Evaluation of SF XXXX – Coverage for Opioid Alternatives for Pain Treatment and Management

Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J. 26

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Executive Summary

If enacted, this bill would require health issuers to provide coverage for alternatives to prescription opioids to treat and manage pain, such as nonopioid drugs and nonpharmacologic, nonoperative modalities. This coverage would include at least two alternative prescription drugs as approved by the United States Food and Drug Administration (FDA) to treat and manage pain that are not Schedule I, II, or III controlled substances and at least three alternative nonpharmacologic, nonoperative modalities to treat and manage pain.

This proposed mandate would prohibit plans from providing preferential coverage for opioids and would also prohibit utilization controls (e.g., prior authorization or step therapy) for alternative modalities. The proposed mandate would also require health plans to provide annual education material to in-network providers and enrollees on these requirements.

Pain can come on suddenly and last a short time, often resulting from an injury or medical treatment, such as surgery. However, if not effectively treated, this type of short-term pain, known as acute pain, can become chronic, defined as lasting longer than three months, and can be linked to an underlying disease, medical treatment, or injury. Chronic pain significantly impacts daily functioning and work activities, affecting an estimated 51.6 million adults in the United States, and its widespread impact contributes to significant healthcare costs and lost productivity.

Opioid medications are commonly prescribed to treat acute pain, and for certain cases of chronic pain when other options are not effective. However, they come with significant risks of dependence, addiction, and overdose. Nonopioid medications and nonpharmacologic interventions have been proven to be effective in treating acute and chronic pain conditions while minimizing the risks associated with opioids. Clinical guidelines recommend prioritizing the use of nonopioid and nonpharmacologic interventions and only consider opioids for pain management after carefully evaluating the benefits and risks to the patient. Consistent with clinical guidelines, the proposed mandate encourages plans to provide coverage for nonopioid and nonpharmacologic treatments for pain treatment and management and prohibits them from giving preferential access to opioids.

There are several federal programs and laws related to cost-sharing for both nonopioid and nonpharmacologic alternatives, such as Medicare Part B and the Non-Opioids Prevent Addiction in the Nation Act for Medicare enrollees. Minnesota has several currently proposed laws focused on opioid alternatives for pain treatment and management. In 2019, Minnesota allocated funding to map locations of non-narcotic pain management services and launch pilot demonstration projects evaluating availability and effectiveness of nonopioid treatments. Several other states have passed or proposed laws to ensure access to opioid alternatives for pain treatment and management.

Public comments for this proposed mandate noted the bill language could be revised to clarify what services or medications are covered under the bill. There were differing opinions on the potential impact of limitations for utilization management and several respondents noted a recent FDA approval of the first nonopioid treatment for acute pain.

The potential state fiscal impact of this mandate is as follows:

- There is no estimated cost for the State Employee Group Insurance Program because the required services associated with the bill are covered in the program's medical benefit package.
- It is unclear if the proposed mandate would be subject to partial defrayal.
- While the proposed mandate, as written, does not explicitly apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare), licensed health maintenance organizations that participate in the programs as managed care organizations are required to meet the requirements of coverage in chapter 62Q.

Introduction

In accordance with Minn. Stat. § 62J.26, the Minnesota Department of Commerce (Commerce), in consultation with the Minnesota Department of Health (MDH) and Minnesota Management and Budget (MMB), performs a detailed evaluation of all relevant benefit mandate proposals. For evaluation criteria and required evaluation components, please review the Evaluation Report Methodology, available at https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

Bill Requirements

This Senate bill is sponsored by Sen. Kupec and was introduced in the 94th Legislature (2025-26) on February 27, 2025.

If enacted, this bill would require health issuers to provide coverage for alternatives to prescription opioids to treat and manage pain, such as nonopioid drugs and nonpharmacologic, nonoperative modalities. This coverage would include at least two alternative prescription drugs as approved by the United States Food and Drug Administration (FDA) to treat and manage pain that are not Schedule I, II, or III controlled substances and at least three alternative nonpharmacologic, nonoperative modalities to treat and manage pain.

This proposed mandate would prohibit plans from providing preferential coverage for, and access to, opioids and would also prohibit utilization controls (e.g., prior authorization or step therapy) for alternative modalities. The proposal would also require health plans to provide annual education material to in-network providers and enrollees on these requirements.

