



Medical Licensing Board of Indiana
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Michael R. Pence, Governor

Nicholas W. Rhoad, Executive Director

To: Gayle Pierson
Budget Analyst, Office of Management and Budget

From: Michael Minglin
Director
Medical Licensing Board of Indiana

Cc: Nicholas W. Rhoad, Executive Director
John McCullough, Deputy Director
Jeff Collins, Chief Counsel
Benjamin Evans, Legislative Director
Adam Berry, Office of the Governor

Date: July 1, 2014

Re: LSA Document #14-____ Fiscal Analysis

Introduction. On behalf of the Medical Licensing Board of Indiana (“Board”), the Indiana Professional Licensing Agency (“IPLA”) is submitting this proposed rule and fiscal impact statement for your review and approval pursuant to the November 1, 2013 Financial Management Circular #2010-4. A copy of the proposed rule is attached. This proposed rule establishes standards and protocols for physicians in the prescribing of controlled substances for chronic pain management treatment. The Board is required to adopt this rule before November 1, 2014, in accordance with P.L. 185-2013 which was adopted during the 2013 legislative session. Emergency rules are currently in effect but will expire when this permanent rule takes effect. If you have any questions or concerns about this rule, please contact me at (317) 234-2011 or by email at mminglin@pla.in.gov

Proposed Hearing Date. August 28, 2014

Effective Date. Effective November 1, 2014

I. Calculation of the Estimated Fiscal Impact on State and Local Government

This rule will have no fiscal impact on state and local government.

II. Sources of Revenue Affected by the Rule

This rule has no sources of revenue.

III. Identification of any Appropriation, Distribution or Expenditures of State and Local Government that Would Result from the Implementation of the Rule

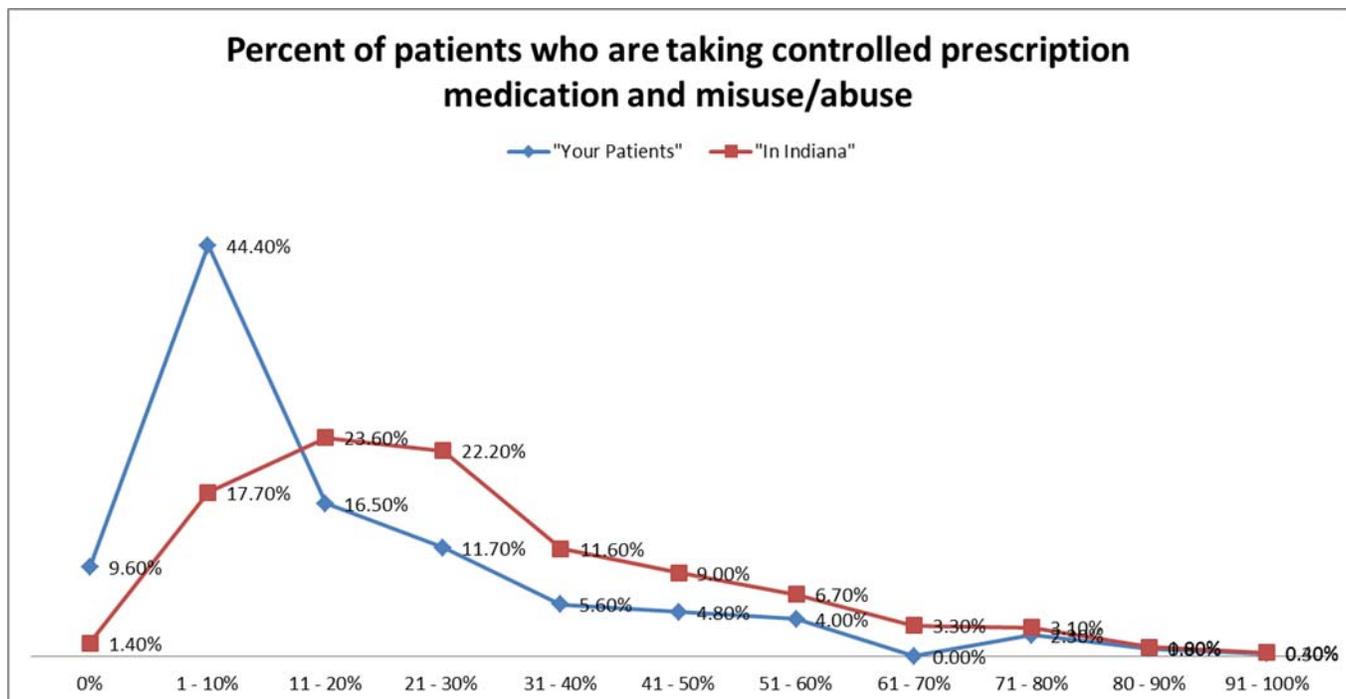
The proposed rule will have no fiscal impact on the state or local government.

