House of Representatives

File No. 736

General Assembly

February Session, 2016 ***(Reprint of File No. 7)***

Substitute House Bill No. 5053
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
April 27, 2016

AN ACT CONCERNING OPIOIDS AND ACCESS TO OVERDOSE REVERSAL DRUGS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17a-714a of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For purposes of this section, "opioid antagonist" means naloxone hydrochloride or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of drug overdose.

(b) A licensed health care professional who is permitted by law to prescribe an opioid antagonist may prescribe **[**,**]** or dispense **[**or administer**]** an opioid antagonist to any individual to treat or prevent a drug overdose without being liable for damages in a civil action or subject to criminal prosecution for prescribing **[**,**]** or dispensing **[**or administering**]** such opioid antagonist or for any subsequent use of such opioid antagonist. A licensed health care professional who

prescribes [,] or dispenses [or administers] an opioid antagonist in accordance with the provisions of this subsection shall be deemed not to have violated the standard of care for such licensed health care professional.

(c) A licensed health care professional may administer an opioid antagonist to any person to treat or prevent an opioid-related drug overdose. Such licensed health care professional who administers an opioid antagonist in accordance with the provisions of this subsection shall not be liable for damages in a civil action or subject to criminal prosecution for administration of such opioid antagonist and shall not be deemed to have violated the standard of care for such licensed health care professional.

[(c)] (d) Any person [,] who in good faith believes that another person is experiencing an opioid-related drug overdose may, if acting with reasonable care, administer an opioid antagonist to such other person. Any person, other than a licensed health care professional acting in the ordinary course of such person's employment, who administers an opioid antagonist in accordance with this subsection shall not be liable for damages in a civil action or subject to criminal prosecution with respect to the administration of such opioid antagonist.

(e) Not later than October 1, 2016, each municipality shall amend its local emergency medical services plan, as described in section 19a-181b, to ensure that the emergency responder, including, but not limited to, emergency medical services personnel, as defined in section 20-206jj, or a resident state trooper, who is likely to be the first person to arrive on the scene of a medical emergency in the municipality is equipped with an opioid antagonist and such person has received training, approved by the Commissioner of Public Health, in the administration of opioid antagonists.

Sec. 2. (NEW) (*Effective January 1, 2017*) No individual health insurance policy providing coverage of the type specified in

subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs and includes on its formulary naloxone hydrochloride or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of drug overdose shall require prior authorization for such drug.

Sec. 3. (NEW) (*Effective January 1, 2017*) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs and includes on its formulary naloxone hydrochloride or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of drug overdose shall require prior authorization for such drug.

Sec. 4. Section 17a-667 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) There is established a Connecticut Alcohol and Drug Policy Council which shall be within the Department of Mental Health and Addiction Services.

(b) The council shall consist of the following members: (1) The Secretary of the Office of Policy and Management, or the secretary's designee; (2) the Commissioners of Children and Families, Consumer Protection, Correction, Education, Mental Health and Addiction Services, Public Health, Emergency Services and Public Protection and Social Services, Commissioner on Aging, and the Insurance Commissioner, or their designees; (3) the Chief Court Administrator, or the Chief Court Administrator's designee; (4) the chairperson of the Board of Regents for Higher Education, or the chairperson's designee; (5) the president of The University of Connecticut, or the president's

designee; (6) the Chief State's Attorney, or the Chief State's Attorney's designee; (7) the Chief Public Defender, or the Chief Public Defender's designee; and (8) the cochairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to public health, criminal justice and appropriations, or their designees. The Commissioner of Mental Health and Addiction Services and the Commissioner of Children and Families shall be cochairpersons of the council and may jointly appoint up to seven individuals to the council as follows: (A) Two individuals in recovery from a substance use disorder or representing an advocacy group for individuals with a substance use disorder; (B) a provider of community-based substance abuse services for adults; (C) a provider of community-based substance abuse services for adolescents; (D) an addiction medicine physician; (E) a family member of an individual in recovery from a substance use disorder; and (F) an emergency medicine physician currently practicing in a Connecticut hospital. The cochairpersons of the council may establish subcommittees and working groups and may appoint individuals other than members of the council to serve as members of the subcommittees or working groups. Such individuals may include, but need not be limited to: (i) Licensed alcohol and drug counselors; (ii) pharmacists; (iii) municipal police chiefs; (iv) emergency medical services personnel; and (v) representatives of organizations that provide education, prevention, intervention, referrals, rehabilitation or support services to individuals with substance use disorder or chemical dependency.

