Attachment E

May 5, 2021

Thank you, Madam Chair and members of the committee, for the opportunity to provide written testimony to the House Health & Insurance Committee. My name is Bethany Pace-Danley, testifying in support of HB21-1276 for the Colorado Providers Association (COPA). COPA's member organizations provide substance use disorder services across the full spectrum of SUD services from prevention to early intervention, and all types of treatment and recovery support services.

My testimony supports the entirety of HB21-1276. HB21-1276 will enable the following:

- For private insurance, the bill imposes new requirements to provide coverage for nonpharmacological treatment as an alternative to opioids. This includes certain requirements related to coverage of physical therapy, occupational therapy, chiropractic, acupuncture visits, and atypical opioids that are approved by the FDA for the treatment of acute or chronic pain. These efforts could realize meaningful prevention.
- Current law limits specified prescribers from prescribing more than a 7-day supply of an opioid to a patient who has not obtained an opioid prescription from that prescriber within the previous 12 months unless certain conditions apply. This prescribing limitation is set to repeal on September 1, 2021. The bill continues the prescribing limitation indefinitely. We really need to pass this.
- Requires the executive director of the department of regulatory agencies (DORA) to promulgate rules that limit the supply of a benzodiazepine, which is a sedative commonly prescribed for anxiety and as a sleep aid, that a prescriber may prescribe to a patient who has not had a prescription for a benzodiazepine in the last 12 months.
- Requires a licensed physician and licensed physician assistant to demonstrate compliance with continuing medical education concerning prescribing practices for opioids as a condition of license renewal. Requires the Colorado medical board (board) to consult with the center for research into substance use disorder prevention, treatment, and recovery support strategies (center) to promulgate rules establishing competency-based continuing education requirements for physicians and physician assistants concerning prescribing practices for opioids. Requires the center to include in its continuing education activities the best practices for prescribing benzodiazepines and the potential harm of inappropriately limiting prescriptions to chronic pain patients.
- Continues indefinitely the requirement that a health-care provider query the prescription drug monitoring program (PDMP) before prescribing an opioid, **including a benzodiazepine**, and changes current law to require the query on every prescription fill, not just the second fill.
- Directs the office of behavioral health to convene a collaborative with institutions of higher education, nonprofit agencies, and state agencies for the purpose of gathering feedback from local public health agencies, institutions of higher education, nonprofit agencies, and state agencies concerning evidence-based prevention practices.

As a state, we must move upstream on the continuum and implement effective prevention strategies. We will never get ahead of this national opioid epidemic if we focus solely on treatment. HB21-1276 represents prevention and early intervention strategies.

Thank you again.

Bethany Pace-Danley, BSW, MA, CPS II
Program Manager, SBIRT in Colorado 303-369-0039 ext. 245
Peer Assistance Services, Inc.

Hello esteemed committee members,

I'm an **emergency medicine physician-researcher, national expert in prescription drug monitoring programs, chair of the Colorado Consortium's PDMP work group and founding member of the Colorado Consortium**. I have spent the last 7 years working to improving the Colorado PDMP. I'm writing to convey my personal opinion regarding HB 21-1276 and ask that you **please consider removing the PDMP mandate** in section 16.

