the opioid overdose crisis as a major issue, in particular because of its impact on every community in Connecticut. In 2014, CCM created a Drug Abuse Prevention Workgroup which was tasked with examining the growing concern of drug abuse in Connecticut. Through meetings with local and state stakeholders, a set of policy initiatives were developed to help combat the growing epidemic. The Workgroup met regularly with a wide range of partners, service providers, advocates, experts and organizations to gather the broadest possible perspective on the issue. Local leaders continue to collaborate and advocate for polices that will help control this public health crisis.

CCM believes the Governor's proposals outlined in HB 7159 will strengthen current laws and help further combat the opioid crisis. CCM urges support of 7159.

★★★★

If you have any questions, please contact Zachary McKeown, Legislative Associate of CCM at zmckeown@ccm-ct.org or 860-462-9556.

[i] Governor Lamont's Fact Sheet HB 7159

Keith Overland, DC, CCSP, FICC
83 East Ave.
Norwalk, CT 06851

Re: HB 7159 An Act Addressing Opioid Use.

Senator Fonfara, Senator Witkos, Representative Cheeseman and members of the General Law Committee

My Name is Dr. Keith Overland. I am the past president of the American Chiropractic Association, Connecticut Chiropractic Association, a past chairman of the Connecticut Governor's Council on Physical Fitness, and maintain a full-time integrative practice in Norwalk.

I would like to thank you and your committee for taking the time to hold a hearing and allowing testimony on one of the most important public health issues we face in Connecticut in Raised bill HB 7159: "An Act Addressing Opioid Use". As outlined the bill, among other important concepts, has a goal of pharmacists providing additional counseling with patients on the adverse effects of opioid usage. It is my opinion that this bill is important and should be favorably considered, but should take the additional step of encouraging the explanation of opioid prevention by empowering pharmacists to suggest a second opinion from provider groups that typically provide alternative treatments to opioids for pain management.

Studies tell us that over 60 percent of opioid addicted patients began their potentially deadly journey taking a prescription medication for some form of non-cancer related musculoskeletal pain. Alarmingly, this is often after routine visits to their primary care or orthopedic physician for a routine injury or arthritic pain. According to an article published in the "Journal of the American Academy of Orthopedic Surgeons" in 2015, it was shown that among providers that treat pain related condition: Primary care MD's prescribed - 28.8 %, Internists - 14.6%, and Orthopedic Surgeons - 7.7 % of all opioids in the United states. That is in contrast to 0.0% from Chiropractic physicians.

In fact, during a presentation by Optum Health of United Health Care on 12/5/18 at the National Academics of Sciences, Engineering and Medicine, they spoke about steps they are taking to help reduce health care costs and opioid usage among their members. In the presentation I am citing, they used non-surgical back pain as a basis of their study. They found that, currently, 30 percent seek initial care from their PCP, 40 percent seek initial care from a medical specialist and 30 percent seek care initially from a Chiropractic physician, PT or acupuncturist. The findings of the study showed a dramatic decrease in costs and secondarily, in opioid usage when the patients sought their **initial** care from the conservative cohort of providers. (DC, PT, LaC). The initial analysis of findings compelled United to look for patient incentives for patients with non-surgical back pain to choose a chiropractor, PT or acupuncturist **first.**

Why? In further analyzing their findings, they project, for patients in their membership with non-surgical back pain, if they could change the current 30 percent of patients (those who initiate care with a conservative provider versus a PCP or medical specialist) to 50 percent, **incredibly**, they will save 230 million dollars and decrease opioid usage for back pain by 25%!

According to the National Association of Attorneys General (NAAG), the opioid epidemic is the preeminent public health care crisis of our time. Statistics from the Surgeon General of the United States indicate that as many as 2 million Americans are currently addicted to prescription opioids. They claimed that the "human cost is staggering" as opioid overdoses kill 91 Americans every single day. While not nearly as impactful to loved ones, the economic toll of the epidemic, according to the NAAG, is costing the United States economy 78.5 billion dollars annually. State and local governments spend nearly 8 billion dollars a year on criminal justice costs related to opioid abuse.