(c) The council shall review policies and practices of state agencies and the Judicial Department concerning substance abuse treatment programs, substance abuse prevention services, the referral of persons to such programs and services, and criminal justice sanctions and programs and shall develop and coordinate a state-wide, interagency, integrated plan for such programs and services and criminal sanctions.

(d) Such plan shall be amended not later than January 1, 2017, to contain measurable goals, including, but not limited to, a goal for a reduction in the number of opioid-induced deaths in the state.

Sec. 5. Subsection (h) of section 20-206bb of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(h) Notwithstanding the provisions of subsection (a) of this section, any person **[**certified by an organization approved by the Commissioner of Public Health**]** who maintains certification with the National Acupuncture Detoxification Association may practice the five-point auricular acupuncture protocol specified as part of such certification program as an adjunct therapy for the treatment of alcohol and drug abuse and other behavioral interventions for which the protocol is indicated, provided the treatment is performed under the supervision of a physician licensed under chapter 370 and is performed in **[**either**]** (1) a private freestanding facility licensed by the Department of Public Health **[**for the**]** that provides care or treatment **[**of**]** for substance abusive or dependent persons, **[**or**]** (2) a setting operated by the Department of Mental Health and Addiction Services, or (3) any other setting where such protocol is an appropriate adjunct therapy to a substance abuse or behavioral health treatment program. The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, to ensure the safe provision of auricular acupuncture **[**within private freestanding facilities licensed by the Department of Public Health for the care or treatment of substance abusive or dependent persons**]** in accordance with the provisions of this subsection.

Sec. 6. Subdivision (4) of subsection (a) of section 20-74s of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(4) "Practice of alcohol and drug counseling" means the professional application of methods that assist an individual or group to develop an understanding of alcohol and drug dependency problems, define goals, and plan action reflecting the individual's or group's interest, abilities and needs as affected by alcohol and drug dependency problems, and may include, as appropriate, (A) conducting a

substance use disorder screening or psychosocial history evaluation of an individual to document the individual's use of drugs prescribed for pain, other prescribed drugs, illegal drugs and alcohol to determine the individual's risk for substance abuse, (B) developing a preliminary diagnosis for the individual based on such screening or evaluation, (C) determining the individual's risk for abuse of drugs prescribed for pain, other prescribed drugs, illegal drugs and alcohol, (D) developing a treatment plan and referral options for the individual to ensure the individual's recovery support needs are met, and (E) developing and submitting an opioid use consultation report to an individual's primary care provider to be reviewed by the primary care provider and included in the individual's medical record;

Sec. 7. (NEW) (*Effective July 1, 2016*) (a) As used in this section:

(1) "Opioid drug" has the same meaning as provided in 42 CFR 8.2, as amended from time to time;

(2) "Adult" means a person who is at least eighteen years of age;

(3) "Prescribing practitioner" has the same meaning as provided in section 20-14c of the general statutes;

(4) "Minor" means a person who is under eighteen years of age;

(5) "Opioid agonist" means a medication that binds to the opiate receptors and provides relief to individuals in treatment for abuse of or dependence on an opioid drug;

(6) "Opiate receptor" means a specific site on a cell surface that interacts in a highly selective fashion with an opioid drug;

(7) "Palliative care" means specialized medical care to improve the quality of life of patients and their families facing the problems associated with a life-threatening illness; and

(8) "Opioid antagonist" has the same meaning as provided in section 17a-714a of the general statutes, as amended by this act.

(b) When issuing a prescription for an opioid drug to an adult patient for the first time for outpatient use, a prescribing practitioner who is authorized to prescribe an opioid drug shall not issue a prescription for more than a seven-day supply of such drug, as recommended in the National Centers for Disease Control and Prevention's Guideline for Prescribing Opioids for Chronic Pain.

(c) A prescribing practitioner shall not issue a prescription for an opioid drug to a minor for more than a seven-day supply of such drug at any time. When issuing a prescription for an opioid drug to a minor for less than a seven-day supply of such drug, the prescribing practitioner shall discuss the risks associated with use of an opioid drug, including, but not limited to, the risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants, and the reasons why the prescription is necessary with (1) the minor, and (2) the custodial parent, guardian or other person having legal custody of the minor if such parent, guardian or other person is present at the time of issuance.

(d) Notwithstanding the provisions of subsections (b) and (c) of this section, if, in the professional medical judgment of a prescribing practitioner, more than a seven-day supply of an opioid drug is required to treat an adult patient's or minor patient's acute medical condition, as determined by the prescribing practitioner, or is necessary for the treatment of chronic pain, pain associated with a cancer diagnoses or for palliative care, then the prescribing practitioner may issue a prescription for the quantity needed to treat the acute medical condition, chronic pain, pain associated with a cancer diagnosis or pain experienced while the patient is in palliative care. The condition triggering the prescription of an opioid drug for more than a seven-day supply shall be documented in the patient's medical record and the practitioner shall indicate that an alternative to the opioid drug was not appropriate to address the medical condition.