This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, and the State Employee Group Insurance Program (SEGIP). This would not apply to Medicare supplemental policies, Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare), self-insured employer plans, or grandfathered plans.

This bill would create Minn. Stat. § 62Q.474.

Related Health Conditions and Associated Services

Opioid alternatives can be used to treat and manage acute and chronic pain, such as low back pain and headaches, as well as conditions such as fibromyalgia.[1] Opioid alternative prescription drugs that are not Schedule I, II, or III controlled substances include, but are not limited to:[2]

- Acetaminophen;
- Nonsteroidal anti-inflammatory drugs (NSAIDs);
- Neuropathic pain medications (e.g., gabapentin); and
- Muscle relaxants.

Alternative nonpharmacologic, nonoperative modalities for pain management include, but are not limited to:[1]

- Rehabilitative therapies (e.g., physical therapy, occupational therapy, and chiropractic care);
- Therapeutic massage;
- Psychotherapy;
- Acupuncture; and
- Transcutaneous electrical nerve stimulation.

Related State and Federal Laws

This section provides an overview of state and federal laws related to the proposed mandate and any external factors that provide context on current policy trends related to this topic.

Relevant Federal Laws

There are several federal laws and program requirements that address nonopioid treatments for pain, including nonopioid pharmacologic and nonpharmacologic options. Medicare Part B reimburses for various nonpharmacologic services for chronic and acute pain, such as acupuncture, chiropractic services, physical therapy, and occupational therapy, in addition to Medicare Part D prescription pain medication coverage. Enrollees in Medicare Part B pay 20% coinsurance for their doctor visits after the Part B deductible has been met.[3] Additionally, the SUPPORT Act of 2018 directed the Centers for Medicare and Medicaid Services (CMS) to issue guidance to states on covering nonopioid pharmacologic and nonpharmacologic pain treatments under Medicaid and the Children's Health Insurance Program (CHIP) to encourage state adoption of multimodal pain management strategies to reduce opioid reliance.[4] In 2019, CMS released an informational bulletin that outlines guidance for state Medicaid programs on coverage for pain relief alternatives to opioids. The bulletin mandates state Medicaid plans to include benefits such as inpatient and outpatient hospital services, Federally Qualified Health Center services, and Rural Health Clinic services, as well as optional benefits like rehabilitative services, physical therapy, and occupational therapy.[5]

In 2022, Congress passed the Non-Opioids Prevent Addiction in the Nation Act (NOPAIN Act) that increased patient access to nonopioid pharmacologic pain treatments and FDA-approved medical devices for Medicare

enrollees by requiring opioid and nonopioid treatments to be reimbursed separately. This change eliminates the earlier bundled payment structure under which low-cost opioids were financially favored over higher-cost nonopioids, often shifting added nonopioid costs to patients. The Act also established separate reimbursements for nonopioid pain medication used in surgical procedures covered by Medicare Part B.[6]

Relevant Minnesota Laws

Minnesota has introduced legislation related to opioid alternative pain management options and developed programs addressing utilization and access to nonopioid treatments. Minnesota introduced two pieces of legislation relating to opioid alternatives for pain treatment and management in 2025: 1) SF 1947/HF 1807 would assert that health issuers must not disadvantage or discourage a nonopioid drug with respect to coverage of an opioid drug for Medicaid in establishing and maintaining Minnesota's preferred drug list[7] and 2) SF 1966/HF 1806 would require health issuers to cover nonopioid treatments and distribute nonopioid educational materials to in-network providers and enrollees.[8,9]

Minnesota spent $1.25 million appropriated from the Minnesota laws, Chapter 63 to map non-narcotic pain management services across the state and launched five pilot demonstration projects evaluating availability and effectiveness of nonopioid treatments.[10] MDH developed, piloted, and evaluated programs that aimed to improve patient access to chronic pain management between June 2020 and June 2022. During this time, they observed noticeable positive outcomes, including a reduction in pain symptoms, an increase in connection to others experiencing pain, and feelings of hope for continued maintenance of pain.[11]

