THE DOCTOR PATIENT FORUM

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Re: Written Testimony – H7628 and H7923 (March 3, 2026 Hearing)

Dear Chair and Members of the House Health & Human Services Committee,

We write on behalf of the Doctor Patient Forum (DPF), a nonprofit organization that advocates for people living with severe and chronic pain and for evidence-based, individualized pain care policy.

We supported the legislation considered on March 3, 2026, as it addressed arbitrary opioid prescribing thresholds. However, we strongly disagree with the scientific and policy framing presented in the oral and written testimony of Rob Horowitz.

This rebuttal focuses on correcting specific factual inaccuracies and misinterpretations contained in Mr. Horowitz's written and oral testimony from the March 3, 2026 hearing on H7628 [1] and H7923 [2], as well as his earlier written testimony submitted on April 10, 2025 regarding H5615 [3]. These statements reflect a consistent pattern across multiple hearings rather than isolated comments.

1. The "5 days to dependence" claim misrepresents the evidence

Mr. Horowitz stated that dependence can begin "in as little as 5 days." [1, 2, 3] This claim is based on a 2017 CDC study that measured continued opioid use, not addiction or dependence [4].

The study did not assess pain severity, diagnosis, or clinical need, and cannot distinguish between appropriate ongoing treatment and misuse. It therefore does not support the claim that dependence begins within five days.

2. Claims that non-opioids are "all that is needed" are overstated and based on limited evidence

Mr. Horowitz asserted that there is "mounting evidence" that ibuprofen and acetaminophen are often "all that is needed," citing a dental study [1, 2, 3].

That study involved a single procedure, third-molar extraction, and cannot be generalized to broader acute or chronic pain conditions [5]. It does not establish that non-opioid therapy is

sufficient in "most cases" and omits a key clinical point: when non-opioid treatments fail, opioids may still be necessary for adequate pain control.

3. The claim that acute prescribing commonly leads to addiction or heroin use is not supported

The testimony suggests that prescribing opioids for acute pain frequently leads to addiction, heroin use, and long-term payer costs [1].

A large BMJ study found opioid misuse in 0.6% of opioid-naïve surgical patients [6]. A 2021 study likewise found that opioid use disorder following an initial prescription was relatively uncommon. [7].

Large-scale studies of opioid-naïve patients show that the absolute risk of long-term misuse or overdose following initial prescriptions remains low [6–7]. These findings do not support the claim that routine acute prescribing commonly leads to addiction or transition to heroin.

4. The testimony relies on outdated narratives and ignores current prescribing trends

Mr. Horowitz cited a 2017 federal commission report to argue that the crisis currently begins in medical settings [1].

Prescribing has already declined substantially over the past decade. In Rhode Island, opioid prescriptions have fallen 61.8% and total MME 71.6% since 2012 [8]. The American Medical Association states:

"Policies designed to restrict access to opioid analgesics may have reached their maximum effect." [8]

Despite this decline, overdose deaths have continued to rise, driven primarily by illicit fentanyl rather than prescription opioids [8].

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Framing the current crisis as originating primarily from medical prescribing is inconsistent with current data.

5. The claim that chronic pain patients can access opioids when needed is not supported

Mr. Horowitz previously stated that there are no meaningful restrictions on prescribing and that chronic pain patients can still access opioids when appropriate [3].

This is not consistent with current practice. Patients face multiple barriers, including:

- physician reluctance to prescribe
- pharmacy refusals or supply shortages
- insurance denials and prior authorization requirements
- regulatory pressure and stigma

In Rhode Island, opioid prescribing has decreased by 61.8% since 2012, while total opioid dosage, measured in morphine milligram equivalents (MME), has declined by 71.6% over the same period. Despite these substantial and sustained reductions, overdose deaths have continued to rise, demonstrating that further restrictions on prescribing are not addressing the primary drivers of the crisis [8].