(e) The provisions of subsections (b), (c) and (d) of this section shall

not apply to medications designed for the treatment of abuse of or dependence on an opioid drug, including, but not limited to, opioid agonists and opioid antagonists.

Sec. 8. Subdivision (3) of section 21a-240 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(3) "Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, **[**or**]** dispenser or prescribing practitioner. It does not include a common or contract carrier, public warehouseman, or employee of the carrier or warehouseman;

Sec. 9. Subsection (j) of section 21a-254 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2016*):

(j) (1) The commissioner shall, within available appropriations, establish an electronic prescription drug monitoring program to collect, by electronic means, prescription information for schedules II, III, IV and V controlled substances that are dispensed by pharmacies, nonresident pharmacies, as defined in section 20-627, outpatient pharmacies in hospitals or institutions or by any other dispenser. The program shall be designed to provide information regarding the prescription of controlled substances in order to prevent the improper or illegal use of the controlled substances and shall not infringe on the legitimate prescribing of a controlled substance by a prescribing practitioner acting in good faith and in the course of professional practice.

(2) The commissioner may identify other products or substances to be included in the electronic prescription drug monitoring program established pursuant to subdivision (1) of this subsection.

(3) Prior to July 1, 2016, each pharmacy, nonresident pharmacy, as defined in section 20-627, outpatient pharmacy in a hospital or

institution and dispenser shall report to the commissioner, at least weekly, by electronic means or, if a pharmacy or outpatient pharmacy does not maintain records electronically, in a format approved by the commissioner, the following information for all controlled substance prescriptions dispensed by such pharmacy or outpatient pharmacy: (A) Dispenser identification number; (B) the date the prescription for the controlled substance was filled; (C) the prescription number; (D) whether the prescription for the controlled substance is new or a refill; (E) the national drug code number for the drug dispensed; (F) the amount of the controlled substance dispensed and the number of days' supply of the controlled substance; (G) a patient identification number; (H) the patient's first name, last name and street address, including postal code; (I) the date of birth of the patient; (J) the date the prescription for the controlled substance was issued by the prescribing practitioner and the prescribing practitioner's Drug Enforcement Agency's identification number; and (K) the type of payment.

(4) **[**On**]** (A) Except as provided in this subdivision, on and after July 1, 2016, each pharmacy, nonresident pharmacy, as defined in section 20-627, outpatient pharmacy in a hospital or institution, and dispenser shall report to the commissioner by electronic means, in a format approved by the commissioner, the following information for all controlled substance prescriptions dispensed by such pharmacy or outpatient pharmacy immediately upon, but in no event **[**more**]** later than **[**twenty-four hours**]** the next business day after, dispensing such prescriptions: **[**(A)**]** (i) Dispenser identification number; **[**(B)**]** (ii) the date the prescription for the controlled substance was filled; **[**(C)**]** (iii) the prescription number; **[**(D)**]** (iv) whether the prescription for the controlled substance is new or a refill; **[**(E)**]** (v) the national drug code number for the drug dispensed; **[**(F)**]** (vi) the amount of the controlled substance dispensed and the number of days' supply of the controlled substance; **[**(G)**]** (vii) a patient identification number; **[**(H)**]** (viii) the patient's first name, last name and street address, including postal code; **[**(I)**]** (ix) the date of birth of the patient; **[**(J)**]** (x) the date the prescription for the controlled substance was issued by the prescribing

practitioner and the prescribing practitioner's Drug Enforcement Agency's identification number; and **[**(K)**]** (xi) the type of payment.

(B) If the electronic prescription drug monitoring program is not operational, such pharmacy or dispenser shall report the information described in this subdivision not later than the next business day after regaining access to such program. For purposes of this subdivision, "business day" means any day during which the pharmacy is open to the public.

(C) Each veterinarian, licensed pursuant to chapter 384, who dispenses a controlled substance prescription shall report to the commissioner the information described in subparagraph (A) of this subdivision, at least weekly, by electronic means or, if the veterinarian does not maintain records electronically, in a format approved by the commissioner.

(5) The commissioner may contract with a vendor for purposes of electronically collecting such controlled substance prescription information. The commissioner and any such vendor shall maintain the information in accordance with the provisions of chapter 400j.

