AMA
AMERICAN MEDICAL ASSOCIATION

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February 18, 2021

The Honorable George Keiser
North Dakota Legislative Branch
422 Toronto Drive
Bismarck, ND 58503-0276

The Honorable Jerry Klein
North Dakota Legislative Branch
P.O. Box 265
Fessenden, ND 58438-0265

Re: American Medical Association concerns with House Bill No. 1139

Dear Representative Keiser and Senator Klein:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I am writing with concerns about House Bill No. 1139 (H.B. 1139). The AMA is specifically concerned that this bill would inappropriately limit access to legitimate medical care based on the use of arbitrary thresholds that assume all patients are the same. While we share the goal of ensuring that patients with pain receive opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient, and that this bill is trying to avoid harmful contraindications for opioid analgesics and benzodiazepines, we ultimately conclude that H.B. 1139 would impose non-clinical thresholds that may not correspond with patients' clinical needs as determined by their physician.

In addition, the AMA supports broad access to non-opioid therapy for pain care, as appropriate, but have great concerns that such therapy is too often unaffordable or inaccessible for too many patients. In a state like North Dakota, with considerable rural areas and shortages of health care providers in those areas, the AMA is concerned that this bill would restrict access to legitimate care while not affording access to other types of pain care. In addition, while we support the exceptions in H.B. 1139 for certain types of chronic conditions, similar exceptions often are not honored by health insurers, pharmacy benefit management companies, pharmacy chains, and other payers who often have considerable difficulty in distinguishing different types of patient histories from a prescription. As a result, the AMA has seen far too many examples of patients with cancer, in hospice, and other conditions denied opioid therapy—resulting in damaging stigmatization and suffering from untreated pain. These denials are examples of how states have misapplied the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain (CDC Guideline), and why the CDC said in 2019 that:

> Unfortunately, some policies and practices purportedly derived from the guideline have in fact been inconsistent with, and often go beyond, its recommendations. A consensus panel has highlighted these inconsistencies, which include inflexible application of recommended dosage and duration thresholds and policies that

> encourage hard limits and abrupt tapering of drug dosages, resulting in sudden opioid discontinuation or dismissal of patients from a physician's practice. The panel also noted the potential for misapplication of the recommendations to populations outside the scope of the guideline. Such misapplication has been reported for patients with pain associated with cancer, surgical procedures, or acute sickle cell crises. There have also been reports of misapplication of the guideline's dosage thresholds to opioid agonists for treatment of opioid use disorder. Such actions are likely to result in harm to patients.

This is, in part, why the AMA has consistently opposed hard thresholds such as those proposed in H.B. 1139. Some states, including Oklahoma, for example, are seeking to mitigate the problems associated with hard thresholds with the introduction of legislation to protect patients stable on opioid therapy, or who may benefit from a dose greater than a specific number. Language under consideration in Oklahoma reads as-follows:

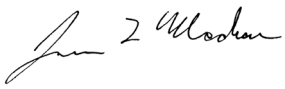
- Nothing in the [Act] shall be construed to require a practitioner to limit or forcibly taper a stable long-term opioid therapy patient. The standard of care requires effective and individualized treatment for each patient without limits or thresholds on dose or quantity.

- When a practitioner thoroughly assesses and documents his or her findings as required by this section and prescribes in good faith using his or her clinical expertise, neither an individual patient's nor practitioner's practice's average prescribed doses or quantities alone shall be used as the basis to initiate an investigation or disciplinary action, or to pursue civil liability or criminal penalties.

Finally, AMA believes that additional restrictions found in H.B. 1139, focused on workers, also are not necessary given multiple positive trends in your state. North Dakota physicians and other health care professionals already have reduced opioid prescribing by more than 40 percent between 2014-2019. Deaths in North Dakota, moreover, have been primarily tied to overdose related to illicit drugs, and North Dakota also has one of the lowest drug overdose mortality rates in the nation. These positive trends, however, mask a larger problem of workers and others not having access to non-opioid pain care options, which is something that this bill does not address—and has largely not been acted upon by health insurers in any state.

In summary, the AMA appreciates your efforts to help patients with pain. AMA concludes, however, that H.B. 1139 will not achieve this goal for all the reasons set forth above. If you have questions, please contact Daniel Blaney-Koen, JD, Senior Legislative Attorney, AMA Advocacy Resource Center, at daniel.blaney-koen@ama-assn.org or (312) 464-4954.

Sincerely,



James L. Madara, MD

cc: North Dakota Medical Association