State Comparison

Seven different states introduced policies regarding nonpharmacological pain treatment coverage and access for either all health plan enrollees or Medicaid enrollees between January 2019 and August 2023 (California[12], Colorado[13], Kentucky[14], Massachusetts[15], New Hampshire[16], Ohio[17], and Pennsylvania[18]). Five of these states proposed mandating coverage for nonpharmacological pain treatments (Colorado, Kentucky, New Hampshire, Ohio, and Pennsylvania). California enacted legislation recognizing the effectiveness and promoting the use of nonpharmacological treatment options for pain management through work done by the United States Department of Health and Human Services Pain Management Best Practices Inter-Agency Task Force in an effort to encourage the health care system to provide alternatives to patients. Among these states, the most common mandated modalities were acupuncture and chiropractic care.[19] These states did not specify a number of nonpharmacological treatment options that needed to be covered, though some states referred to specific modalities or other means to limit costs for coverage. For example, Colorado passed HB 1276 in 2021 which requires the cost-sharing amount to not exceed the amount for non-preventative services administered, including at least six physical therapy, six occupational therapy, six chiropractic, and six acupuncture visits per year.[13]

Nevada mandates coverage for nonopioid pharmacologic treatments, but does not specify which types should be covered.[20] Virginia prohibits health issuers from imposing stricter requirements (e.g., cost-sharing, prior authorization, step therapy, etc.) to FDA-approved nonopioid pain treatments compared to FDA-approved

opioid pain treatments.[21] Illinois similarly prohibits issuers from denying coverage of a nonopioid prescription drug in favor of an opioid prescription drug.[22]

Across the country, 12 states have passed legislation, and an additional 23 states have introduced legislation, to ensure that nonopioid and opioid pain treatments are covered equally across issuers. This legislation varies by state but can include prohibiting utilization barriers (e.g., prior authorization and step therapy) and/or aligning cost-sharing requirements. These policies help to prevent patients and providers from being disincentivized from choosing nonopioid treatments due to higher costs compared to opioid treatments.[8] Several states (e.g., Oklahoma,[23] Louisiana,[24] Arkansas,[25] Oregon,[26] and Tennessee[27]) require or propose for their state Medicaid to establish parity for opioid and nonopioid treatment options and prevents Medicaid from denying coverage for a nonopioid in favor of an opioid. Some states (e.g., Massachusetts,[28] Maine,[29] Illinois,[22] Louisiana,[24] and North Dakota[30]) also require either the health department or health issuers to develop educational materials regarding nonopioid treatments for patients or providers.

Public Comments Summary

Commerce solicited public input on the potential health benefit mandate through a request for information (RFI) posted to Commerce's website and the Minnesota State Register. The summary below represents only the opinions and input of the individuals and/or organizations who responded to the RFI.

Key Stakeholder Comment Themes

For this proposed mandate, Commerce received RFI responses from three commercial health issuers, two pharmaceutical organizations, and one advocacy organization.

Clarity of Bill Language. Multiple respondents stated that the bill's language is vague and insufficient to capture the current treatment or relative alternatives. Several respondents also raised concerns about limitations on utilization management and suggest clarifying the language to preserve utilization management for safety and cost-effectiveness. Respondents indicated that several health plans in Minnesota already provide some coverage for opioid alternatives for pain, but noted it is difficult to discern exactly what services and medications would be covered based on the bill's current language.

Removing Barriers to Nonopioid Alternatives. One respondent noted that expanding insurance coverage for nonpharmacologic modalities, together with increased provider education, enhances patient self-management and reduces overall health care spending. The respondent noted that removing administrative and financial barriers to alternatives will help reduce preventable opioid exposure and the risk of long-term addiction. Multiple respondents indicated that insurance designs currently incentivize patients and health care providers to treat pain with prescription opioids and disincentivize the use of nonopioid options for pain management. Commercial health issuer respondents indicated they currently cover prescription opioid alternatives.

Existing Regulatory Framework. Multiple respondents noted that Minnesota already has a robust regulatory environment to address opioid addiction, including, but not limited to, mental health parity requirements, and that additional mandates would be unnecessary and administratively burdensome.

Emerging Treatments. Multiple respondents referenced the FDA's approval of the first nonopioid treatment for acute pain. One respondent indicated that enactment of this bill is needed to ensure patients have access to newly approved nonopioid pharmaceuticals and other nonopioid pharmaceuticals that may receive FDA approval in the future. Another respondent noted similar legislation was introduced in other states in 2025 and expressed concern that this proposed mandate is being supported by a manufacturer of a nonopioid pharmaceutical. The respondent stated concerns regarding the limited data to support critical elements of this proposed legislation, such as prohibition on utilization management, for newly approved opioid alternatives. Multiple respondents indicated potential concerns about the cost of new nonopioid pharmaceuticals, in light of a potential coverage mandate for the drug through the bill's requirements.

