F I S C A L I M P A C T R E P O R T

SPONSOR Soules **ORIGINAL DATE** 1/23/17 **LAST UPDATED** 2/10/17 **HB**

SHORT TITLE Opioid Overdose Medication Counseling **SB** 16/aSPAC/aSFL#1

ANALYST Esquibel

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY17	FY18	FY19	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	Minimal	Minimal	Minimal	Minimal	Recurring	General Fund/Federal Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files

Responses Received From
Public School Insurance Authority
Retiree Health Care Authority
Regulation and Licensing Department
Human Services Department
Workers' Compensation Administration
Department of Health
Children, Youth and Families Department
Corrections Department

SUMMARY

Synosis of Senate Floor Amendments

The Senate Floor amendments to Senate Bill 16 as amended by the Senate Public Affairs Committee (SPAC) strike SPAC amendment #1 which designated Section 24-2D-1 NMSA 1978 as "The Pain Relief Act" and changes it to the "Pain Relief Act."

Synopsis of SPAC Amendments

The Senate Public Affairs Committee (SPAC) amendments to Senate Bill 16 (SB16) designate Section 24-2D-1 NMSA 1978 as "The Pain Relief Act" and add a new section. Additionally, the amendments change the definition of opioid to read:

> "a drug in the class of drugs that includes the natural derivatives of opium, which are morphine and codeine, and related synthetic and semi-synthetic compounds that act upon opious receptors."

This definition of opioid is more inclusive and replaces the list of different specific opioids previously listed in the original bill.
The SPAC amendments also strike the term "opioid antagonist" and replace it with "naloxone," which specifically defines which of a series of opiod antagonists currently on the market is to be prescribed under the provisions of the bill.

The SPAC amendments also strike the term "opioid analgesic" and replace it with "prescription opioid."

The amendments renumber the remaining sections of the bill.

Synopsis of Original Bill

Senate Bill 16 (SB16) amends the Pain Relief Act (NMSA 1978 §24-2D-2) to add definitions for opioid analgesic and opioid antagonist, and to add requirements for health care providers who prescribe, distribute, or dispose opioid analgesics. The new requirements call for qualifying providers to counsel patients on the risks of overdose and the availability of opioid antagonists on qualifying occasions (first-time prescription, or first prescription of the calendar year), and to offer the patient a prescription of Naloxone insofar as they are able to under the restrictions of their authorized practice and within the dictates of their professional judgment.

FISCAL IMPLICATIONS

Senate Bill 16 does not include an appropriation.

The Human Services Department indicates opioid analgesics are covered by Medicaid/Centennial Care. There is the potential for increased pharmaceutical costs for Medicaid/Centennial Care members who are prescribed both opioid analgesics and opioid antagonists.

The Workers' Compensation Administration indicates required education under the provisions of the bill may have a positive impact on the workers' compensation system by reducing opioid dependency and deaths among patients receiving opioids as treatment for a workers' compensation injury. However, requiring health care providers to offer Naloxone may increase claims costs for medical benefits minimally, ultimately increasing workers' compensation system costs.

SIGNIFICANT ISSUES

The Board of Pharmacy/Regulation and Licensing Department writes SB16 includes a new definition given for "opioid analgesic" which attempts to list all the items that may fall into this category. The definition for "opiod analgesic" is missing Fentanyl, a major substance that causes accidental overdose death. In addition, other popular opiates missing from the definition are Tramadol, Hydromorphone, and Alfentanil, and perhaps other substances as well. The definition for "opioid analgesic" includes an opiate called Propoxyphene; however, Propoxyphene is no

longer available for use in humans due to possible side effects. A possible alternative is to use the definition of "Narcotic Drug" or "Opiate" found in the Controlled Substances Act.

Also, it could be considered that certain medications, when included with an opiate, increase the risk of accidental overdose deaths. These medications fall into the class called Benzodiazepines. A Benzodiazepine includes products such as Valium (Diazepam) and Xanax (Alprazolam) and similar products such as Ambien (Zolpidem). If a practitioner prescribes a Benzodiazepine and observes that the patient is also on an opiate, additional counseling should be required.

