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BILL ANALYSIS

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Senate Bill 47 (Substitute S-5 as passed by the Senate)
Senate Bill 166 (Substitute S-1 as passed by the Senate)
Senate Bill 167 (Substitute S-2 as passed by the Senate)
Senate Bill 270 (Substitute S-3 as passed by the Senate)
Senate Bill 273 (Substitute S-1 as passed by the Senate)
Senate Bill 274 (Substitute S-2 as passed by the Senate)
Senate Bill 360 (Substitute S-1 as passed by the Senate)
Sponsor: Senator Dale W. Zorn (S.B. 47)
Senator Tonya Schuitmaker (S.B. 166 & 167)
Senator Steven Bieda (S.B. 270)
Senator Rick Jones (S.B. 273)
Senator Marty Knollenberg (S.B. 274)
Senator Margaret O'Brien (S.B. 360)
Committee: Health Policy

Date Completed: 7-25-17

RATIONALE

The term "opioid epidemic" is commonly used to refer to the prescription drug and opioid abuse, misuse, and overdose deaths that are occurring at an increasing rate in the United States. According to the Centers for Disease Control and Prevention (CDC), more than six out of 10 drug overdose deaths involve an opioid, and since 1999, the number of drug overdose deaths involving opioids, including prescription pain relievers and heroin, has quadrupled. An October 2015 report from the Michigan Prescription Drug and Opioid Abuse Task Force found that the number of drug overdose deaths in the State had more than tripled since 1999. Evidently, Michigan ranked 15th in the nation for drug overdose deaths between 2014 and 2015.

The Federal government has been taking measures through legislation to address opioid addiction and prevent future abuse, and many Federal agencies, such as the CDC, the Drug Enforcement Agency (DEA), and the Substance Abuse and Mental Health Services Administration, have taken an active role in addressing the problem, as well. This strategy includes creating Federal grants to help states plan, establish, or enhance prescription drug monitoring systems. At the state level, most have passed legislation to prohibit "doctor-shopping" (which occurs when patients seek controlled substances from multiple health care providers without their knowledge of the other providers or prescriptions), some have taken a "tough on crime" approach that focuses on incarcerating drug traffickers, and many have advocated increased Federal funding for medication-assisted treatment.

In its 2015 report, Michigan's Task Force proposed several recommendations to address the issue of opioid abuse and prescription drug addiction. These recommendations included requiring additional training for prescribers, eliminating doctor-shopping, increasing accessibility to Naloxone (a drug used to treat and reduce the effects of an opioid overdose), updating or replacing the Michigan Automated Prescription System (MAPS) (which tracks the prescription of Schedule 2 to 5 controlled substances), and enhancing licensing sanctions for improper prescribing and

dispensing practices.[1] In April 2017, Michigan was awarded a State Targeted Response to the Opioid Crisis Grant to be used to promote prevention and increase treatment by funding State initiates, such as updating MAPS.

In addition to taking this action, many have suggested enacting legislation to implement other recommendations of the Task Force in order to reduce opioid misuse, prevent addiction from occurring, and prevent further drug overdose deaths.

CONTENT

Each of the bills would amend the Public Health Code

Senate Bill 47 (S-5) would revise provisions concerning exemptions from the MAPS reporting requirements for the administration of a controlled substance directly to a patient; and would require reporting when certain opioid treatment medication was dispensed.

Senate Bills 166 (S-1) and 167 (S-2) would do the following:

-- Require licensed prescribers, beginning January 1, 2020, to obtain and review a report concerning a patient from MAPS, before prescribing or dispensing a controlled substance to that patient.
-- Provide that the requirement would not apply if the dispensing occurred in a licensed hospital and the controlled substance were for the patient's inpatient use.
-- Include a violation of the proposed requirement among the grounds for disciplinary action.
-- Prescribe disciplinary sanctions, including license revocation, for a violation.

Senate Bill 270 (S-2) would do the following:

-- Prohibit a licensed prescriber from prescribing a Schedule 2 to 5 controlled substance to a patient unless the prescriber was in a bona fide prescriber-patient relationship with the patient, beginning March 31, 2018.
-- Require a licensed prescriber who prescribed a controlled substance to provide follow-up care to the patient, and if the licensed prescriber were unable to do so, require him or her to refer the patient to the patient's primary care provider or to another licensed prescriber, depending on the circumstances.
-- Allow the Department of Licensing and Regulatory Affairs to promulgate rules describing circumstances in which a bona fide prescriber-patient relationship would not be required for the prescription of a Schedule 2 to 5 controlled substance.
-- Include a violation of the proposed requirements among the grounds for disciplinary action.
-- Prescribe disciplinary sanctions, including license revocation, for a violation.

