ASSEMBLYWOMAN
Autumn Burke
DISTRICT 62

FACT SHEET

AB 2741 –Protecting Children from Opioid Addiction Act

SUMMARY

AB 2741 promotes safe prescribing strategies as recommended by the Center for Disease Control and the Medical Board of California for minors suffering from acute pain. In addition, AB 2741 ensures that parents or legal guardians are educated and made aware of the dangers of extended opioid use.

BACKGROUND

Prescription opioids (like hydrocodone, oxycodone, and morphine) are one of the many options for treating severe acute pain. While these medications can reduce pain during short-term use, they come with serious risks including addiction and death from overdose when taken for longer periods of time or at high doses.

Each day, the opioid crisis claims 91 American lives. In 2016, 46 lives were lost a day due to prescription opioids, and today, it is estimated that over 120,000 addicts are adolescents under the age of 21. On top of that, it is estimated that over two million Americans struggle with opioid addiction. According to the Partnership for a Drug-Free America, one in five teens has abused prescription pain medication.

California has been no exception to the opioid crisis; in some cities and towns, the amount of opioid prescriptions outnumbers the population. In 2016 1,925 Californians lost their lives from opioid overdose. While the state as a whole has not been the hardest hit nationally, many rural California counties have some of the highest overdose rates in the country.

In 2015, the amount of opioids prescribed was enough for every American to be medicated around the clock for 3 weeks. Several reputable health organizations, including the U.S. Food & Drug Administration (FDA) and the Center for Disease Control (CDC), all agree that overprescribing of opioid medications has directly contributed to the addiction crisis.

In July 2017, the CDC released updated guidelines that recommended no more than a 3-day prescription for acute pain management. The Medical Board of California recommends opioids for acute pain management with minors only after non-opioid alternatives have failed.

According to the National Institute on Drug Abuse, nearly half of young people who inject heroin reported abusing prescription opioids before turning to heroin. The U.S. Substance Abuse and Mental Health Services Administration estimates a full 80% of all users arrive at heroin after abusing opioid painkillers.

ASSEMBLY BILL 2741

AB 2741 sets a 5-day limit on all opioid prescriptions for acute pain management for minors, with exceptions for chronic pain management, hospice & palliative care patients, cancer patients and minors who are under treatment for substance abuse disorders.

The bill also requires prescribers to assess whether the minor is being treated for a substance abuse disorder, to discuss the potential risks associated with opioid use and obtain written consent from a minor's parent or guardian before prescribing the medication.

CONTACT

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Assembly Bill 2760 – Opioid Co-Prescribing
Assemblymember Jim Wood

EXISTING LAW

Under existing law, health care practitioners are regulated by their respective licensing board. Specific categories of practitioners, including physicians and dentists are authorized to issue prescriptions for dangerous drugs listed in the Uniform Controlled Substances Act (specifically for purposes of this bill Schedule II narcotics).

BACKGROUND

California and the nation are experiencing an opioid epidemic. For the 24 month period July 2015 through July 2017, 9,490 Californians lost their lives as a result of drug overdoses, a trend primarily driven by opioids including heroin and fentanyl. California ranks in the top five states when it comes to the raw number of drug-overdose deaths. Enough prescription opioids are prescribed every year to kill every Californian more than twice.

Some California counties have overdose drug rates three to five times higher than the national average. After alcohol, prescription drugs are the most commonly abused substance by Americans over 12 years of age. Most alarming is that driven by the continued surge in drug deaths, life expectancy in the United States dropped for the second year in a row in 2016, resulting in the first consecutive decline in national life expectancy since 1963 - and the annual overdose death toll is still rising.

While our nation and state are firmly ensconced in an epidemic, there is some good news in that 14 states, including California, did experience a decline in overdose deaths between 2016 and 2017. A likely reason for a tapering in death counts is the widespread use of the overdose antidote naloxone hydrochloride (naloxone).

Naloxone is an opioid antagonist that acts immediately upon administration to reverse the effects of the opioids. Naloxone is available as a nasal spray or injection.