The 2025 AMA reports that national opioid prescribing has decreased by 52% since 2012, yet policy proposals continue to emphasize further reductions "even when they harm patients with cancer, sickle cell disease or who are receiving hospice or palliative care." [9]

We are not presenting statistics to quantify the full extent of patient harm, as it has not been systematically measured. However, the absence of measurement does not indicate the absence of harm, and available evidence confirms that barriers to appropriate pain care are affecting patients.

6. The presentation of non-opioid alternatives as a complete solution is incomplete

Mr. Horowitz's testimony presents non-opioid alternatives as broadly safe and effective solutions and references medications "coming on the market" [1].

Medications described as "coming on the market" do not address current patient needs. The limited available evidence on newer agents, such as Journavx, is not sufficient to support broad claims of effectiveness or safety.

This framing is incomplete. These medications carry known risks and limitations, and the testimony does not address what occurs when they fail to provide adequate pain control.

Policies based on the assumption that non-opioids are sufficient in most cases do not reflect the variability and complexity of real-world pain management.

7. The same pattern of claims appeared in 2025 testimony

In 2025 testimony, Mr. Horowitz opposed removing thresholds and claimed that there are no restrictions on prescribing and that patients can still access opioids when needed [3].

Patients continue to face well-documented barriers across the healthcare system. Assertions that access remains intact are not supported by current data or patient experience.

Conclusion

The testimony presented relies on the following:

- misinterpretation of studies
- overgeneralization from limited evidence
- outdated data
- omission of current prescribing trends and patient impact

We supported efforts to remove arbitrary thresholds. However, policy decisions should not be based on inaccurate or incomplete representations of the evidence.

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We respectfully request that this rebuttal be entered into the record for H7628 and H7923.

Sincerely,
Claudia A. Merandi
The Doctor Patient Forum (DPF)

Footnotes

[1] Horowitz, Rob. Written and oral testimony to the Rhode Island House Health and Human Services Committee regarding H7628 and H7923 (Mar. 3, 2026).

[2] Horowitz, Rob. Oral testimony to the Rhode Island House Health and Human Services Committee regarding H7923 (Mar. 3, 2026).

[3] Horowitz, Rob. Written testimony submitted to the Rhode Island House Health and Human Services Committee regarding H5615 (Apr. 10, 2025).

[4] Shah, A., Hayes, C.J., & Martin, B.C. "Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use." *MMWR Morbidity and Mortality Weekly Report* 66, no. 10 (2017): 265–269.

[5] Feldman, C.A., Fredericks-Younger, J., Desjardins, P.J., et al. "Nonopioid vs Opioid Analgesics After Impacted Third-Molar Extractions: The Opioid Analgesic Reduction Study Randomized Clinical Trial." *Journal of the American Dental Association* 156, no. 2 (2025): 110–123.e9. https://www.sciencedirect.com/science/article/pii/S0002817724006391

[6] Brat, G.A., Agniel, D., Beam, A., et al. "Postsurgical Prescriptions for Opioid Naive Patients and Association With Overdose and Misuse." *BMJ* 360 (2018): j5790. https://www.bmj.com/content/360/bmj.j5790

[7] Hadland, S.E., Bagley, S.M., Rodean, J., et al. "Opioid Use Disorder and Overdose Among Youth Following an Initial Opioid Prescription." *JAMA Network Open* 4, no. 4 (2021): e215872. https://pubmed.ncbi.nlm.nih.gov/33739476/

[8] American Medical Association. "Opioid Prescriptions Have Declined in Rhode Island Since 2012 (IQVIA data)." 2025.

[9] American Medical Association. *2025 AMA Report on Substance Use and Treatment: Progress, Policy and Future Directions.* 2026.

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Horowitz, Rob. Written and oral testimony to the Rhode Island House Health and Human Services Committee regarding H5615 (Apr. 10, 2025), H7628 (Mar. 3, 2026), and H7923 (Mar. 3, 2026).

Shah, A., Hayes, C.J., & Martin, B.C. "Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use." *MMWR Morbidity and Mortality Weekly Report* 66, no. 10 (2017): 265–269.