Cost Estimates Provided in Stakeholder Comments

Stakeholders and MMB provided the following cost estimates related to the proposed benefit mandate:

- MMB does not estimate any state fiscal impact to the state plan, as SEGIP currently provides coverage for at least two alternative prescription drugs that are not Schedule I, II, or III controlled substances as well as at least three alternative nonpharmacologic, nonoperative modalities to treat and manage pain.
- Multiple respondents noted that if this mandate were enacted, it would likely result in increased costs for commercial health plan coverage. Two commercial health plan issuers provided cost estimates. The estimates varied widely, ranging from an estimated cost increase of $0.40 PMPM up to $5.05 PMPM.

Stakeholders' results may or may not reflect generalizable estimates for this mandate, depending on the methodology, data sources, and assumptions used for analysis.

Evaluation of Proposed Health Benefit Mandate

Methodology

The following section includes an overview of the literature review performed to examine the potential public health and economic impact of the mandate. The literature review includes moderate- to high-quality relevant peer-reviewed literature and/or independently conducted domestic research that was published within the last 10 years and is related to the public health, economic, or legal impact of the proposed health benefit mandate. For further information on the literature review methodology, please reference https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

Public Health Impact

Chronic Pain Prevalence and Opioid Utilization. There are various kinds of pain, largely defined by how long they last. Acute pain starts suddenly and is typically resolved within a few weeks, subacute pain lasts one to three months, and chronic pain lasts longer than three months.[31] Acute pain is often caused by injury, trauma, or surgery.[31] Acute or subacute pain that is left untreated can evolve into chronic pain, which can result from a medical condition, treatment, injury, inflammation, or an unknown cause.[31] Examples include chronic low back pain, fibromyalgia, diabetic neuropathy, and radicular pain.[32] Patients with chronic pain often experience

ongoing symptoms that are difficult to manage, resulting in significant physical, psychological, and social implications that reduce quality of life.[33]

Recent national data highlights the increasing burden of chronic pain among adults in the United States. In 2023, 24.3% of adults had chronic pain, compared to 20.4% in 2019.[34] Of these adults, 8.5% reported having high-impact chronic pain in 2023, defined as pain that limits life and work activities within the past three months, compared with 7.4% in 2019.[34] Women were more likely than men to have chronic pain (25.4% and 23.2%, respectively) and high-impact chronic pain (9.6% and 7.3%, respectively), and the rates of chronic pain increased with age (36.0% in adults aged 65 and older and 12.3% in adults aged 18-29). American Indian and Alaska Native non-Hispanic adults were more likely to have chronic pain in the past 3 months (30.7%) compared with Asian (11.8%) and Hispanic (17.1%) adults. Additionally, chronic pain was more common in less urban areas, affecting 11.5% adults in nonmetropolitan areas compared with 7.3% in metropolitan areas.[34]

Opioid medications are used to treat acute, subacute, and chronic pain conditions and clinicians are advised to prescribe only the amount needed for the period of severe pain.[31,35] While effective, they come with significant risks of misuse, dependence, and overdose and have many adverse side effects (e.g., drowsiness, constipation, slurred speech, and sedation).[31,35] The United States continues to face an ongoing opioid epidemic.[33] In Minnesota, 676 deaths (68.2% of total overdose deaths) involved opioids in 2024.[36] Moreover, Native American Minnesotans had overdose deaths more than nine times the rate of their white counterparts, while Black Minnesotans had rates three times higher.[37]

Clinical Considerations and Guidelines. Some research has found that nonopioid medications are at least as effective as opioids for managing common types of pain.[38] Pain-related functioning over a 12 month period has been shown to be statistically similar when comparing nonopioid and opioid treatment approaches.[39] Use of a nonopioid pain management approach in a hospital emergency department has also been shown to maintain patient satisfaction scores while decreasing the use of IV opioids.[40] Consistent with clinical evidence, the 2022 Centers for Disease Control and Prevention (CDC)'s Clinical Practice Guideline for Prescribing Opioids for Pain recommends clinicians prioritize nonpharmacologic and nonopioid pharmacologic therapies whenever appropriate and consider opioids for acute pain only when the benefits outweigh the risks.[31]