- While well intentioned, legislating PDMP checks is **not evidence-based** practice and will have the unintended consequence of **taking up significant healthcare resources and valuable provider time** for limited or unproven benefit.
    - There is no definitive proof that PDMP mandates lead to better outcomes. All population level studies supporting mandates occur in the setting of multiple interventions and show marginal benefit.
    - There is proof that PDMP checks can take significant time; an average of 4 minutes and 50 mouse clicks (pub med ID: 26806310).
        - Multiple that by 8 million controlled prescriptions per year in CO (based on Colorado Data Profile) = **533,000 hours/year of provider time spent on PDMP checks** in CO if this statute is fully implemented.
        - This **time could be put to better use:** screening, alternatives pain modalities, addressing co-morbidities, talking about risk, setting up treatment for those in need, etc.
- Currently **7-15% of controlled medication prescriptions having a PDMP check by a provider in CO.** The suggested legislation would be a massive alteration from current practice, a significant resource investment, and a challenge to implement; again, with no definitive evidence of benefit.
- This is particularly important in the current setting of (see Colorado Data Profile):
    - Decreasing controlled medication prescribing in CO
    - Decreasing high risk opioid prescribing
    - Decreasing combined opioid and benzodiazepine prescribing
    - Decreasing percentage of overdose deaths due to prescription opioids relative to heroin and fentanyl deaths
- **We are presently working with CDPHE to evaluate the impact of SB 18-22 mandates** on prescribing across Colorado. While we are not able to comment until it is cleared by CDPHE, I strongly recommend **waiting on this evaluation to make a data informed decision on further legislation**
- Language:
    - *"continues indefinitely…"* This is not a continuation: SB 18-22 only mandates a PDMP check on the second fill and does not include benzodiazepines (which are misclassified as opioids in this language)
    - Legislation that is not built on solid on evidence should **not be indefinite** without a clear evaluation plan and/or evidence of benefit.

I’m sorry I could not join in person, but I am happy to meet to discuss further. Thanks for your consideration,

Jason Hoppe, DO

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

May 5, 2021

Representative Susan Lontine – Chair
House Health & Insurance Committee
200 E Colfax Avenue
Denver, CO 80203

Re: AHIP's Comments on HB 1276 (Nonpharmacological Treatment Mandate)

Representative Lontine and Members of the Committee:

America's Health Insurance Plans (AHIP)[1] appreciates this opportunity to express our concerns regarding HB 1276, which mandates coverage for specified nonpharmacological treatment as an alternative to opioids.

Health insurance plans have taken critical steps to increase access to innovative and high-quality health care products and implement cost control mechanisms that better allow individuals and employers to obtain and provide coverage in the private market. However, these bills will lead to higher premiums, harming affordability, and access for small businesses and individual market consumers.

The state must assume the cost of mandates in excess of the essential health benefits package.

The Affordable Care Act (ACA) requires qualified health plans sold on Colorado's health insurance exchange - Connect for Health Colorado (C4HCO), as well as health plans offered in the small group and individual markets outside of C4HCO to cover a comprehensive package of "essential health benefits" (EHB) and services. States have the option of choosing a benchmark plan to define that state's specific EHB package, or building their own set of benefits that will become its benchmark plan.[2] To preserve the balance between comprehensive coverage and affordability, federal law requires states to bear the costs attributable to mandates that exceed the generosity of the most generous comparable plans.[3] The requirement that states defray the costs of mandates exceeding this threshold was recently affirmed by the Center for Consumer Information and Insurance Oversight.[4] Consequently, these mandates would increase premiums, raising costs on Colorado's businesses, taxpayers, and families. Governor Polis affirmed this point in his signing statement for HB20-1158, stating:

[1] AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, AHIP improves and protects the health and financial security of consumers, families, businesses, communities and the nation. AHIP is committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

[2] HHS Notice of Benefit and Payment Parameters for 2019. https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-07355.pdf

[3] 45 CFR Parts 147, 155, and 156

[4] Frequently Asked Questions on Defrayal of State Additional Required Benefits. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Defrayal-State-Benefits.pdf.

> *Additional mandates, which may, by themselves, be important advancements in expanding coverage or reducing long term costs, often do not meet the second goal of lowering health insurance costs for people today, and can have the unintended consequence of making coverage less accessible to those who need it most.*[5]

At a time when health care costs continue to rise, and there is so much uncertainty regarding the future of health care reform, fiscal restraint is more important than ever.

Health benefit mandates stifle the use of innovative, evidence-based medicine.

Health insurance plans develop competitively priced high-quality products that balance access to comprehensive benefits and services with medical necessity and evidence-based principles regarding safety, effectiveness, and cost.