(6) The commissioner and any such vendor shall not disclose controlled substance prescription information reported pursuant to subdivisions (3) and (4) of this subsection, except as authorized pursuant to the provisions of sections 21a-240 to 21a-283, inclusive, as amended by this act. Any person who knowingly violates any provision of this subdivision or subdivision (5) of this subsection shall be guilty of a class D felony.

(7) The commissioner shall provide, upon request, controlled substance prescription information obtained in accordance with subdivisions (3) and (4) of this subsection to the following: (A) The prescribing practitioner **[**,**]** or such practitioner's authorized agent, **[**who is also a licensed health care professional,**]** who is treating or has treated a specific patient, provided the information is obtained for purposes related to the treatment of the patient, including the

monitoring of controlled substances obtained by the patient; (B) the prescribing practitioner with whom a patient has made contact for the purpose of seeking medical treatment or such practitioner's authorized agent, provided the request is accompanied by a written consent, signed by the prospective patient, for the release of controlled substance prescription information; or (C) the pharmacist who is dispensing controlled substances for a patient, provided the information is obtained for purposes related to the scope of the pharmacist's practice and management of the patient's drug therapy, including the monitoring of controlled substances obtained by the patient. The prescribing practitioner, such practitioner's authorized agent, or the pharmacist shall submit a written and signed request to the commissioner for controlled substance prescription information. Such prescribing practitioner or pharmacist shall not disclose any such request except as authorized pursuant to sections 20-570 to 20-630, inclusive, or sections 21a-240 to 21a-283, inclusive, as amended by this act.

(8) No person or employer shall prohibit, discourage or impede a prescribing practitioner or pharmacist from requesting controlled substance prescription information pursuant to this subsection.

(9) Prior to prescribing greater than a seventy-two-hour supply of any controlled substance to any patient, the prescribing practitioner or such practitioner's authorized agent **[**who is also a licensed health care professional**]** shall review the patient's records in the electronic prescription drug monitoring program established pursuant to this subsection. Whenever a prescribing practitioner prescribes a controlled **[**substances**]** substance, other than a schedule V nonnarcotic controlled substance, for the continuous or prolonged treatment of any patient, such prescriber, or such prescriber's authorized agent, **[**who is also a licensed health care professional,**]** shall review, not less than once every ninety days, the patient's records in such prescription drug monitoring program. Whenever a prescribing practitioner prescribes a schedule V nonnarcotic controlled substance, for the continuous or prolonged treatment of any patient, such prescribing practitioner, or

such prescribing practitioner's authorized agent, shall review, not less than annually, the patient's records in such prescription drug monitoring program. If such electronic prescription drug monitoring program is not operational, such **[**prescriber**]** prescribing practitioner may prescribe greater than a seventy-two-hour supply of a controlled substance to a patient during the time of such program's inoperability, provided such **[**prescriber**]** prescribing practitioner or such authorized agent reviews the records of such patient in such program not more than twenty-four hours after regaining access to such program.

(10) (A) A prescribing practitioner may designate an authorized agent to review the electronic prescription drug monitoring program and patient controlled substance prescription information on behalf of the prescribing practitioner. The prescribing practitioner shall ensure that any authorized agent's access to such program and patient controlled substance prescription information is limited to the purposes described in this section and occurs in a manner that protects the confidentiality of information that is accessed through such program. The prescribing practitioner and any authorized agent shall be subject to the provisions of 45 CFR 164.308, as amended from time to time, concerning administrative safeguards for the protection of electronic protected health information. A prescribing practitioner may receive disciplinary action for acts of the authorized agent as provided in section 21a-322, as amended by this act.

(B) Notwithstanding the provisions of subparagraph (A) of this subdivision, a prescribing practitioner who is employed by or provides professional services to a hospital shall, prior to designating an authorized agent to review the electronic prescription drug monitoring program and patient controlled substance prescription information on behalf of the prescribing practitioner, (i) submit a request to designate one or more authorized agents for such purposes and a written protocol for oversight of the authorized agent or agents to the commissioner, in the form and manner prescribed by the commissioner, and (ii) receive the commissioner's approval to designate such authorized agent or agents and of such written

protocol. Such written protocol shall designate either the hospital's medical director, a hospital department head, who is a prescribing practitioner, or another prescribing practitioner as the person responsible for ensuring that the authorized agent's or agents' access to such program and patient controlled substance prescription information is limited to the purposes described in this section and occurs in a manner that protects the confidentiality of information that is accessed through such program. A hospital medical director, a hospital department head, who is a prescribing practitioner, or another prescribing practitioner designated as the person responsible for overseeing an authorized agent's or agents' access to such program and information in the written protocol approved by the commissioner may receive disciplinary action for acts of the authorized agent or agents as provided in section 21a-322, as amended by this act. The commissioner may inspect hospital records to determine compliance with written protocols approved in accordance with this section.