It is common practice for emergency rooms and emergency first responders to administer naloxone when encountering a drug overdose.

The American Medical Association's Opioid Task Force recently issued updated naloxone guidelines recommending that family physicians and other clinicians consider a set of factors when determining whether to co-prescribe naloxone to a patient and/or their caregivers. Among others, those factors include whether the patient is on a concomitant benzodiazepine prescription and has a history of overdose or substance use disorder. (The risk of overdose death goes up nearly fourfold when benzodiazepines are combined with opioids. Overdose deaths involving benzodiazepines increased more than sevenfold between 1999 and 2015.)

In 2010 Kaiser Permanente Southern California (KPSC) launched its Safe and Appropriate Opioid Prescribing Program (SAOP) after discovering that its most prescribed nonformulary medication was not related to diabetes, heart disease or cancer, but rather was long-acting OxyContin (oxycodone) and its most prescribed formulary medications were hydrocodone products. During the course of their efforts to develop the program they identified several groups that are at high-risk for overdose including patients on more than 120 morphine milligram equivalents (mme) a day and patients also on combinations of opioids with benzodiazepines and/or carisoprodol. (Since initiating the program, KPSC announced it plans to emphasize the new CDC guidelines and has moved this threshold down to 100 mme per day.)

Finally, the CDC "Guidelines for Prescribing Opioids for Chronic Pain" state that clinicians should evaluate risk factors for opioid-related harm and incorporate into the management plan, strategies to mitigate risk, including considering offering naloxone when factors that increase risk for overdose are present. These factors include history of overdose, history of substance use disorder, higher opioid dosages (for CDC guidelines a high dose is over 50 mme) or concurrent benzodiazepine use.

There is consensus as to the most prominent overdose risk factors associated with opioid use.

While efforts aimed at stemming the opioid crisis appear to be making some inroads, the sheer number and potential for ever increasing numbers requires pro-active action on the part of the legislature. Requiring the co-prescribing of naloxone for those at high-risk places an immediate deterrent into the hands of those directly impacted or into the hands of their family and caregivers. It is a tool that can immediately save lives and hopefully provide an opportunity for discussion of treatment for individuals suffering from substance use disorder.

BILL SUMMARY

AB 2760 requires a healthcare practitioner authorized to prescribe controlled substances to also provide (co-prescribe) a prescription for naloxone whenever one or more of the following conditions are present:

1) The prescription dosage for a patient is between 50 and 100 morphine milligram equivalents (mme) of an opioid medication per day.

2) An opioid medication is prescribed concurrently with a prescription for a benzodiazepine.

3) The patient presents with an increased risk for overdose, including a patient with a history of overdose, a patient with a history of substance use disorder, or a patient at risk for returning to a high dose of opioid medication which the patient may no longer be able to tolerate.

AB 2760 would also require a practitioner to provide education to patients and their household members on overdose prevention and the appropriate use of naloxone.

Violation of the provision contained in AB 2760 would be unprofessional conduct and would subject the prescriber to discipline by their respective licensing board.

STATUS

Assembly B&P

FOR MORE INFORMATION

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Senator Scott Wiener, 11th Senate District

Senate Bill 1021 – Affordable Prescription Drug Coverage

SUMMARY

SB 1021 will protect prescription drug users by eliminating the sunset date on provisions of AB 339 (Gordon, 2015). The relevant provisions cap copays on a monthly supply of any prescription drug at $250 and prevent health plans from placing drugs in more expensive "tiers" based on the cost of purchase from the manufacturer alone. This legislation will also add preventive treatments to the definition of the AIDS drug cocktail, codify an existing regulation capping copays at the drug's retail price, and limit drug formularies (lists of drugs offered) to four pricing tiers.