Keith Overland, DC, CCSP, FICC
83 East Ave.
Norwalk, CT 06851

While this bill highlights many areas of concern surrounding how to manage those already addicted, there is no significant discussion focused on the non-opioid management by providers that may be appropriate for the first contact with a chronic pain patient. Utilizing preventive approaches to pain management, specifically non-pharmacological options **before** a patient's first prescription is a key step in the comprehensive effort to address and end the opioid epidemic.

Recent reports from the FDA, the Joint Commission, the CDC, and the President's Commission on the Opioid Crisis all have come to similar conclusions as the NAAG which states "When patients seek treatment for any of the myriad of conditions that cause non-cancer related chronic pain, doctors should be encouraged to explore effective non-opioid alternatives including physical therapy, acupuncture, massage and chiropractic care." Recently completed studies in the states of Rhode Island and New Hampshire found that when patients who presented with chronic pain were referred for non-pharmacologic care such as chiropractic and acupuncture treatments, they had incredible outcomes. The studies found that Emergency visits were reduced by 13 to 42 percent. Total prescriptions were reduced by 21 to 60 percent. Opioid prescriptions were reduced by 33 to 77 percent and costs of care reduced by 12 to 30 percent. The studies also found a large reduction in inpatient days, outpatient procedures, and a whopping 85 percent reduction in pharmaceutical utilization.

In conclusion, there is ample evidence that prevention works. It significantly reduces the human toll and the multiple costs to society of opioid prescription addiction.

If we are to successfully tackle the opioid epidemic in Connecticut, this (proposed bill HB 7159) and other proposals must add prevention to their list of approaches when any health care provider, including pharmacists, have a professional contact with a patient.

Physical therapy, acupuncture, massage, and chiropractic care should be part of the response to chronic pain. Based on available literature some of which are stated above, we recommend, as a first phase, targeting changes in access to these four interventions for at least two types of chronic pain: low back pain and neck pain.

It is time that we look at first-line treatment for chronic pain management in a different light - one that includes non-opioid medications and non-medication. This is not a novel idea - it is one being recommended by the most credible public health experts and organizations in our country as well as many multi-disciplinary and integrative offices like mine across the state. Connecticut has always been ranked among the healthiest states in the nation. We promote health living and lifestyles, and have some of the finest health care providers in the nation. Bills such as HB 7159 and any others that address the opioid epidemic must not ignore the power of prevention in ALL aspects of health and our health care delivery system.

Thank you again for the opportunity to submit my testimony. I can be reached if there are any questions or comments. My contact information is Dr. Keith Overland, 83 East Ave suite 313, Norwalk, CT. (P) 203- 838-9795 or doco57@aol.com

Connecticut Department of Public Health

Testimony Presented Before the General Law Committee

March 12, 2019

Commissioner Raul Pino, M.D., M.P.H.
860-509-7101

House Bill #7159 – An Act Addressing Opioid Use.

The Department of Public Health (DPH) supports House Bill #7159, which would strengthen existing laws on prescribing and dispensing opioid medications, and further impact the prevention of overdose and opioid use disorder. Thank you for the opportunity to testify on this important issue.

DPH, along with other state agencies and drug overdose prevention advocates and experts, has been closely monitoring the opioid crisis over the last several years. The Department has been actively engaged with the Alcohol and Drug Policy Council (ADPC), a statewide council that shares prevention and treatment information along with surveillance data, and promotes and supports policies and intervention strategies that 1) aim to reduce the likelihood of misuse of prescription opioids, 2) strengthen oversight of prescriptions for opioids, 3) facilitate use of investigatory tools, 4) prohibit discrimination of individuals who use life-saving opioid antagonists, and 5) enhance communication between health care practitioners and patients regarding opioid use.

DPH is in support of Section 1(d) of the bill, which requires that a pharmacist dispensing an opioid medication offer to discuss the drug with the patient receiving the medication and counsel the patient on the usage of the drug. Additional education that includes not only requiring the pharmacist to counsel the patient on the "usage of the drug", but also safe storage and disposal of opioid drugs, the potential for addiction, and the dangers of opioid misuse may reduce the likelihood of misuse of prescription opioids. DPH is also in support of Section 1(e) of the bill, which requires the pharmacist offering counseling to keep a record of the counseling provided and whether the patient accepts or refuses the counseling being offered. Continued education of the patient about the potential for addiction and overdose is important for purposes of primary prevention.