Senate Bill 273 (S-1) would require a licensee or registrant who treated a patient for an opioid-related overdose to give the patient information on substance use disorder services.

Senate Bill 274 (S-2) would do the following:

-- Allow a pharmacist to partially fill in increments a prescription for a Schedule 2 controlled substance under certain circumstances.

[1] For a more detailed description of the Michigan Prescription Drug and Opioid Abuse Task Force's recommendations, please see the Report of Findings and Recommendations for Action, available at http://www.michigan.gov/documents/snyder/Presciption_Drug_and_Opioid_Task_Force_Report_504140_7.pdf.

-- Limit the amount and supply of opioids a prescriber could prescribe for a patient who was being treated for acute pain, beginning July 1, 2018.

Senate Bill 360 (S-1) would allow a pharmacist to dispense additional quantities of a prescription drug up to the amount authorized on an original prescription.

Each of the bills, except Senate Bills 166 (S-1) and 167 (S-2), would take effect 90 days after its enactment. Senate Bills 166 (S-1) and 167 (S-2) are tie-barred.

Senate Bill 47 (S-5)

The Code requires the Department of Licensing and Regulatory Affairs (LARA) to establish, by rule, an electronic system for monitoring Schedule 2, 3, 4, and 5 controlled substances dispensed in Michigan by veterinarians, and by pharmacists and dispensing prescribers (physicians and dentists who dispense prescription drugs to their own patients); or dispensed to a Michigan address by a pharmacy licensed in the State. (This is known as the Michigan Automated Prescription System.) The rules must provide an electronic format for the reporting of data, including patient identifiers, the name of the controlled substance dispensed, the date of dispensing, the quantity dispensed, the prescriber, and the dispenser.

The rules must exempt the following circumstances from the reporting requirements:

-- The administration of a controlled substance directly to a patient.
-- The dispensing from a health facility or agency licensed under the Public Health Code of a controlled substance by a dispensing prescriber in a quantity adequate to treat a patient for not more than 48 hours.

The bill would delete the exemptions to the reporting requirements. Instead, under the bill, the following would apply for the purposes of reporting to MAPS:

-- The dispensing of a controlled substance in a hospital that administers a controlled substance to an inpatient would be exempt from the reporting requirements, and, as currently required, the dispensing from a health facility or agency of a controlled substance in a quantity adequate to treat a patient for not more than 48 hours would be exempt.
-- A dispensing prescriber would have to report the required data if the prescriber dispensed buprenorphine, or a drug containing buprenorphine or methadone, in a substance use disorder program and the patient consented to have the data reported to MAPS.

A dispensing prescriber who received the patient's consent would have to maintain the patient's consent form and make it available to LARA upon the Department's request.

("Substance use disorder program" would mean a program as that term is defined in Section 260 of the Mental Health Code, an approved services program, a nonregulated substance use disorder services program, a Federal certified substance use disorder program, or a federally regulated substance use disorder program.

Section 260 of the Mental Health Code defines "program" as a hospital, clinic, organization, or health professional licensed under the Public Health Code to provide substance use disorder services.

"Approved services program" would mean that term as defined in Section 100a of the Mental Health Code: a licensed substance use disorder services program licensed to provide substance use disorder treatment and rehabilitation services by the department-designated community mental health entity and approved by the Federal government to deliver a service or combination of services for the treatment of incapacitated individuals.)

The bill also would rescind Rule 338.3162e of the Michigan Administrative Code. (Rule 3162d requires a pharmacist, pharmacy, dispensing prescriber, or veterinarian to report to the Department or its contractor all Schedule 2 to 5 controlled substances dispensed. Rule 3162e provides that a pharmacist, dispensing prescriber, or veterinarian is exempt from the reporting requirements under the following circumstances:

-- When a controlled substance in Schedules 2 to 5 is administered directly to a patient.
-- When a controlled substance in Schedules 2 to 5 is dispensed from a licensed health facility agency by a dispensing prescriber in a quantity adequate to treat a patient for not more than 48 hours.)