BACKGROUND/EXISTING LAW

Prior to implementation of AB 339, patients with chronic conditions like cancer, HIV/AIDS, lupus, and multiple sclerosis faced cripplingly high prices for live-saving drugs, often spending thousands of dollars on medication in a single month. In response, AB 339 capped monthly copays at $250 total per patient; prevented discrimination against patients with specific conditions, by ensuring that all of the drugs for a given disease could not be placed in the most expensive tier; and extended all protections to plans in the large employer market as well as the individual and small employer coverage markets. The legislation also required placement of drugs in health plan's formulary to be based on clinical guidelines as well as safety and efficacy standards, as opposed to just cost. Following implementation of these provisions, patients of all income levels have become better able to purchase the drugs they rely on without facing exorbitant costs.

PROBLEM

Unfortunately, several key provisions of AB 339 are set to expire at the end of 2019. Specifically, the $250 cap on copays as well as the standards for how drugs are placed in a given tier will be eliminated without legislative action, opening the door for consumers to once again face unmanageable costs. Meanwhile, since drug prices have risen even higher since the passage of AB 339, lack of access to affordable prescription drugs would likely prove even more damaging than in the past. Since insurers will begin planning for 2020 (and beyond) in early 2019, the Legislature must act now to ensure that these sunsets are eliminated.

SOLUTION

SB 1021 will eliminate the sunset provision on the $250-per-drug monthly cap copay cap, ensuring that Californians will never again have to skip taking their (often lifesaving) prescription drugs because of high costs. It will also eliminate the sunset on the standards for drug formularies and permanently guarantee that drugs will not be arbitrarily placed in the priciest tiers. SB 1021 also adds several provisions not included in AB 339. Clarifying language ensures that the bill covers drugs such as PEP and PrEP that prevent HIV/AIDS, not just those that treat it. It also codifies an existing Department of Managed Health Care regulation that prevents the cost of a drug copay from exceeding the retail price. Finally, SB 1021 limits the number of tiers in health plans' formularies to four, consistent with Covered California and Medicare formulary standards.

STATUS

- Pending referral

SUPPORT

- Health Access (Sponsor)

CO-AUTHORS

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FOR MORE INFORMATION

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Senate
California Legislature

Mike Morrell
Senator, Twenty-Third District

SB 1336: End of Life Option Act: Effective Reporting

BILL SUMMARY

SB 1336 seeks to improve the quality of data collected and published relating to the implementation of the End of Life Option Act of 2015 (EoLOA). The bill does not alter the EoLOA process in any significant way, nor does it lessen existing EoLOA individual privacy protections.

BACKGROUND

Current law allows for terminally ill patients who meet certain qualifications to receive a Physician aid-in-dying drug (PAD). Prescription of a PAD hinges on the determination of a patient's attending physician that the patient has a "terminal disease," as defined in law, and is capable of making an informed decision regarding the end of life procedure.

The California Department of Public Health (CDPH) is responsible for releasing annual reports detailing EoLOA cases, but the information reported is limited and provides an incomplete picture of how the EoLOA is working. The existing reporting requirements include only information regarding the number of PAD prescriptions written, the number of patients who died and their cause of death, along with the age, education level, race, sex, type of insurance, and underlying illness of patients requesting PAD.

PROBLEM

The existing CDPH report does not contain any information about the motivating reason behind a patient's request for the end of life procedure. Nor does the report contain any data regarding: a) the specialties of those physicians who wrote prescriptions for the PAD; b) the number of patients who received a mental health specialist assessment; and c) the length of time the attending physician provided care to the patient prior to prescribing the PAD. This information is critical in enabling policymakers to properly assess the performance of the EoLOA.

SOLUTION

To rectify the existing limitations in reporting requirements, SB 1336 would:

1. Require attending physicians to request a qualified individual to specify in writing or orally the individual's reason for requesting an aid-in-dying drug prior to prescription. An individual who chooses not to answer this question is not precluded from receiving the PAD.

2. Increase public reporting requirements for CDPH to include, in addition to the information regarding a patient's motivating reasons: a) the specialties of those physicians who wrote prescriptions for the PAD; b) the number of patients who received a mental health specialist assessment prior to receiving the PAD; and c) the length of time the attending physician provided care to the patient prior to prescribing the PAD.

BILL STATUS

Introduced 2/16/18

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Updated: 3/7/2018