Across the country, health insurance plans have taken proactive steps to address the opioid crisis. These efforts include the launch of AHIP's Safe, Transparent Opioid Prescribing (STOP) Initiative in 2017, which was designed to support the widespread adoption of evidence-based clinical recommendations developed by the CDC for pain care and opioid prescribing, and to further capture and disseminate relevant best practices.[6]

We are concerned that enacting benefit mandates such as those outlined in HB 1276 will impede the adoption of measures that are responsive to evolving medical literature and clinical guidelines, limiting the ability of health insurance plans to provide the most up-to-date and cost-effective product to consumers. The adoption of benefit mandates that do not promote evidence-based medicine may lead to lower-quality care, over-or misutilization of services, and higher costs for treatments that may be ineffective, less safe, or higher cost than other benefits and services.

Consumers and employers benefit from a robust health insurance marketplace offering competition and choice.

The private market is best situated to balance the cost and efficacy of medical treatments and services. Large employers, unions, small businesses, and consumers want choices to find the right health plan – at the right price – to best fits their needs. Benefit mandates eliminate the ability of health insurers and HMOs to develop innovative and competitive benefit packages and force employers and individuals to purchase a prescribed set of benefits driven by the Legislature rather than consumer choice.

For these reasons, AHIP opposes HB 1276.

AHIP and its members appreciate the opportunity to provide these comments and look forward to continued discussions with you on this important issue.

---

[5] HB20-1158 Signing Statement, April 1, 2020, available at https://drive.google.com/file/d/1kBXFHpDXMQodmEGAq04ARwOQnMfGKYKk/view

[6] STOP Playbook: How Health Plans Are Tackling the Opioid Crisis, March 2019, available at https://www.ahip.org/wp-content/uploads/AHIP_STOPPlaybook_2019.pdf

Sincerely,

Sara Orrange, Regional Director
America's Health Insurance Plans

Thank you chairwoman Lontine and vice-chair Caraveo. Thank you members of House Health and Insurance for the opportunity to testify. Thank you Rep. Kennedy and Rep. Herod for bringing this bill before us. I stand before you to strongly urge you to amend HB 1276. While the goal of this bill is highly laudable and Colorado is certainly in the grip of an opiate crisis, the restriction of Section 5 of the bill on benzodiazepines, including diazepam, which I take, will have severely negative unintended consequences. While I do believe you tried to narrow these consequences by only providing for the constriction of prescription ability to those doctors who have not seen a patient in twelve months, this provision would seriously harm patients who switch doctors, whether because of switching from a pediatric to an adult provider or because of retirement or other reasons for the inability to have continuity of care. Furthermore, the seven day limit proposed limits the ability of a person taking benzodiazepines from taking overseas trips longer than this period. As much as I support alternative healthcare modalities and treatments such as physical therapy, massage, and acupuncture, my spasticity will not decrease over an extensive duration of time based on massage, six physical therapy visits and six occupational therapy visits. I have therapy at least three times per week and still take my medication for spasticity. Section 17 seems to indicate the existence of chronic benzodiazepine users like myself, but seems to run contrary to the intent of Section 5. For these reasons, I strongly urge you to amend HB 1276 and would be in a position of opposition if such changes are not made, which would be unfortunate given the positive intent of most of this bill.

House Health & Insurance

HB21-1276 Prevention Of Substance Use Disorders

Typed Text of Testimony Submitted

Name, Position, Representing	Typed Text of Testimony
Jason Hoppe Amend Self	(I apologize if this is a duplicate, I did not receive a confirmation of my prior submission) Hello esteemed committee members, I'm an emergency medicine physician-researcher, national expert in prescription drug monitoring programs, chair of the Colorado Consortium's PDMP work group and founding member of the Colorado Consortium. I have spent the last 7 years working to improving the Colorado PDMP. It is my personal opinion that you please consider removing the PDMP mandate in section 16 in HB 21-1276 • While well intentioned, legislating PDMP checks is not evidence-based and will have the unintended consequence of taking up significant healthcare resources and valuable provider time. o There is no definitive proof that PDMP mandates lead to better outcomes. o There is proof that PDMP checks can take significant time; an average of 4 minutes and 50 mouse clicks (pub med ID: 26806310). □ With 8 million controlled prescriptions per year in CO (based on Colorado Data Profile) that equals 533,000 hours/year of provider time spent on PDMP checks in CO if this statute is fully implemented. □ This time could be put to better use for our patients benefit • Currently 7-15% of controlled medication prescriptions having a PDMP check by a provider in CO. The suggested legislation would be a massive alteration from current practice, a significant resource investment, and a challenge to implement. • This is particularly important in the current setting of (see Colorado Data Profile): o Decreasing controlled medication prescribing in CO o Decreasing high risk opioid prescribing