Senate Bills 166 (S-1) & 167 (S-2)

Under Senate Bill 166 (S-1), beginning January 1, 2020, before prescribing or dispensing a controlled substance to a patient, a licensed prescriber would be required to obtain and review a report concerning that patient from MAPS. This requirement would not apply if the dispensing occurred in a hospital and the controlled substance was for the patient's inpatient use.

The Public Health Code requires the Department of Licensing and Regulatory Affairs to investigate activities related to the practice of a health profession by a licensee, a registrant, or an applicant for licensure or registration. The Department may hold hearings, administer oaths, and order the taking of relevant testimony. After its investigation, LARA must provide a copy of the administrative complaint to the appropriate disciplinary subcommittee. If one or more grounds for disciplinary subcommittee action exist, the disciplinary subcommittee must impose sanctions.

Under Senate Bill 167 (S-2), a violation of the requirement proposed by Senate Bill 166 (S-1) would be grounds for disciplinary subcommittee action. The sanctions for such a violation would be denial, fine, reprimand, probation, limitation, suspension, revocation, or permanent revocation, subject to the following provision.

For a first violation, the disciplinary subcommittee would have to order the licensee, registrant, or applicant to complete a remedial continuing education program focused on prescription drug and opioid addiction. The program would have to be completed within 180 days after the Department notified the individual of its order. The failure to timely complete a remedial continuing education program would be a separate violation for purposes of sanctions.

For a second or subsequent violation, or a failure to complete the remedial continuing education program, the disciplinary subcommittee would have to impose denial, fine, reprimand, probation, limitation, suspension, revocation, or permanent revocation. However, the disciplinary subcommittee would not be allowed to impose suspension, revocation, or permanent revocation for a violation without a finding that the licensee, registrant, or applicant willfully disregarded his or her duty to obtain and review a report from MAPS, or a finding that the licensee, registrant, or applicant engaged in a pattern of intentional acts of fraud or deceit resulting in personal financial gain to the licensee, registrant, or applicant.

Senate Bill 270 (S-3)

Section 7303a of the Code sets forth requirements for a licensed prescriber who prescribes a controlled substance. Under the bill, beginning March 31, 2018, except as otherwise provided by rules promulgated by the Department of Licensing and Regulatory Affairs, a licensed prescriber would be prohibited from prescribing a Schedule 2 to 5 controlled substance unless the prescriber was in a bona fide prescriber-patient relationship with the patient for whom the controlled substance was being prescribed.

("Bona fide prescriber-patient relationship" would mean a treatment or counseling relationship between a prescriber and a patient in which both of the following are present:

-- The prescriber has reviewed the patient's relevant medical or clinical records and completed a full assessment of the patient's medical history and current medical condition, including a relevant, in-person, medical evaluation of the patient conducted in person or via telehealth.
-- The prescriber has created and maintained records of the patient's condition in accordance with medically accepted standards.

("Telehealth" would mean that term as defined in Section 16283 of the Code: the use of electronic information and telecommunication technologies to support or promote long-distance clinical health care, patient and professional health-related education, public health, or health administration. Telehealth may include, but is not limited to, telemedicine. Telemedicine means the use of an electronic media to link patients with health care professionals in different locations. The health care professional must be able to examine the patient via a real time, interactive audio or video, or both, telecommunications system and the patient must be able to interact with the off-site health care professional at the time the services are provided.)

Except as otherwise provided, if a licensed prescriber prescribed a controlled substance, the prescriber would have to provide follow-up care to the patient to monitor the efficacy of the use of the controlled substance as a treatment of the patient's medical condition. If the prescriber were unable to provide follow-up care, he or she would be required to refer the patient to the patient's primary care provider for follow-up care or, if the patient did not have a primary care provider, the provider would be required to refer the patient to another licensed prescriber who was geographically accessible to the patient for follow-up care.

Within one year after the bill took effect, LARA, in consultation with the Michigan Board of Medicine, the Michigan Board of Osteopathic Medicine and Surgery, the Michigan Board of Dentistry, the Michigan Board of Podiatric Medicine and Surgery, the Michigan Board of Optometry, and the Michigan Task Force on Physician's Assistants, could promulgate rules describing the circumstances under which a bona fide prescriber-patient relationship would not be required for purposes of prescribing a Schedule 2 to 5 controlled substance. The rules could include an alternative requirement for prescribing a Schedule 2 to 5 controlled substance when a bona fide prescriber-patient relationship would not be required.

A violation of the proposed requirements would be grounds for disciplinary subcommittee action. The sanctions for such a violation would be probation, limitation, denial, fine, suspension, revocation, or permanent revocation.