Section 5 of this bill states that life insurance policies cannot exclude or alter coverage on the basis of prescriptions for naloxone, a life-saving medication that can reverse an opioid overdose.

DPH and other state agencies, along with the federal Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA), recommend that friends and family members of someone who uses and misuses opioid drugs, and others with an interest to reverse an opioid overdose if needed, carry a prescription for naloxone or have it accessible to save someone from dying from a drug overdose. Connecticut health officials are finding that naloxone is being used more frequently to reverse overdoses, especially after awareness and accessibility has increased and Good Samaritan Laws went into effect. DPH supports removing any barriers that may inhibit individuals from purchasing naloxone.

Section 6 requires prescribing practitioners to write the medical diagnosis on the opioid drug prescription sent to the pharmacy and uploaded to the Connecticut Prescription Monitoring and Reporting System. In this way, it will not only help other practitioners and pharmacists to be better informed about their patients and to offer needed care and counseling, but it will help health officials evaluate strategies for provider education and training. Over the past 2 years, DPH and the CT Department of Mental Health and Addiction Services have sponsored and coordinated primary care provider trainings to educate prescribers throughout the state on best practices for providing medication-assisted treatment (or MAT) for their patients addicted to opioids. Knowledge of the medical diagnosis would clear up misconceptions about the use of the prescribed drug and help to better assess if there has been an increase in office-based treatment for opioid use disorder as a result of the expanded availability of primary care provider training. A case in point, the CT Department of Consumer Protection currently does not report on buprenorphine and other MAT-related drug prescription rates due to the uncertainty about the purpose of the drug, making it difficult for DPH and others to evaluate prevention strategies. Thus, pairing a medical diagnosis with the prescription would better inform providers and those involved in surveillance of opioid prescriptions and prevention of opioid addiction and overdoses.

Finally, Section 7 includes a requirement for a provider-patient treatment agreement at 12 weeks from the start of a patient's opioid regimen for chronic pain. This is consistent with CDC guidelines that recommend that clinicians should evaluate the benefits and harms of continued therapy for chronic pain with patients at least every 3 months. The 2016 CDC Guidelines for Treatment of Chronic Pain recommend that clinicians should evaluate benefits and harms within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Experts noted that risks for opioid overdose are greatest during the first 3–7 days after opioid initiation or increase in dosage, particularly when methadone or transdermal fentanyl are prescribed or when total daily opioid dosage is ≥50 MME (milligram morphine equivalent). Frequent assessment, re-assessment and patient follow up may be necessary to provide the greatest opportunity to prevent the development of opioid use disorder.

Thank you for your consideration of this information.

CTChiro
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March 7, 2019

Re: HB 7159 An Act Addressing Opioid Use.

Senator Fonfara, Senator Witkos, Representative Cheesman and members of the General Law Committee

My name is Dr. Joanne Santiago and I am the president of the Connecticut Chiropractic Association. We commend you and Governor Lamont for remaining diligent on this opioid crisis and pursuing ways to reduce the use and abuse of opioids. This bill revises the general statutes for opioid prescription and control to help combat the opioid crisis. The revisions suggested should help alleviate the crisis and are reasonable. While we focus on alleviating the opioid crisis through pharmaceutical treatment and control of prescriptions, we must also realize there are effective non-pharmaceutical methods of care that can help alleviate the need of current opioid use and abuse and especially prevent the initiation of opioid use for those with various acute and chronic pain conditions. We submit it is essential this bill includes the disclosure and possible use of non-pharmacologic methods of care for those receiving opioid prescription, specifically as recommended by the Workgroup of the Connecticut Alcohol and Drug Policy Council. Their report to the legislature recommended the following:

> "Physical therapy, acupuncture, massage, and chiropractic care should be part of the response to chronic pain. Based on available literature regarding alternative opioid treatment therapies, we recommend, as a first phase, targeting changes in access to these four interventions for two types of chronic pain: low back pain and neck pain. Given experience and results of phase one, additional types of chronic pain could be added."