Nonopioid therapies are recommended as the preferred first-line treatment for managing chronic pain. The Department of Veterans Affairs (VA) and Department of Defense (DoD)'s Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain recommends against initiating opioid therapy for chronic non-cancer pain, as well as long-term use for younger patients and those with a substance use disorder. Consistent with the CDC guidelines, the VA also recommends prescribing the lowest effective opioid dose, based on patient-specific risks and benefits. [41]

Similarly, the Comprehensive, Evidence-Based, Consensus Guidelines for Prescription of Opioids for Chronic Non-Cancer Pain from the American Society of Interventional Pain Physicians (ASIPP) also advises clinicians to discuss risks and benefits of opioid therapy with patients before initiating treatment, and to discontinue treatment if the benefits no longer outweigh the risks. When opioids are prescribed, the ASIPP recommends starting with the lowest effective dose, using short-acting drugs, and ensuring close monitoring during treatment.[42]

Opioid vs. Nonopioid Prescription Trends. Opioid prescription rates decreased from 2014 to 2016, and remained stable from 2016 to 2018, yet opioids remain the most commonly prescribed pain medication in the United States.[43] Moreover, in Minnesota, 26.5 opioid prescriptions were written for every 100 people in 2023.[36] In this same timeline there was also an increased prevalence of nonopioid pain medication prescriptions, including acetaminophen, gabapentin, and antidepressants, suggesting shifts in opioid prescribing patterns that align with current clinical practice guidelines.[43]

Pharmacologic Interventions

Alternative Nonopioid Medications. Understanding how opioid medications are regulated provides important context for considering nonopioid medications for pain management. The United States Drug Enforcement Agency (DEA) classifies controlled substances into five categories, or schedules, based on their accepted medical use and potential for abuse or dependence. Schedule I substances have the highest risk, and the potential for dependence and abuse decreases from Schedule II through IV. Many opioid medications, such as oxycodone and hydromorphone, are classified under Schedule II, meaning they have accepted medical use but carry high risk for abuse and can lead to physical and psychological dependence.[44]

In contrast, there are several FDA-approved nonopioid medications, not classified as Schedule I, II, or III, that are commonly used to treat acute and chronic pain. For acute pain, recommended options include topical or oral NSAIDs, acetaminophen, triptans, antiemetics, and dihydroergotamine (for migraine).[38] Acetaminophen is recommended first for mild to moderate pain and often used to treat headaches, skin injuries, and muscle or bone pain.[35] NSAIDs are effective for mild to moderate pain with inflammation, including arthritis and injuries like sprains, strains, and back or neck pain.[35] Nonopioid therapies are recommended to treat subacute and chronic pain, with options such as NSAIDs and acetaminophen, as well as tricyclic and tetracyclic antidepressants, serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressants, anticonvulsants (e.g., pregabalin/gabapentin), capsaicin and lidocaine patches.[31,38] Anticonvulsants and antidepressants are used for chronic nerve pain relief, for conditions such as fibromyalgia, back pain, and diabetic neuropathy.[35]

In January 2025, the FDA approved Journavx (suzetrigine), a medication in a new class of nonopioid analgesics, to treat moderate to severe acute pain in adults.[45] This approval creates an opportunity to reduce opioid-related risks while expanding nonopioid pain management options for patients. Based on two clinical trials, Journavx showed a significantly greater reduction in pain compared with the placebo.[45] This approval also reflects the growing interest in novel, emerging nonopioid analgesics, including nerve growth factor (NGF) monoclonal antibodies, transient receptor potential vanilloid 1 (TRPV1) antagonists, and selective sodium channel blockers.[46]

Side Effects of Nonopioid Medications. Nonopioid medications come with risks of side effects, although the symptoms and likelihood vary depending on the specific drug, dosage, and patient. Common side effects include stomach irritation, drowsiness, and mood changes, while less common and severe effects can include liver damage or increased risk of bleeding.[35] Taking NSAIDs for long periods or in high doses for example, can increase the risk of kidney damage, stomach ulcers and bleeding.[35] NSAIDs can only relieve pain up to a certain point, therefore taking more than the recommended amount will not provide effective pain relief and increases the risk for serious side effects.[35] While acetaminophen does not cause stomach pain or bleeding, taking more than

the recommended amount or in combination with alcohol can increase the risk of kidney and liver damage over time.[35]