Senate Bill 273 (S-1)

The bill would require a licensee or registrant under the Public Health Code who treated a patient for an opioid-related overdose to give the patient information on substance use disorder services.

"Substance use disorder services" would mean that term as defined in Section 6230 of the Code (i.e., substance use disorder prevention services or substance use disorder treatment and rehabilitation services, or both, as those terms are defined in the Mental Health Code).

(The Mental Health Code defines "substance use disorder prevention services" as services that are intended to reduce the consequences of substance use disorders in communities by preventing or delaying the onset of substance abuse and that are intended to reduce the progression of substance use disorders in individuals.

"Substance use disorder treatment and rehabilitation services" means providing identifiable recovery-oriented services including:

-- Early intervention and crisis intervention counseling services for individuals who are current or former individuals with substance use disorder.
-- Referral services for individuals with substance use disorder, their families, and the general public.

-- Planned treatment services, including chemotherapy, counseling, or rehabilitation for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs.)

Senate Bill 274 (S-2)

Under the Public Health Code, except for a terminally ill patient whose terminal illness the pharmacist documents pursuant to promulgated rules, a prescription for a Schedule 2 controlled substance must not be filled more than 90 days after the date on which it was issued. Under the bill, the 90-day limit would apply except as provided below.

Currently, for a terminally ill patient, a prescription for a Schedule 2 controlled substance may be partially filled in increments for not more than 60 days after the date on which the prescription was issued. The bill instead would allow a pharmacist to partially fill a prescription for a Schedule 2 controlled substance in increments if one of the following applied:

-- The pharmacist was unable to supply the full quantity prescribed or the patient requested a smaller quantity than what was prescribed, in which case the prescription would have to be filled within 30 days after the date it was issued.
-- The prescription was filled upon the oral prescription of a practitioner, in which case it would have to be filled within 72 hours after the first partial filling.
-- The prescription was for a terminally ill patient, in which case the prescription would have to be filled within 60 days after the date on which it was issued.

Beginning July 1, 2018, if a patient were being treated for acute pain, a prescriber would be prohibited from prescribing the patient more than a seven-day supply of an opioid within a seven-day period. "Acute pain" would mean pain that is the normal, predicted physiological response to a noxious chemical or a thermal or mechanical stimulus and is typically associated with invasive procedures, trauma, and disease and usually lasts for a limited amount of time.

Senate Bill 360 (S-1)

Under the bill, if a pharmacist determined in the exercise of his or her professional judgment, after consulting with a patient, that dispensing additional quantities of a prescription drug was appropriate for the patient, the pharmacist could dispense, at one time, additional quantities of the prescription drug up to the total number of dosage units authorized by the prescriber on the original prescription for the patient and any refills for the prescription. Except for a controlled substance included in Schedule 5 that did not contain an opioid, this provision would not apply to a prescription for a controlled substance.

MCL 333.7333a (S.B. 47)
MCL 333.7303a (S.B. 166)
MCL 333.16221 & 333.16226 (S.B. 167)
MCL 333.7303a et al. (S.B. 270)
Proposed MCL 333.16282 (S.B. 273)
MCL 333.7333 et al. (S.B. 274)
MCL 333.17751 (S.B. 360)

BACKGROUND

The Michigan Automated Prescription System, commonly referred to as MAPS, is the State's prescription monitoring program that tracks Schedule 2 to 5 controlled substances. Like other prescription monitoring programs, MAPS is a tool used to assess patient risk, as well as to prevent drug abuse and diversion at the prescriber, pharmacy, and patient levels by collecting prescriptions for Schedule 2 to 5 controlled substances that are dispensed by practitioners and pharmacies.

Under Rule 338.3162b of the Administrative Code, a pharmacist, dispensing prescriber, and veterinarian who dispenses a prescription for a Schedule 2 to 5 controlled substance or a licensed

pharmacy that dispenses a Schedule 2 to 5 controlled substance in the State must report to the Department of Licensing and Regulatory Affairs[2] or its contractor by means of an electronic data transmittal process the following information for each prescription of a Schedule 2 to 5 controlled substance that is dispensed:

-- The patient identifier.
-- The name of the controlled substance dispensed.
-- The metric quantity of the controlled substance dispensed.
-- The national drug code number (NDC) of the controlled substance.
-- The date of issue of the prescription.
-- The date of dispensing.
-- The estimated days of supply of the controlled substance dispensed.
-- The prescription number assigned by the dispenser.
-- The DEA registration number of the prescriber and the dispensing pharmacy.
-- The Michigan license number of the dispensing pharmacy.