This recommendation is consistent with recommendations from many reputable government and non-profit healthcare organizations such as the following:

Centers for Disease Control and Prevention:

Determining When to Initiate or Continue Opioids for Chronic Pain

> 1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate (recommendation category: A, evidence type: 3).
> https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

Joint Commission for the Accreditation of Healthcare Organizations:

The identification and management of pain is an important component of [patient]-centered care. [Patients] can expect that their health care providers will involve them in their assessment and

management of pain. Both pharmacologic and nonpharmacologic strategies have a role in the management of pain. The following examples are not exhaustive, but strategies may include the following:

- Nonpharmacologic strategies: physical modalities (for example, acupuncture therapy, chiropractic therapy, osteopathic manipulative treatment, massage therapy, and physical therapy), relaxation therapy, and cognitive behavioral therapy
- Pharmacologic strategies: nonopioid, opioid, and adjuvant analgesics
  https://www.jointcommission.org/assets/1/18/Clarification_of_the_Pain_Management__Standard.pdf

Food and Drug Administration Guidelines:

I. COMPONENTS OF AN EFFECTIVE TREATMENT PLAN

1. The goals of treatment – It is important to establish a set of goals early in the course of treatment, including expectations about the following:
   - The degree of improvement in pain
   - The degree of improvement in function, where relevant

2. Possible constituents of the treatment plan – The HCP should be knowledgeable about which therapies can be used to manage pain and how these should be implemented.
   - Nonpharmacologic therapies – includes psychological, physical rehabilitative, surgical approaches; and complementary therapies
   - Pharmacologic therapies – non-opioid, opioid, and adjuvant medications

II. NONPHARMACOLOGIC THERAPIES

A number of nonpharmacologic therapies are available that can play an important role in managing pain, particularly musculoskeletal pain and chronic pain.
- Psychological approaches – e.g., cognitive behavioral therapy
- Physical rehabilitative approaches – e.g., physical therapy, occupational therapy
- Surgical approaches
- Complementary therapies – e.g., acupuncture, chiropractic

HCPs should be knowledgeable about the range of available therapies, when they may be helpful, and when they should be used as part of a multidisciplinary approach to pain management.
https://www.fda.gov/downloads/Drugs/NewsEvents/UCM557071.pdf

National Association of Attorney Generals: *(Includes Connecticut Attorney General George Jepsen)*

Reducing the frequency with which opioids are prescribed will not leave patients without effective pain management options. While there are certainly situations where opioids represent the appropriate pain remedy, there are many other circumstances in which opioids are prescribed despite evidence suggesting they are ineffective and even dangerous. For example, the American Academy of Neurology has explained that while the use of opioid painkillers can provide "significant short-term pain relief," there is "no substantial evidence for maintenance of pain relief or improved function over long periods of time." Another recent study concluded that the use of opioids to treat chronic, non-cancer related pain lasting longer than three months is "ineffective and can be life-threatening." When patients seek treatment for any of the myriad conditions that cause chronic pain, **doctors should be encouraged to explore and prescribe effective non-opioid alternatives, ranging from non-opioid medications (such as NSAIDs) to physical therapy, acupuncture, massage, and chiropractic care**.

We are thus committed to utilizing all the powers available to our individual offices to ameliorate the problems caused by the over-prescription of opioids and to promote policies and practices that result in reasonable, sustainable, and patient-focused acute and chronic pain management therapies. In the near

> future, working in conjunction with other institutional stakeholders (such as State Insurance Commissioners), we hope to initiate a dialogue concerning your members' incentive structures in an effort to identify those practices that are conducive to these efforts and those that are not. **We hope that this process will highlight problematic policies and spur increased use of non-opioid pain management techniques.** The status quo, in which there may be financial incentives to prescribe opioids for pain which they are ill-suited to treat, is unacceptable. We ask that you quickly initiate additional efforts so that you can play an important role in stopping further deaths.
> Letter to America's Health Insurance Plans, September 18, 2017

There is substantial scientific evidence that firmly supports the use of chiropractic care on the front lines of health care for conditions that may lead to opioid use and abuse. Unfortunately, these benefits are often suppressed due to various health care policies which, we submit, are a contributing factor to the opioid crisis. Disclosing to patients the benefits of chiropractic and other non-pharmaceutical treatment prior to prescribing opioid medication will bring reduced use and abuse of opioid medication.