Certain populations (e.g., older adults, pregnant women, and individuals with heart, kidney, stomach, and liver conditions) may require additional clinical consideration when using these medications.[38] The risks of nonopioid medications differ from those associated with opioids. Therefore when considering nonopioid medications for pain management, relevant factors include the patient's understanding of benefits and risks of opioid use, including the potential for dependence, addiction, and overdose, as well as awareness of available nonopioid alternatives and the benefits and risks associated with those options.[33]

Nonpharmacologic Interventions

There are various nonpharmacologic, nonoperative interventions that can be used to manage pain. These include exercise therapy, mind-body practices (e.g., yoga, tai-chi), psychological therapies (e.g., cognitive behavioral therapy), low-level laser therapies, acupuncture, massage, and spinal manipulation.[38] However, there is limited evidence on how these modalities as a whole compare with opioids or nonopioid medications. Most available research evaluates the effectiveness of individual interventions rather than examining these nonpharmacologic, nonoperative interventions as a broad category of treatments.

Furthermore, studies have shown the effectiveness of various individual therapies on alleviating pain. Mind-body practices, such as cognitive behavioral therapy, are associated with moderate improvements in pain.[47] There has also been sufficient clinical evidence supporting the use of psychological and behavioral therapies, exercise, and manual therapies as nonpharmacological approaches to pain management.[48] However, there continues to be a lack of clarity on which therapies are appropriate for various pain types.[49]

Barriers to Accessing Opioid Alternatives. There is evidence that suggests access to opioid alternatives can be limited by financial costs, insurance coverage, transportation, and geographic location.[38] Many nonpharmacologic interventions are often not covered by insurance.[50] Insurance barriers can affect access to nonopioid medications and nonpharmacologic interventions as well, as issuers are more focused on restricting opioid use, rather than expanding access to nonopioid medications and nonpharmacologic options for chronic pain.[51] As a result, some nonopioid medications and many nonpharmacologic interventions may be unaffordable for individuals with insurance coverage.[33]

Patients living in rural and remote areas may have limited access to certain services, such as therapy or rehabilitation programs.[38] Lack of reliable transportation for longer travel distances, limited local providers, and fewer available resources can make it difficult for individuals in these areas to receive timely or consistent care.

Economic Impact

Cost Data for Chronic Pain. Chronic pain affects over 100 million Americans daily and costs the United States over $600 billion each year in lost productivity and health care expenses.[32] These costs highlight the broad economic burden of chronic pain across the nation.

Additionally, opioid use disorder has significant downstream economic costs. In Minnesota, the healthcare costs associated with opioid use disorder in 2017 included $235.3 million, with $26.6 million associated with substance use treatment, and $2.93 billion in reduced quality of life.[52] Given the economic burden of chronic pain and the costs related to opioid use disorder, expanding access to nonopioid alternatives has the potential to reduce reliance on opioids by offering more nonopioid treatment options and, in turn, lessen opioid-related impacts on individuals and the healthcare system.

Current Coverage. Coverage for nonopioid prescription medications varies across insurance types, and coverage for nonpharmacologic pain interventions is often inconsistent or absent. Commercial plans often cover a greater proportion of nonopioid and opioid medications compared to Medicaid or Medicare Advantage plans.[51] All plans tend to cover a larger proportion of NSAIDs and antidepressants compared to anticonvulsants or muscle relaxants, meaning patients may have better access to certain nonopioid medications over others.[51]

Across insurance plans, one in four nonopioids have prescribing limits, with slightly lower rates in Medicaid (24%) compared to commercial plans (28%) or Medicare Advantage (32%).[51] On average, commercial insurance restricts about seven medications per plan, compared with seven in Medicare Advantage plans and five in Medicaid.[51] Furthermore, prior authorization limits access to nonopioid medications, and is most common in Medicaid plans.[53] Additionally, prior authorization requirements vary by drug class, with muscle relaxants having the most restrictions (25% of covered products), followed by antidepressants (17.4%) and NSAIDs (6.7%). In 2019, the American Medical Association (AMA) reported that 92% of pain specialists said they needed to submit prior authorizations for nonopioid pain treatment, leading to delays in care, and 66% had to hire additional staff to manage the added workload.[54]

In terms of coverage for nonpharmacologic interventions, there is widespread coverage of physical and occupational therapy across issuers but less consistent coverage of other treatments (e.g., acupuncture, psychological interventions, and therapeutic massage).[51] However, even for covered services, such as physical therapy, access can be limited by requirements, such as limits to direct access and quantity of annual visits.[55]