The pharmacist, dispensing prescriber, or veterinarian who dispenses a prescription drug that is a Schedule 2 to 5 controlled substance must transmit the data by electronic media or other means as approved by the Department or its contractor (R 338.3162c). The data must be forwarded by the end of the next business day or, if the prescriber does not have the capacity to do so, the data must be mailed or delivered within seven calendar days (R 338.3162d).

In April 2017, Michigan launched a new MAPS platform that uses a system called PMP AWARxE. Part of the larger initiative to combat opioid addiction in the State, the system upgrade is designed to ease integration of electronic health records and pharmacy dispensation systems in one user-friendly platform, decrease the amount of time it takes to run a patient report, allow for interstate data-sharing, and provide financial support for the integration of MAPS into Michigan health systems, physician groups, and pharmacies, according to descriptions of the system.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

Updating MAPS was one of the first steps to addressing the growing problem of prescription painkiller, controlled substance, and opioid abuse in Michigan. Organizations at the local level are developing and implementing collaborative and comprehensive strategies for increasing education and awareness of the issue. This series of bills is the latest step in the long journey to combat the opioid epidemic. While legislation alone will not solve the problem, policy changes, such as those proposed by the bills, would help make communities safer by improving prescribing protocols, promoting the development of better enforcement and prevention strategies, and improving access to treatment and recovery resources. Although opioid abuse is ultimately a local issue, on many levels, the State can provide structure and tools to assist community-based organizations that are working to prevent abuse and save lives.

Supporting Argument

Senate Bill 47 (S-5) would supply a critical piece of a comprehensive plan to reduce prescription drug abuse in the State. Currently, the Public Health Code allows certain exemptions to the reporting of controlled substances dispensed at pain treatment centers and the dispensing and administration of buprenorphine and methadone. These exemptions significantly undermine the effectiveness of MAPS and provide a loophole for corrupt medical professionals who profit from cash-only visits, and who knowingly provide medication to active addicts. The bill would enable

[2] The rule refers to the Department of Community Health (now part of the Department of Health and Human Services), but the related responsibilities of that Department were transferred to LARA by Executive Order 2011-4.

physicians to obtain information about all of the medications that their patients are being prescribed and would ensure that there was a complete and accurate record of a patient's prescription history in MAPS.

Supporting Argument
Too many doctors and pharmacies are willing to prescribe and fill medications for patients with no medical need, and patients actively seek out these types of doctors and pharmacies to illegally obtain prescription medications. Additionally, it appears that only a small percentage of doctors consult MAPS before prescribing highly addictive substances. According to testimony provided on behalf of LARA, roughly only 31% of prescribers are registered in MAPS, and the data do not reflect the number of prescribers who regularly run reports on their patients. This means that medical professionals are prescribing controlled substances without determining whether patients with pain symptoms have multiple prescriptions or if they are engaging in drug diversion or doctor-shopping. By requiring prescribers to review and obtain a report from MAPS before prescribing or dispensing a controlled substance, Senate Bills 166 (S-1) and 167 (S-2) would help eliminate doctor-shopping and ensure that physicians had all relevant information regarding a patient's prescription history before writing a prescription.

Supporting Argument
Senate Bill 270 (S-2) would help to address the problems of doctor-shopping and overprescribing by requiring prescribers to have an established relationship with a patient before issuing a prescription for a Schedule 2 to 5 controlled substance.

Response: Many dental providers do not maintain electronic health records and would be unable to review a patient's medical history and clinical records before prescribing a Schedule 2 to 5 controlled substance. Additionally, many dentists could not provide follow-up care to one-time, out-of-town, emergency patients.

Supporting Argument
By requiring a person licensed or registered under the Public Health Code to educate a patient about substance use disorder if the patient were being treated for a drug overdose, Senate Bill 273 (S-1) would increase emphasis on treating addiction rather than just treating the symptoms of addiction.

Response: Currently, this care can be provided by other professionals, such as substance use disorder counselors or addiction therapists, who have specialized training in the field of substance use disorders. The scope of the bill should be expanded to include these providers.

Supporting Argument
In regard to Senate Bill 360 (S-1), allowing pharmacies to dispense a 90-day supply of a nonopioid prescription could result in cost-savings for the patient if he or she would be paying only a single copayment for the 90-day supply, as opposed to three copayments for three 30-day supplies.