In closing, I would like to say I am a second-generation chiropractic physician and my daughter Joelle is our third-generation doctor which is now six Chiropractors in our family tree. My parents mastered this healing art and brought great health and well-being to their patients *without the use of drugs*. I have seen many patients achieve excellent health without the use of drugs, especially opioids. One of my brothers was the Chiropractic Physician for the Olympics. There they triage and use natural health care when indicated. My daughter will see greater numbers and will have more opportunity to prevent her patients from getting started on opioid medications as the chiropractic profession helps alleviate this terrible crisis. Please amend this bill to include the experts in the natural and non-drug-based health care for chronic pain conditions as recommended in the report. Patients are first and foremost and must have knowledge of the non-drug approaches to chronic pain treatments.

Respectfully,

Dr Joanne A Santiago DC DABCI

Joanne Santiago, D.C.

President

CONNECTICUT DEPARTMENT OF CONSUMER PROTECTION

MICHELLE H. SEAGULL | COMMISSIONER

Testimony of Michelle Seagull
Commissioner of Consumer Protection

General Law Committee
Public Hearing, March 12, 2019

HOUSE BILL 7159 "AN ACT ADDRESSING OPIOID USE"

Senator Fonfara, Senator Witkos, Representative D'Agostino, Representative Cheeseman and Honorable Members of the General Law Committee, thank you for the opportunity to offer testimony regarding several of the bills on your agenda for today's public hearing.

I am Michelle Seagull, Commissioner of the Department of Consumer Protection (DCP). I am here today to offer testimony in support of HB 7159, An Act Addressing Opioid Use. DCP appreciates this opportunity to express enthusiastic support for the Governor's proposed legislation, which would make several changes to DCP's Drug Control Statutes in order to strengthen patient care as well as the tools available to DCP in the ongoing fight to combat the prescription drug misuse and abuse epidemic.

First, this bill would require that pharmacists offer counseling to patients regarding their prescriptions. Currently, Connecticut General Statutes Sec. 20-620, requires pharmacists to offer such counseling, but only to Medicaid patients. Expanding this requirement to all patients will encourage a dialogue between patients and pharmacists at the point of dispensing which will allow pharmacists to ensure that patients understand the importance of the medication and that they are using the medicine properly. This will also increase opportunities for pharmacists to

catch errors, flag drug interactions, and when dispensing controlled substances, discuss the potential for abuse and overdose, and offer naloxone as a safety precaution. Many pharmacies already do this to ensure that all of their patients are better informed about the proper way to administer their medicine, possible side effects and other issues about which patients might have questions or concerns.

This proposed legislation would also allow pharmacists to designate an authorized agent to utilize the Connecticut Prescription Monitoring and Reporting System (CPMRS) to lookup patients, similar to prescribing practitioners and their designees. While pharmacists aren't required to look patients up in the CPMRS, they often do, and we believe allowing them to designate a pharmacy technician to assist with that process will increase the efficiency of their utilization and thereby encourage more use. Increased utilization of the CPMRS adds another level of protection of patients and can assist in identifying controlled substance misuse and abuse.

This bill would also to require that when a drug manufacturer or wholesaler terminates or declines a pharmacy's business they report said action to DCP. Last legislative session, the Legislature passed a requirement that suspicious orders be reported, this would further strengthen investigatory tools and allow the department to identify issues faster.

Additionally, this proposal would require a practitioner who writes a prescription for an opioid to include on the prescription a diagnosis code, consistent with the International Classification of Diseases, for the medical condition being treated. This will further enhance patient care by providing a pharmacist with information at the time of dispensing that will allow them to fill a prescription for patients who truly need these medications. In addition, this information will minimize delays in dispensing opioid medication to patients in need because pertinent information will be on the prescription.