[(10)**]** (11) The commissioner shall adopt regulations, in accordance with chapter 54, concerning the reporting, evaluation, management and storage of electronic controlled substance prescription information.

[(11)**]** (12) The provisions of this section shall not apply to (A) samples of controlled substances dispensed by a physician to a patient, or (B) any controlled substances dispensed to hospital inpatients.

[(12)**]** (13) The provisions of this section shall not apply to any institutional pharmacy or pharmacist's drug room operated by a facility, licensed under section 19a-495 and regulations adopted pursuant to said section 19a-495, that dispenses or administers directly to a patient an opioid agonist for treatment of a substance use disorder.

Sec. 10. Section 21a-322 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

The commissioner may suspend, revoke or refuse to renew a registration, place a registration on probation, place conditions on a

registration and assess a civil penalty of not more than one thousand dollars per violation of this chapter, for sufficient cause. Any of the following shall be sufficient cause for such action by the commissioner: (1) The furnishing of false or fraudulent information in any application filed under this chapter; (2) conviction of a crime under any state or federal law relating to the registrant's profession, controlled substances or drugs or fraudulent practices, including, but not limited to, fraudulent billing practices; (3) failure to maintain effective controls against diversion of controlled substances into other than duly authorized legitimate medical, scientific, or commercial channels; (4) the suspension, revocation, expiration or surrender of the practitioner's federal controlled substance registration; (5) prescribing, distributing, administering or dispensing a controlled substance in schedules other than those specified in the practitioner's state or federal registration or in violation of any condition placed on the practitioner's registration; (6) suspension, revocation, expiration, surrender or other disciplinary action taken against any professional license or registration held by the practitioner; (7) abuse or excessive use of drugs; (8) possession, use, prescription for use or distribution of controlled substances or legend drugs, except for therapeutic or other proper medical or scientific purpose; (9) a practitioner's failure to account for disposition of controlled substances as determined by an audit of the receipt and disposition records of said practitioner; **[**and**]** (10) failure to keep records of medical evaluations of patients and all controlled substances dispensed, administered or prescribed to patients by a practitioner; (11) failure to establish and implement administrative safeguards for the protection of electronic protected health information pursuant to 45 CFR 164.308, as amended from time to time; and (12) breach of any such safeguards by a prescribing practitioner's authorized agent.

Sec. 11. (*Effective from passage*) Not later than October 1, 2016, the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall convene a working group concerning the issuance of opioid drug prescriptions by prescribing practitioners, as defined in section 7 of this act. The

working group shall study whether it is a best practice for prescribing practitioners to limit prescriptions to not more than a three-day supply of opioid drugs for the purpose of treating a minor patient's acute medical condition. Not later than February 1, 2017, the working group shall report, in accordance with the provisions of section 11-4 of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health concerning the results of such study.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	17a-714a
Sec. 2	*January 1, 2017*	New section
Sec. 3	*January 1, 2017*	New section
Sec. 4	*October 1, 2016*	17a-667
Sec. 5	*October 1, 2016*	20-206bb(h)
Sec. 6	*October 1, 2016*	20-74s(a)(4)
Sec. 7	*July 1, 2016*	New section
Sec. 8	*October 1, 2016*	21a-240(3)
Sec. 9	*July 1, 2016*	21a-254(j)
Sec. 10	*October 1, 2016*	21a-322
Sec. 11	*from passage*	New section

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact:

Municipalities	Effect	FY 17 $	FY 18 $
Various Municipalities	Cost	Potential	Potential

Explanation

The bill may result in a cost to municipalities, estimated to be less than $10,000 per municipality, associated with: (1) purchasing opioid antagonists, and (2) training emergency service providers to administer opioid antagonists.

This cost will vary based on the type of antagonist and the amount purchased by a municipality. Municipalities that currently purchase and administer opioid antagonists will not incur any cost as a result of the bill.

The bill will not result in a cost to the state employee and retiree health plan, municipal health plans, or the state in accordance with the Affordable Care Act (ACA).[1] The state plan and fully insured municipal plans currently provide coverage in accordance with the bill.[2] In addition, the bill's prescribing restrictions outlined in section 7 are not anticipated to conflict with the state health plan's 90-day refill policy for maintenance drugs.

[1] The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state has traditionally adopted all state health mandates.