IV. Estimated Increase or Decrease in Revenues or Expenditures of State and Local Government that Would Result from the Implementation of the Rule

Impact of Rule to Societal Costs in Indiana

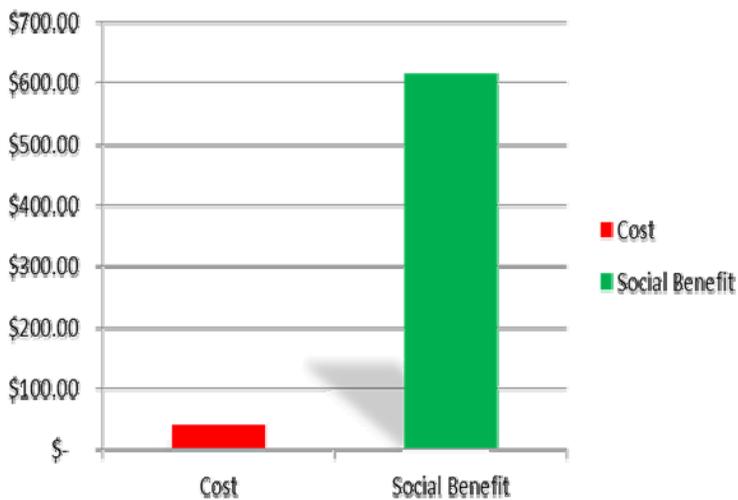
In 2006 the CDC estimated the total cost of nonmedical use of prescription opioids was \$53.4 Billion. In 2009 this cost rose to \$72 billion dollars. If we make a linear forecast of these figures, the U.S. cost of non-medical use of opioids is \$103 billion in 2014. Based on our previous breakout of Indiana for estimating the population of individuals prescribed opioids, we can estimate that Indiana bears 2.39% of these costs (population 2.079% adjusted against 115% opioid prescription prevalence). If this holds, Indiana suffers a \$2,462,044,729.49 cost related to lost productivity, criminal justice, drug abuse treatment, and medical complications. In 2011 the National Council on Alcoholism & Drug Dependence estimated \$81,000,000,000 in costs to employers. If this figure holds proportionately against previous estimates in this paper, the cost to Indiana's employers would be \$2,362,862,832.81. The ongoing cost this rule represents 0.4534% of societal costs to Indiana's population.

A 2013 study from the Center for Health Policy found 57.4% of Indiana physicians to be at least "Moderately concerned" about prescription drug abuse among the patients in their practices, and 85.7% to be at least "Moderately concerned" about prescription drug abuse in their community. A culmination of studies central to West Virginia, Utah and Ohio found 25% - 66% of those who died of pharmaceutical overdoses used opioids prescribed to someone else. The Center for Health Policy study used throughout this report also highlights the need to practice standardization to address this epidemic. When physicians were asked about the percent of patients who are taking controlled prescriptions they felt were misusing or abusing the medications, there is a stark difference between "their" patients and patients in "Indiana:"



While the majority of prescribers to this question believed 1-10% of their patients misused/abused prescriptions to controlled medications (44.4%), they believed the Indiana population of prescription holders misused/abused in range of 11 -30% (45.8%). If we use the low of the ranges in the histogram, the perceived misuse of a practitioner’s patients average equates to 13.01%, while the average of “in Indiana” equates to 23.52%. Is the rule is used to standardize and implemented the best practices of respondents and all patients move toward the lower of the spectrum of misuse found in “your patients” the average decrease would be 10.51% of the population. If we assume diversion and misuse equate for a range of 75% - 50% of prescription opioids being abused (and some other source equates to the other) the overall abuser population shift would be a decrease would be between 7.88% - 5.255%, if we assume the societal cost is equally distributed across all individuals misusing or abusing opioids, the subsequent reduction in societal cost to Indiana would be between \$194,070,675.80 - \$129,380,450.53 of this rule. Using the lower of the ongoing costs identified (which is based on an overly inclusive universe of opioid patients and lacks full discounting against current industry practices) we see a cost to benefit of 8.628% and can calculate that for each shared spent on this rule, \$11.59 will be returned in societal benefits. If we take the high side of both costs and benefits these figures are 21% in cost to benefit and a per dollar return of \$4.86. For each patient under this rule, each patient may increase a practice cost by \$108.26 based on a variety of methodological averages, this costs will be spread across individuals, commercial insurance, Medicaid and Medicare and not fully born by the physician, and may provide \$615.99 in reduced societal costs related to the prescription price epidemic based on derived figures. **See also Exhibit H**

Per Patient Under Rule



V. Assumptions Used in Making the Fiscal Impact Calculation

Not applicable.