Finally, if enacted, this legislation would also require a practitioner who writes a prescription for an opioid drug to a patient for a period of more than 12 weeks for the treatment of pain, to establish a treatment agreement with the patient, which would need to include

treatment goals, risks of using opioids, and urine drug screens. The risk of addiction and other complications is significant for patients who take opioids on a long term basis. Requiring such an agreement, which some practitioners already do, will ensure that patients and prescribing practitioner are setting more clear plans around the use of opioid medications.

DCP, looks forward to continuing our work with Governor Lamont's Office, our sister agencies, this Legislature and our various counterparts in the health care industry.

Thank you again for allowing us to provide information about this proposal. I am happy to answer any questions you may have.

920

Michael Solla
5 Allentown Road
Wolcott, CT 06716

March 10, 2019

Re: HB 7159 An Act Addressing Opioid Use.

Senator Fonfara, Senator Witkos, Representative Cheeseman and members of the General Law Committee

My name is Mr. Michael Solla and I am the co-president of the Student Connecticut Chiropractic Association. I commend you and Governor Lamont for remaining diligent on this opioid crisis and pursuing ways to reduce the use and abuse of opioids that is close to the heart of many of us. This bill revises the general statutes for opioid prescription and control to help combat the opioid crisis and therefore we need to look at all areas of non-pharmaceutical treatments. While we focus on alleviating the opioid crisis through pharmaceutical treatment and control of prescriptions, we must also realize there are effective non-pharmaceutical methods of care. These methods can help alleviate the need of current opioid use, abuse and especially prevent the initiation of opioid use for those with various acute and chronic musculoskeletal pain conditions especially those with multiple health conditions. We submit it is essential this bill includes the disclosure and possible use of non-pharmacologic methods of care for those receiving opioid prescription, specifically as recommended by the Workgroup of the Connecticut Alcohol and Drug Policy Council. Their report to the legislature recommended the following:

> "Physical therapy, acupuncture, massage, and chiropractic care should be part of the response to chronic pain. Based on available literature regarding alternative opioid treatment therapies, we recommend, as a first phase, targeting changes in access to these four interventions for two types of chronic pain: low back pain and neck pain. Given experience and results of phase one, additional types of chronic pain could be added."

This recommendation is consistent with recommendations from many reputable government and non-profit healthcare organizations.

- The Surgeon General Pain Management Task Force reported the possible overreliance on medications to treat pain caused other unintended consequences, such as the increased prevalence of prescription medication abuse and has recommended that integrative and alternative therapeutics should be incorporated into a patient centered plan of care; and

Michael Solla
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- The Joint Commission acknowledges that patients can expect that their health care providers to involve them in their assessment and management of pain and that non-pharmacological strategies have a role in the management of their pain; and

- CDC Guidelines for prescribing opioids has identified the fact that non-pharmacological therapies are a preferred treatment for chronic pain; and

- The National Association of Attorneys General are committed to ameliorate the over-prescription of opioids and encourages State Insurance Commissioners to assure non-opioid pain management including chiropractic care is adequately available to patients, and

- An Integrated Chronic Pain Program utilizing chiropractic care in Rhode Island demonstrated reduced medical costs by 27%, decreased the average number of ER visits by 61%, lowered the number of average total prescriptions by 63% and reduced the average number of opioid scripts by 86% for enrolled Community of Care Medicaid members with chronic pain conditions.

A personal take on the issue of opioid addiction is something that many do not want to talk about, but it must be dealt with head on. With your help by including all non-pharmaceutical alternatives we can fight this epidemic together.

Respectfully Submitted,

Michael J Solla

Michael J Solla

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Testimony
General Law Committee
March 12, 2019

Committee Chairs, Vice Chairs, Ranking Members, and Members of the General Law Committee, the Insurance Department appreciates the opportunity to testify in strong support of Governor's House Bill No. 7159.

Governor's House Bill No. 7159 An Act Addressing Opioid Use.

Governor Lamont's bill would create meaningful public policies to continue to combat the opioid crisis. The Insurance Department has been a partner in working with all stakeholders including consumer groups, legislators, other executive branch agencies, insurance carriers and others to create sound public policy to combat the opioid epidemic and is an active member of the Alcohol and Drug Policy Council.