	o Decreasing combined opioid and benzodiazepine prescribing o Decreasing percentage of overdose deaths due to prescription opioids relative to heroin and fentanyl deaths • We are presently working with CDPHE to evaluate the impact of SB 18-22 mandates on prescribing across Colorado. While we are not able to comment until it is cleared by CDPHE, I strongly recommend waiting on this evaluation to make a data informed decision on further legislation • Language: o "continues indefinitely…" This is not a continuation: SB 18-22 only mandates a PDMP check on the second fill and does not include benzodiazepines (which are misclassified as opioids in this language) o Legislation that is not built on solid on evidence should not be indefinite without a clear evaluation plan and/or evidence of benefit. Thanks, Jason Hoppe, DO
Michael Neil Amend Self	Thank you chairwoman Lontine and vice-chair Caraveo. Thank you members of House Health and Insurance for the opportunity to testify. Thank you Rep. Kennedy and Rep. Herod for bringing this bill before us. I stand before you to strongly urge you to amend HB 1276. While the goal of this bill is highly laudable and Colorado is certainly in the grip of an opiate crisis, the restriction of Section 5 of the bill on benzodiazepines, including diazepam, which I take, will have severely negative unintended consequences. While I do believe you tried to narrow these consequences by only providing for the constriction of prescription ability to those doctors who have not seen a patient in twelve months, this provision would seriously harm patients who switch doctors, whether because of switching from a pediatric to an adult provider or because of retirement or other reasons for the inability to have continuity of care. Furthermore, the seven day limit proposed limits the ability of a person taking benzodiazepines from taking overseas trips longer than this period. As much as I support alternative healthcare modalities and treatments such as physical therapy, massage, and acupuncture, my spasticity will not decrease over an extensive duration of time based on massage, six physical therapy visits and six occupational therapy visits. I have therapy at least three times per week and still take my medication for spasticity. Section 17 seems to indicate the existence of chronic benzodiazepine users like myself, but seems to run contrary to the intent of Section 5. For these reasons, I strongly urge you to amend HB 1276 and would be in a position of opposition if such changes are not made, which would be unfortunate given the positive intent of most of this bill.

Colorado Society of Addiction Medicine

A Chapter of American Society of Addiction Medicine

OFFICERS
President
Joshua Blum, MD, FASAM
Immediate Past President
Charles Shuman, MD, FASAM
Treasurer
Martin Krsak, MD, MSc, FASAM
Secretary
Daniel Bebo, MD, FASAM
Public Policy Liaison
Stephanie Stewart, MD

April 29, 2021

The Honorable Susan Lontine
200 East Colfax Avenue
Colorado State Capitol, Room 307
Denver, CO 80203-1784

Re: Support for HB21-1276

Dear Chair Lontine and members of the House Committee on Health and Insurance,

On behalf of the Colorado Society of Addiction Medicine (COSAM), the medical specialty society representing physicians and clinicians in Colorado who specialize in the prevention and treatment of addiction, we would like to take this opportunity to provide our support for HB21-1276, which would take important steps to lessen harms associated with opioid analgesics while improving the health of Colorado's citizens. With opioid-involved deaths surging in Colorado, likely due to the COVID-19 pandemic,[i] now more than ever, it is vital that Coloradans living with acute and chronic pain have access to high-quality, evidence-based and comprehensive treatment.

Importantly, this bill requires that insurance carriers provide a minimum of six physical therapy visits, six occupational therapy visits, and six acupuncture visits per year. This measure will not only improve pain management, it may decrease healthcare costs while helping to curb the prescription opioid epidemic.