Cost of Pharmacologic Interventions. There are variations in cost among nonopioid medications depending on several factors. Prices for common medications such as acetaminophen (500 mg, 6 tablets) start at $4.42, gabapentin (300 mg, 90 units) at $8.68, and diclofenac (50 mg, 30 units) at $19.53.[56–58] Newer, brand name-only nonopioid prescription medications, such as Journavx, can be more expensive than their nonopioid counterparts and generic opioid medications. A 30-tablet supply of Journavx costs $15.40 per unit, compared to opioid medications such as hydrocodone, which costs $8.67 per unit for a 60-capsule supply, or oxycodone, which starts at $4.97 per unit.[59–61] Comparing an opioid/acetaminophen post-operative therapy regimen with an opioid-free regimen results in an average cost difference of $16.68, with the opioid group costing $8.92 and the opioid-free group costing $25.60.[62]

Cost of Nonpharmacologic Interventions. Pharmacologic interventions, including both opioid and nonopioid prescription medications, may have lower upfront costs than nonpharmacologic treatment options. Median in-network co-payments for nonpharmacologic treatments, such as physical therapy, occupational therapy, and chiropractic care, ranged from $40 to $60 per visit and typically required multiple visits.[50] In contrast, prescription medications generally require one co-payment per prescription, with the median cost of a 30-day

supply of preferred generic opioids by commercial plans being $10.[50,51] However, these comparisons reflect short-term costs at the time care is received and do not account for longer-term outcomes or potential downstream costs, such as treatment for opioid use disorder. As a result, while nonpharmacologic interventions may have higher upfront costs, there is potential for these modalities to be more cost-effective over time.

Utilization. Cost-sharing and utilization of nonopioid therapies vary widely. In 2019, United Healthcare started a pilot program for enrollees in five states to promote physical therapy for patients with low back pain, by waiving the costs of co-pays and deductibles for three visits.[55] This program found that higher co-payments and deductibles were associated with a lower likelihood of patients seeing a physical therapist or chiropractor.[55] By having fewer provider restrictions, patients were more likely to choose a physical therapist or chiropractor over a primary care provider.[55] This is a key finding as treatment for low back pain as prescribed from a primary care provider may involve medications, including the potential use of opioids, whereas physical therapists or chiropractors typically provide guideline-recommended nonpharmacologic pain treatment.

When looking at cost-sharing, plans that have less out-of-pocket spending have more members that use an in-network acupuncture service.[63] Additionally, having insurance coverage for acupuncture has a higher impact on increased in-network utilization than changing cost-sharing percents.[63]

Cost Savings. Evidence discussed earlier in this review shows that several alternative nonopioid therapies are effective in alleviating pain and may reduce downstream costs by preventing complications, such as opioid use disorder, associated with long-term opioid use. One study indicates Minnesota patients receiving nonopioid therapies reported an average reduction in self-reported pain and these treatments were associated with an estimated $898 in cost savings per admission, when compared to those receiving opioid treatment.[64] This finding suggests that the wider use of nonopioid therapies could provide pain relief comparable to opioids while offering potential savings in health care costs in Minnesota.

This aligns with recommendations from MDH's Non-Narcotic Pain Management Demonstration and Mapping Project, which piloted programs to improve patient access to chronic pain management from June 2020 to June 2022. Key findings informed recommendations to standardize and promote a non-narcotic pain management standard of care and to expand insurance coverage and reimbursement for nonpharmacologic therapies, in efforts to reduce opioid prescription and misuse. [65]

Limitations

While there is some literature addressing opioid alternatives and related cost-sharing, particularly nonpharmacological, nonoperative modalities for pain management and treatment (e.g., cognitive behavioral therapy, psychotherapy, massage, physical therapy, etc.), there is more limited literature focused on nonopioid medications (e.g., NSAIDs, acetaminophen, anticonvulsants, etc.). Additionally, it is beyond the scope of this evaluation to assess the effectiveness and potential impact of each available opioid alternative due to the variation in outcomes associated with the potentially covered range of medications and services. Furthermore, there is limited literature on current utilization of opioid alternatives and on how this might change if insurance coverage were expanded.