This bill, generally, makes changes to reduce the misuse of prescription opioids, strengthen oversight of prescription opioids, facilitate the use of the state's Prescription Drug Monitoring Program and enhances communication among health care practitioners and patients regarding the use of opioids. Additionally, section 5 of this bill would prohibit life insurance carriers from excluding coverage to individuals who have filled prescriptions for life-saving opioid antagonists.

While the Department supports the entire bill, we would like to provide the Committee with particular insight into section 5. This section would prohibit life insurance and annuity policies from excluding coverage solely on the basis of a prescription for an opioid antagonist, such as Naloxone. When an individual applies for life insurance the carrier may undergo a formal underwriting process which could investigate the applicant and their health history which could include filled prescriptions and medical treatments, among other things.

It has been found that during this process individuals have been denied coverage due to a history that included either filling and/or using an opioid antagonist. Governor Lamont's bill would prohibit this practice and the Department stands in strong support with the Governor in pursuing this important consumer protection. In fact, just a few months ago it was widely reported that a nurse in Massachusetts was denied life insurance as she had previously purchased Naloxone – a prescription she filled as a good Samaritan in case she came across someone experiencing an overdose.

It is important to protect people who have decided to carry an opioid antagonist to treat potential and unexpected opioid overdoses and save a life – the life of a friend, family member or even someone they don't know experiencing an overdose. This law makes it clear that these good Samaritans should not and will not be denied coverage of a life insurance or annuity policy solely for having filled a prescription for an opioid antagonist.

The Department urges the Committee to take affirmative action on this important bill proposed by Governor Lamont.

The Department thanks the members of the General Law Committee for the opportunity to provide comments in support of Governor's House Bill No. 7159.

About the Connecticut Insurance Department: The mission of the Department is to protect consumers through regulation of the industry, outreach, education and advocacy. In FY 2018, the Department recovered more than $4.5 million on behalf of consumers and regulates the industry by ensuring carriers adhere to state insurance laws and regulations and are financially solvent to pay claims. The Department's annual budget is funded through assessments from the insurance industry. For every dollar of direct expense, the Department brings in about $8.35 to the state in revenues. In FY 2018, the Department returned more than $145 million in assessments, fees, fines and penalties, and taxes to the state's General Fund.

CONNECTICUT PHARMACISTS ASSOCIATION

TESTIMONY BEFORE THE GENERAL LAW COMMITTEE
MARCH 12, 2019

HB 7159, AN ACT ADDRESSING OPIOID USE

Chairmen D'Agostino and Fonfara, and members of the Committee:

My name is Nathan Tinker, and I am chief executive of the Connecticut Pharmacists Association, which represents over 1,000 pharmacists, technicians, students, and others in every pharmacy setting across the state.

The opioid epidemic has hit Connecticut hard, and as a profession whose entire focus is the safe and effective use of all medications—including pain medications—pharmacists have been at the forefront of this crisis since its inception.

HB 7159 offers a number of paths to addressing the opioid problem and we support it, but we do have some brief comments about the bill's potential impact on pharmacy practice.

First, HB 7159 requires pharmacists to offer counseling to patients receiving opioids. As a matter of course, pharmacies already ask every patient whether they have any questions regarding their medications, and opioids are no exception. Pharmacists are always ready and willing to provide this service to their patients, which has been shown to improve adherence and patient outcomes.

Second, HB 7159 offers the opportunity for pharmacists to designate a pharmacy technician to access the electronic prescription drug monitoring program. We believe that with appropriate training and certification of technicians, this can be a useful tool to help pharmacists perform their duties more quickly and efficiently. It should be clear that utilizing a technician in this role is at the discretion of a given pharmacist and only with duly trained/certified technicians.

Finally, HB 7159 requires prescribers to include a "diagnosis code" (ICD) on any opioid prescription, which is already a requirement for Medicaid. We are somewhat concerned that extending this rule to *any* opioid prescription, regardless of insurance or payer, will necessarily increase the number of times pharmacists must reach out to prescribers for clarification which, in turn, could lead to delays in delivering prescriptions to patients in need. It is also possible that this requirement could put pharmacies at risk of fines or having reimbursement threatened during an audit.

As always, Connecticut's pharmacists are ready to work closely with DCP and the Legislature to assure safety and quality in our practice.

Thank you for the opportunity to comment on this important bill.