[2] *Source*: Office of State Comptroller and State Dept. of Insurance

Lastly, the bill (1) makes various other changes to current law and (2) requires a working group to be convened by the General Assembly to study opioid prescribing and report on its findings by February 1, 2017, these provisions do not result in a fiscal impact to the state or municipalities.

House "A" eliminates the original bill and its associated fiscal impact and results in the impact described above.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sHB 5053 (as amended by House "A")*

AN ACT INCREASING ACCESS TO OVERDOSE REVERSAL DRUGS.

SUMMARY:

This bill contains various provisions on opioid abuse prevention and treatment and related issues. It:

1. prohibits, with certain exceptions, a prescribing practitioner authorized to prescribe an opioid drug from issuing a prescription for more than a seven-day supply to (a) an adult for the first time for outpatient use or (b) a minor (§ 7);

2. makes various changes to the electronic prescription drug monitoring program, such as (a) expanding who may serve as a prescriber's authorized agent, (b) modifying reporting deadlines, and (c) decreasing prescriber reviews for prolonged treatment of schedule V nonnarcotic drugs (§§ 8 & 9);

3. allows any licensed health care professional to administer an opioid antagonist (e.g., Narcan) to treat or prevent a drug overdose without civil or criminal liability (§ 1);

4. requires municipalities, by October 1, 2016, to amend their local emergency medical services (EMS) plans to ensure that specified first responders are equipped with an opioid antagonist and trained in administering it (§ 1);

5. prohibits certain health insurance policies that provide prescription drug coverage for opioid antagonists from requiring prior authorization for these drugs (§§ 2 & 3); and

6. requires the Public Health Committee chairpersons to establish a working group on the issuance of opioid drug prescriptions by prescribing practitioners.

The bill also makes changes affecting the (1) practice of auricular acupuncture, (2) scope of practice of alcohol and drug counseling, (3) disciplining of controlled substance registrants, and (4) Alcohol and Drug Policy Council.

Finally, the bill makes technical and conforming changes.

*House Amendment "A" replaces the original bill (File 7). It adds the provisions on the (1) seven-day limit on opioid prescriptions, (2) Alcohol and Drug Policy Council, (3) prescription drug monitoring program, (4) practice of auricular acupuncture, (5) scope of practice of alcohol and drug counseling, and (6) disciplinary action against controlled substance registrants. It also modifies how municipalities must amend their local EMS plans regarding the provision of opioid antagonists to first responders.

EFFECTIVE DATE: Various, see below

§ 7 — OPIOID DRUG PRESCRIPTIONS

Seven-Day Supply

The bill prohibits a prescribing practitioner authorized to prescribe an opioid drug from issuing a prescription for more than a seven-day supply to (1) a minor or (2) an adult for the first time for outpatient use.

When prescribing an opioid drug to a minor for less than seven days, the bill requires the practitioner to discuss with the (1) minor and (2) if present when the prescription is issued, minor's custodial parent, guardian, or legal custodian:

1. the associated risks of addiction and overdose;

2. the dangers of taking opioid drugs with alcohol,

benzodiazepines, and other central nervous system depressants; and

3. why the prescription is necessary.

The bill defines an "opioid drug" as any drug having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability.

Exceptions

The bill allows the practitioner to prescribe more than a seven-day supply of an opioid drug to an adult or minor if, in his or her professional judgment, the drug is required to treat the person's acute medical condition, chronic pain, cancer-associated pain, or for palliative care. The practitioner must document the patient's condition in his or her medical record and indicate that an alternative to the opioid drug was not appropriate to treat the patient's condition.

The bill's provisions on opioid drug prescriptions do not apply to medications to treat opioid drug dependence or abuse, including opioid antagonists and agonists (e.g., medications such as morphine that activate the same areas of the brain as other opioids).

EFFECTIVE DATE: July 1, 2016

§§ 8 & 9 — ELECTRONIC PRESCRIPTION DRUG MONITORING PROGRAM

Under the electronic prescription drug monitoring program, the Department of Consumer Protection (DCP) collects information on controlled substance prescriptions to prevent improper or illegal drug use or improper prescribing. The bill makes various changes affecting the program.

EFFECTIVE DATE: July 1, 2016, except a conforming change is effective October 1, 2016.

Reporting Deadline

The bill extends, from 24 hours to the end of the following business day, the deadline for pharmacists and other controlled substance dispensers to report specified prescription information to DCP under the program. (PA 15-5, June Special Session, shortened the reporting deadline starting July 1, 2016, from at least weekly to immediately but not later than 24 hours after dispensing the prescription.)