Back pain is the third most common primary care complaint and the most common cause of chronic disability.[ii] Typical treatments provided by medical providers include anti-inflammatory medications, muscle relaxants, and then opioids if initial treatments are ineffective. Unfortunately, opioids provide questionable benefit while carrying substantial risks in the treatment of back pain.[iii] In fact, their efficacy for the treatment of chronic low back pain is so marginal that in 2017 the American College of Physicians published guidelines[iv] recommending that "physicians and patients initially select non-drug therapy with exercise, multidisciplinary rehabilitation, acupuncture" and other non-pharmacologic therapies as first-line treatments for this incredibly common condition. Other studies have demonstrated the cost effectiveness of such an approach, as patients sent to physical therapy early in the course of a low back pain episode undergo fewer costly imaging studies and surgeries than patients managed by physicians.[v] Finally, accumulating evidence on the efficacy of acupuncture for chronic low back pain[vi] has compelled the Centers for Medicare and Medicaid Services to begin covering acupuncture for chronic low back pain for Medicare beneficiaries.

Another key provision of HB21-1276 is the requirement for insurance companies to provide coverage for "atypical" opioids and other non-opioid analgesics without first requiring patients to fail step therapy. These steps often include short-acting, highly habit forming, but inexpensive

full agonist opioids that carry substantial addiction risk. By eliminating the requirement of a step that includes inarguably higher risk, this bill could substantially reduce inappropriate opioid prescribing while increasing utilization of less dangerous alternatives, including atypical opioids.[vii]

Finally, this bill would continue the currently time-limited requirement for providers to check Colorado's Prescription Drug Monitoring database in order to evaluate individuals for possible signs of opioid misuse or diversion, such as acquiring medications from multiple providers or consistently filling medications early. Observational studies have demonstrated that states with robust PDMP programs and mandatory PDMP checking see greater reductions in opioid prescribing and measures of misuse.[viii] Additionally, this bill expands the requirement to include benzodiazepines, another drug class strongly implicated in the drug overdose epidemic.

COSAM applauds these provisions and believes that HB21-1276 will have several beneficial impacts for patients in pain while encouraging a more careful and limited approach to full agonist opioid therapy for pain management. Please do not hesitate to contact Dr. Joshua Blum at Joshua.Blum@dhha.org, if COSAM can be of any service to you. We look forward to working with you.

Sincerely,

Joshua Blum, MD, FASAM
President, the Colorado Society of Addiction Medicine

---

[i] American Medical Association. (2020). "Issue brief: Reports of increases in opioid- and other drug-related overdose and other concerns during COVID pandemic." Available at: https://www.ama-assn.org/system/files/2020-12/issue-brief-increases-in-opioid-related-overdose.pdf

[ii] Hoy D, March L, Brooks P, et al. The global burden of low back pain: estimates from the Global Burden of Disease 2010 study Annals of the Rheumatic Diseases Published Online First: 24 March 2014. doi: 10.1136/annrheumdis-2013-204428

[iii] Chaparro LE, et al. Opioids compared to placebo or other treatments for chronic low-back pain. *Cochrane Systematic Review* 2013.

[iv] Qaseem A, et al. Non-invasive treatments for acute, subacute, and chronic low back pain:a clinical practice guildeine from the American College of Physicians. *Annals of Internal Medicine* 2017; https://doi.org/10.7326/M16-2367.

[v] Fritz JM, et al. Primary care referral of patients with low back pain to physical therapy: impact on future healthcare utilization and costs. *Spine* 2012;27:2114-2121.

[vi] Jun-Hwan L, et al. Acupuncture for acute low back pain: a systematic review. *The Clinical Journal of Pain.* 2013;29:172-185.

[vii] Dart RC et al. Diversion and illicit sale of extended release tapentadol in the United States. *Pain Med* 2016;17:1490-1496.

[viii] Haffajee R et al. States with overall robust prescription drug monitoring programs experienced reductions in opioids prescribed to commercially-insured individuals. *Health Affairs* 2018;37:964-974.