Nathan Tinker
CEO
Connecticut Pharmacists Association

OHS CONNECTICUT Office of Health Strategy

Phone: 860.418.7001 ● www.portal.ct.gov/ohs

Testimony of Victoria Veltri
Office of Health Strategy, Executive Director
Before the General Law Committee
In support of HB 7159, AAC Opioid Use
March 12, 2019

Good afternoon, Representative D'Agostino, Senator Fonfara, Senator Witkos, Representative Cheeseman and members of the General Law Committee. For the record, I am Vicki Veltri, Executive Director of the Office of Health Strategy ("OHS"). OHS brings together current state efforts and staff to provide integrated, comprehensive leadership to implement data driven strategies that promote equal access to high quality health care, control costs and ensure better health for the people of Connecticut.

Governor's Bill 7159, An Act Concerning Opioid Use, proposes common sense measures to address the opioid crisis with which our state and nation continue to struggle. While early data suggests that our efforts to date to mitigate the opioid crisis in Connecticut may be producing tangible benefits, there remains more to be done.

The Department of Public Health projects that the incidents of deaths due to opioid overdose may be stabilizing, with about the same number of people overdosing on opioids in 2018 as did in 2017.[i] While this is a positive sign after years of dramatic and seemingly unrestrained growth in the number of Connecticut citizens who died from overdose of these drugs, the stark reality is that nearly 3 people still die each day as a result of opioid abuse. That is unacceptable, and if Governor's Bill 7159 passes, there will be a day when these statistics are drastically reduced reflecting the enhanced supports and consumer education we are investing in.

One common theme raised routinely in discussions about the opioid crisis concerns consumer's understanding of the strength and consequences of using these drugs. For many people, opioids are a reasonable and beneficial, short term treatment, but if they don't recognize how easy it is to

OHS CONNECTICUT Office of Health Strategy

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develop an addiction, alternate options for treatment of ongoing or chronic conditions, or the risks of alternate sources of opioids, the consequences can be lethal. HB 7159's requirement that pharmacists offer counseling to consumers about their prescriptions, which can be crucial to ensuring that a person knows how to safely and effectively maximize their therapeutic benefit. HB 7159 promotes this important function by expanding access to allow pharmacy technicians to query the state's Prescription Drug Monitoring Program on behalf of the pharmacist for information about a consumer's pertinent prescription history, allowing the pharmacist to spend more time providing these important consumer protections. This legislation also strengthens reporting requirements for manufacturers of controlled substances in an effort to identify and mitigate the improper use or sale of these drugs.

In addition, HB 7159 would bar certain insurers from using history of naloxone prescription for a consumer when underwriting an application for life insurance or annuity. Naloxone is a highly effective drug that those with opioid addiction or their loved ones who proactively obtain a prescription rely on in the event of an overdose, and penalizing people for taking reasonable, effective, life-saving measures for the management of possible overdose disincentivizes utilization of this extremely effective and affordable intervention. Mere possession of naloxone or a prescription is a wildly inaccurate measure of the risk a person represents for underwriting purposes. Instead, Connecticut again led national opioid policy, acknowledging the importance of expanding access to this drug by permitting certified pharmacists to prescribe and dispense naloxone to patients or their caregivers. The elimination of this unnecessary and illogical adverse consequence for those taking reasonable, clinically appropriate and state sanctioned precautions in response to this crisis simply furthers Connecticut's common sense opioid policies.

Finally, for providers prescribing an opioid for a patient for a period of greater than 12 weeks, HB 7159 requires that they execute a pain management contract with their patient. The act of executing this contract requires that there be detailed and comprehensive counseling about the risks and benefits of opioids, the prescribing provider's expectations for the course of treatment, and the provider's expectations for his or her patient. This codifies the education that most providers already provide their patients, and reinforces the importance and seriousness of the drug for the patient.

OHS CONNECTICUT Office of Health Strategy

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Thank you for providing me the opportunity to deliver OHS's testimony today. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.

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[i] https://portal.ct.gov/DPH/Press-Room/Press-Releases---2019/Preliminary-Opioid-Involved-Overdose-ED-Visit-Rate-May-be-Stabilizing

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