The bill also provides that if the program is not operational, the pharmacy or dispenser must report by the next business day after regaining access to the program (i.e., the next day during which the pharmacy is open to the public).

For veterinarians dispensing controlled substance prescriptions, the bill continues the current reporting deadlines, which are currently set to change in July. Thus, the bill requires them to report at least weekly. It also allows veterinarians who do not maintain records electronically to report in other formats approved by the DCP commissioner.

Prescribers and Agents

Under current law, before prescribing more than a 72-hour supply of a controlled substance, the prescribing practitioner or his or her authorized agent must review the patient's records in the prescription drug monitoring program. Additionally, the prescribing practitioner or agent must review a patient's records in the program at least every 90 days when the practitioner prescribes controlled substances for continuous or prolonged treatment.

The bill eliminates the current requirement that the authorized agent be a licensed health care professional. It also requires less frequent reviews of records for continuous or prolonged treatment of schedule V nonnarcotic controlled substances, by requiring such reviews annually rather than every 90 days.

Under the bill, a prescribing practitioner may designate an authorized agent to review the program and patient controlled substance prescription information on the practitioner's behalf. A

practitioner must ensure that his or her agent's access is limited to the program's statutory purposes and occurs in a manner that protects the confidentiality of information accessed through the program.

The bill specifies that prescribers and their authorized agents are subject to the federal Health Insurance Portability and Accountability Act (HIPAA) regulations on administrative safeguards for protecting electronic protected health information. It also provides that DCP may take disciplinary action against a prescribing practitioner for acts of his or her authorized agent.

The bill makes corresponding changes by expanding when the DCP commissioner must release controlled substance prescription information, on request, to prescribing practitioners' authorized agents. It requires him to release information to agents in the same situations as for requests by prescribers themselves (instead of only certain situations as under current law), and specifies that the agents need not be licensed health care professionals.

Specific Requirements for Prescribers in Hospitals

Under the bill, prescribing practitioners who work for or provide professional services to hospitals must receive the DCP commissioner's approval before designating authorized agents as set forth above. Along with the request to designate agents, practitioners must submit for approval a written protocol for oversight of the agents on a commissioner-approved form. The protocol must designate the hospital's medical director, a hospital department head (who is a prescribing practitioner), or another prescribing practitioner as the person responsible for ensuring that the agents' access is limited to the program's statutory purposes and occurs in a manner that protects confidentiality.

The bill allows DCP to (1) take disciplinary action against such designated responsible parties for the agents' acts and (2) inspect hospital records to determine compliance with approved protocols.

§ 1 — ADMINISTRATION OF OPIOID ANTAGONISTS BY LICENSED HEALTH CARE PROFESSIONALS

The bill allows any licensed health care professional to administer an opioid antagonist to treat or prevent a drug overdose without being (1) civilly or criminally liable for such action or (2) deemed as violating his or her professional standard of care. Current law limits such immunity to health care professionals authorized to prescribe an opioid antagonist (see BACKGROUND).

By law, an "opioid antagonist" is naloxone hydrochloride (Narcan) or any other similarly acting and equally safe drug that the Food and Drug Administration (FDA) has approved for treating a drug overdose.

EFFECTIVE DATE: Upon passage

§ 1 — LOCAL EMS PLANS

The bill requires each municipality, by October 1, 2016, to amend its local EMS plan to ensure that the EMS responder (e.g., EMS personnel or resident state trooper) who is likely to be the first person to arrive on the scene of a medical emergency is equipped with an opioid antagonist and has received Department of Public Health (DPH)-approved training in administering it.

Under the bill, "EMS personnel" includes an individual certified as an emergency medical responder, emergency medical technician, advanced emergency medical technician, EMS instructor, or paramedic.

EFFECTIVE DATE: Upon passage

§§ 2 & 3 — PRIOR AUTHORIZATION FOR OPIOID ANTAGONISTS

The bill prohibits health insurance policies that provide prescription drug coverage for opioid antagonists from requiring prior authorization for these drugs. It applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-

surgical expenses; (3) major medical expenses; (4) hospital or medical services, including coverage under an HMO plan; or (5) single service ancillary health coverage.

Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2017

§ 4 — ALCOHOL AND DRUG POLICY COUNCIL

By law, the council is charged with (1) reviewing state policies and practices on substance abuse treatment and prevention programs, referrals to such programs, and criminal sanctions and programs, and (2) developing and coordinating a statewide, interagency, integrated plan for these matters. The bill requires the council to amend this plan by January 1, 2017 to contain measurable goals, including reducing the number of opioid-induced deaths in the state.