Additionally, allowing pharmacies to dispense a 90-day supply could improve patient adherence to medication regimens. According to testimony on behalf of the National Association of Chain Drug Stores, poor medication adherence costs the United States approximately $290 billion annually, representing 13% of total health care costs. Patients would more likely take their medications if they were working with their local pharmacists, whom the patients already know and have formed a relationship with.

Opposing Argument
The majority of these bills deal with regulating the medical profession in some form, and would do little to enhance or support substance use disorder treatment options. While physicians and other medical professionals are willing to do their part, other facets of this issue should be addressed, as well.

Response: Four categories of legislation to address the issue of opioid abuse have been proposed: supply, education and responsibility, treatment, and law enforcement. These categories align with the recommendations of the Prescription Drug and Opioid Abuse Task Force and will ensure that the State is addressing this issue comprehensively. This series of bills applies mainly to the

supply and education and responsibility categories. Furthermore, physicians, other prescribers, and pharmacists are in the best position to help address problems related to the overprescription of opioids and they have direct contact with patients.

Opposing Argument
By applying to Schedule 5 drugs that do not have the same abuse potential as other medications, Senate Bill 166 (S-1) could restrict access to some epilepsy medications. Epilepsy medications are the most common and cost-effective treatment for controlling and reducing seizures. Schedule 5 epilepsy medications show limited potential for abuse, but play a critical role in the management of seizures and epilepsy. Although MAPS is a valuable tool in combating opioid abuse, the requirements associated with MAPS could lead to delays in access. Delaying, changing, limiting, or denying access to these medications could be dangerous to patients. The bill should exempt nonopioid, nonnarcotic Schedule 5 medications from the prescription drug monitoring program.

Response: There are several Schedule 5 drugs, such as cough syrup with codeine, that are widely abused. Even though the bill may encompass some other drugs that do not have the potential for abuse, it is necessary to include all Schedule 5 drugs.

Opposing Argument
Many physicians would not have the time to run a MAPS report for every Schedule 2 to 5 drug that they prescribe. In a typical day, physicians prescribe a large number of Schedule 2 to 5 medications and the amount of time it would take to obtain a MAPS report for each patient and prescription could be a burden. Instead of requiring physicians and other prescribers to consult MAPS for any controlled substance, the mandated checks should be required only for opioids and benzodiazepines, the classes of drugs that are most likely to be diverted and misused.

Additionally, a check of MAPS should be required only for prescriptions exceeding a seven-day supply, with periodic checks required for prescriptions over extended time periods. Michigan should look to states, such as Ohio, that have balanced public safety considerations with the clinical appropriateness of a mandate.

Opposing Argument
The State should avoid enacting any new laws or regulations that would compromise sound clinical judgment and evidence-based practices. Not taking into account the sanctity of the doctor-patient relationship would do a disservice to patients and to the family physicians delivering their care. Any legislative measure that would infringe upon that relationship could limit care and treatment options. The best way for the State to reduce the distribution of opioids to abusers is to control it at its source, the pharmacy.

Legislative Analyst: Stephen Jackson

FISCAL IMPACT

Senate Bills 47 (S-5), 166 (S-1), and 167 (S-2)

The bills would have no fiscal impact on State or local government.

Senate Bill 270 (S-3)

The bill would have a minor, but likely negative fiscal impact on the Bureau of Community and Health Systems (BCHS) within the Department of Licensing and Regulatory Affairs, and no fiscal impact on local units of government. The bill could introduce some new, but likely minor, costs to the BCHS in the form of additional investigations and enforcement actions related to the proposed requirements for health care providers. These costs would be borne by existing BCHS resources, and could be partially offset by any administrative fines collected from providers found to be in violation of the new requirements. The bill also could introduce new costs related to rule promulgation.

Senate Bill 273 (S-1)

The bill would have a minor, but likely negative fiscal impact on the Bureau of Community and Health Systems (BCHS) within the Department of Licensing and Regulatory Affairs, and no fiscal impact on local units of government. The bill could introduce some new, but likely minor, costs to the BCHS in the form of additional investigations and enforcement actions related to the proposed requirements for licensees and registrants. These costs would be borne by existing BCHS resources, and could be partially offset by any administrative fines collected from providers found to be in violation of the requirements.

Senate Bills 274 (S-2) and 360 (S-1)

The bills would have no fiscal impact on State or local government.

Fiscal Analyst: Josh Sefton

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