State Fiscal Impact

The potential state fiscal impact of this legislation includes the estimated cost to SEGIP as assessed by MMB in consultation with health plan administrators, the cost of defrayal of benefit mandates as understood under the Patient Protection and Affordable Care Act (ACA), and the estimated cost to Minnesota Health Care Programs.

- There is no estimated cost for the SEGIP because the required services associated with the bill are covered in the program's medical benefit package.
- It is unclear if the proposed mandate would be subject to partial defrayal.
- While the proposed mandate, as written, does not explicitly apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare), licensed health maintenance organizations (HMOs) that participate in the programs as managed care organizations (MCOs) are required to meet the requirements of coverage in chapter 62Q.

Fiscal Impact Estimate for SEGIP

MMB does not estimate any fiscal impact to the state plan from this legislation. SEGIP currently provides coverage in its medical benefit package for the relevant services listed in the bill, including nonpharmacologic, nonoperative options for pain treatment and management (e.g., physical therapy, occupational therapy, and chiropractic care). Additionally, there is currently coverage for multiple alternative non-Schedule I, II, or III prescription drugs approved by the FDA to treat and manage pain.

Affordable Care Act Mandate Impact and Analysis

States may require qualified health plan issuers to cover benefits in addition to the 10 essential health benefits (EHBs) defined by the ACA but must defray the costs, either through payments to individual enrollees or directly to issuers, and can partially defray the costs of proposed mandates if some of the care, treatment, or services are already covered in the state's benchmark plan or mandated by federal law, pursuant to section 1311(d)(3)(b) of the ACA. For further defrayal requirements and methodology, please visit https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

If enacted, it is unclear if this proposed mandate would constitute as additional benefit mandate requiring partial defrayal, relating to any new requirements for specific care, treatment, or services that are not already covered by Minnesota's EHB Benchmark Plan. Defrayal costs would be primarily tied to the provision of nonpharmacologic, nonoperative modalities. To provide a defrayal estimate, more specific treatment options would need to be outlined to better estimate the defrayal applicability and cost of the "minimum of three alternative nonpharmacologic, nonoperative modalities to treat and manage pain."

Fiscal Impact of State Public Programs

While this proposed mandate, as written, doesn't apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare), licensed HMOs are required to meet 62Q requirements of coverage if the service is not already covered under Medical Assistance. This proposed mandate may have a cost as prescription

drugs, including those for pain management, are managed in Minnesota Health Care Programs using a preferred drug list (PDL). Costs may be incurred from impacts on the management of these treatment options using the PDL. However, a fiscal estimate has not yet been completed on this proposed mandate.

Appendix A. Bill Text

Section 1. **[62Q.474] TREATMENT AND MANAGEMENT OF PAIN.**

Subdivision 1. **Requirement.**

(a) A health plan must provide coverage for alternatives to the prescription of opioids to treat and manage pain, including but not limited to:

(1) prescribing nonopioid drugs; and

(2) providing nonpharmacologic, nonoperative modalities.

(b) A health plan must provide coverage for a minimum of two alternative prescription drugs approved by the federal Food and Drug Administration to treat and manage pain that are not Schedule I, II, or III controlled substances.

(c) A health plan must provide coverage for a minimum of three alternative nonpharmacologic, nonoperative modalities to treat and manage pain.

Subd. 2. **Prohibition.**

(a) A health plan is prohibited from providing preferential coverage for and access to opioids.

(b) A health plan is prohibited from establishing utilization controls, including but not limited to prior authorization or step therapy requirements, for clinically appropriate nonopioid prescription drugs approved by the federal Food and Drug Administration to treat and manage pain that are more restrictive or extensive than the least restrictive or extensive utilization controls applicable to any clinically appropriate opioid drug.

Subd. 3. **Educational materials.** A health plan company must annually distribute educational materials to in-network health care providers and enrollees regarding access to the pain treatment and management options described in subdivision 1 and must make the educational materials and information publicly available on the health plan company's website.

EFFECTIVE DATE. This section is effective January 1, 2026, and applies to health plans offered, issued, or renewed on or after that date.

Appendix B. Key Search Terms for Literature Scan

Alternatives to opioids

Coverage of nonpharmacologic treatments

FDA-approved

Health insurance

Nonoperative modalities Terms listed alphabetically

Nonopioid analgesics

Nonopioid pharmacologic treatments

Nonpharmacological pain management

Opioid alternatives for pain

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