The bill also allows the council's co-chairpersons (the Department of Mental Health and Addiction Services (DMHAS) and children and families commissioners) to (1) establish subcommittees and working groups and (2) appoint individuals who are not council members to serve on them, including licensed alcohol and drug counselors; pharmacists; municipal police chiefs; EMS personnel; and representatives of organizations that provide education, prevention, intervention, referrals, rehabilitation, or support services to individuals with substance use disorder or chemical dependency.

EFFECTIVE DATE: October 1, 2016

§ 5 — AURICULAR ACUPUNCTURE

Under current law, unlicensed individuals who are certified by a DPH-approved organization may practice auricular acupuncture to treat alcohol and drug abuse, under a physician's supervision, in DPH-licensed freestanding substance abuse facilities or DMHAS-operated settings.

The bill specifies that these individuals must be certified by the National Acupuncture Detoxification Association. It allows them to practice the five-point auricular acupuncture protocol specified as part of the association's certification program, as an adjunct therapy to treat alcohol and drug abuse and other behavioral interventions covered by the protocol.

The bill expands the settings in which these individuals may practice, by allowing them to do so in any other setting where the protocol is an appropriate adjunct therapy for such treatment. As under current law, they must practice under a physician's supervision.

The bill also makes a conforming change to the DPH commissioner's duty to adopt regulations on this practice.

EFFECTIVE DATE: October 1, 2016

§ 6 — ALCOHOL AND DRUG COUNSELING

By law, alcohol and drug counselors must be licensed or certified by DPH. Current law defines the practice of alcohol and drug counseling as the professional application of methods that assist individuals or groups to understand alcohol and drug dependency problems; define goals; and plan actions reflecting their interests, abilities, and needs as affected by such dependency. The bill specifies that this may include, as appropriate:

1. conducting a substance use disorder screening or psychosocial history evaluation to document an individual's use of pain medications, other prescribed drugs, illegal drugs, and alcohol, to determine the person's risk for substance abuse;

2. developing a preliminary diagnosis based on this screening or evaluation;

3. determining the person's risk of abusing drugs prescribed for pain, other prescribed drugs, illegal drugs, and alcohol;

4. developing a treatment plan and referral options to ensure that the person receives needed recovery supports; and

5. developing an opioid use consultation report and submitting it to the person's primary care provider for that provider to review and include in the patient's medical record.

EFFECTIVE DATE: October 1, 2016

§ 10 — DCP DISCIPLINARY ACTION AGAINST CONTROLLED SUBSTANCE REGISTRANTS

The bill adds to the list of reasons the DCP commissioner may take disciplinary action against a controlled substance registrant:

1. failing to establish and implement administrative safeguards for protecting electronic protected health information required by the federal HIPAA and

2. breach of any such safeguards by a prescribing practitioner's authorized agent.

By law, the commissioner may, for sufficient cause, suspend, revoke, or refuse to renew a registration; place a registration on probation or put conditions on it; and assess a civil penalty of up to $1,000 for each violation.

EFFECTIVE DATE: October 1, 2016

§ 11 — WORKING GROUP ON OPIOID DRUG PRESCRIPTIONS

The bill requires the Public Health Committee chairpersons, by October 1, 2016, to convene a working group on the issuance of opioid drug prescriptions by prescribing practitioners. The working group must study whether it is a best practice for prescribing practitioners to limit prescriptions to minors to no more than a three-day supply to treat an acute medical condition.

The bill requires the working group to report the study results by February 1, 2017 to the Public Health Committee.

EFFECTIVE DATE: Upon passage

BACKGROUND

Opioid Antagonist Good Samaritan Law

Existing law allows licensed health care practitioners authorized to prescribe an opioid antagonist to prescribe, dispense, or administer it to treat or prevent a drug overdose without being civilly or criminally liable for the action or for its subsequent use.

The law also allows anyone, if acting with reasonable care, to administer an opioid antagonist to a person he or she believes, in good faith, is experiencing an opioid-related drug overdose. It generally gives civil and criminal immunity to such a person regarding the administration of the opioid antagonist (CGS § 17a-714a).

Prescribing Practitioner

Under existing law, the following health providers may prescribe medication within the scope of their practice: physicians, dentists, podiatrists, optometrists, physician assistants, advanced practice registered nurses, nurse-midwives, and veterinarians (CGS § 20-14c).

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 22 Nay 0 (02/24/2016)

Planning and Development Committee

Joint Favorable
Yea 18 Nay 0 (03/28/2016)

Judiciary Committee

Joint Favorable
Yea 40 Nay 0 (04/06/2016)