The Board of Pharmacy/Regulation and Licensing Department also writes the most popular and cost effective opioid antagonist is Naloxone, but there are other opioid antagonists available on the market. The revised language uses the term "opioid antagonist" throughout except in the new section 2.B that reads: "A health care provider who prescribes an opioid analgesic for a patient shall offer the patient a prescription for *naloxone* (emphasis added), within the scope of the health care provider's authorized practice, unless otherwise indicated in the professional judgment of the health care provider." For consistency, the term used should not be naloxone, but instead "opioid antagonist".

The Workers' Compensation Administration writes the bill requires health care providers to only offer a prescription of naloxone, but not other medications approved by the board of pharmacy for the reversal of opioid analgesic overdoses.

The Board of Pharmacy/Regulation and Licensing Department further reports the Psychology Board does not fall under this statute and is therefore not statutorily mandated to report or participate in the prescription monitoring program (PMP). However, psychologists routinely prescribe Benzodiazepines, which can be a deadly combination for patients who have been prescribed an Opiate by another practitioner. Without checking the PMP database, a psychologist may not be aware of the opiate prescription for that patient. The statute could be amended to include mandatory participation by psychologists.

ADMINISTRATIVE IMPLICATIONS

Various professional boards governing medical licensure and prescription of opioid analgesic medication, including Board of Pharmacy, NM Medical Board, and the Board of Nursing would need to amend their regulations if this bill is enacted.

TECHNICAL ISSUES

The Children, Youth and Families Department notes the SPAC amendments to SB16 restrict the opioid antagonist to be used under this act to naloxone, which may limit the affected prescribers from taking advantage of new opioid antagonist drugs entering the market.

OTHER SUBSTANTIVE ISSUES

The Corrections Department reports opioids are not prescribed with regularity in a corrections setting. Regarding the counseling requirement contained in the bill, advising on risk of overdose is consistent with the current standard of care when prescribing opioids. Further, opioids are not "keep on person" medication, which means an inmate will have to go through a pill line to get any prescribed dosage of opioids. By preventing inmates from having keep on person opioids, it

eliminates or greatly reduces the risk of an overdose on prescription medication; however, the bill places no additional burden placed on medical staff regarding the counseling requirement.

The Corrections Department reports making Naloxone a keep on person medication in a prison or jail setting could actually have the opposite outcome to what is intended by the bill as it could result in fewer inmates, not more inmates, seeking treatment for their drug addictions and withdrawals, and inmates might use the Naloxone for dangerous or other improper purposes such as selling it for a profit, or use it to hide the fact that they or their friends who are inmates have smuggled in illegal drugs by self treating with Naloxone without medical notification, evaluation or intervention.

The Human Services Department reports requiring all health care providers to counsel patients would be an effort to address the high number of deaths due to prescribed opioids. In 2012, death from opioid analgesics accounted for almost 17,000 deaths in the United States[1]. For several years, New Mexico has led the nation in mortality and morbidity associated with opioid drug use[2.]

In New Mexico, the number of drug overdose deaths involving prescription opioids is higher than overdose deaths involving heroin. Naloxone is also used to reverse opioid overdoses which are the source of the majority of overdoses. According to federal and state data, in 2014 the majority of drug overdose deaths were from prescribed opioids and not heroin. That year, 60 percent of overdose deaths involved prescription opioids, while 30 percent involved heroin, and 10 percent involved both. [3]

In March 2016, the Centers for Disease Control and Prevention (CDC) published *Guidelines for Prescribing Opioids for Chronic Pain*. Counseling patients about the risks and realistic benefits of opioid therapy was recommended in these guidelines as a step toward educating patients.

The guidelines also offer recommendations regarding Naloxone prescribing. CDC guidelines recommend offering prescriptions of Naloxone to patients with a history of overdose, patients with a history of substance use disorder, patients taking benzodiazepines with opioids, patients at risk for returning to a high dose to which they are no longer tolerant (e.g., patients recently released from prison), and patients taking higher dosages of opioids (≥50 MME/day) [4].

The method of administrating Naloxone is by injection or nasal spray, often referred to as a "kit". Many Naloxone kits distributed in New Mexico are distributed through harm reduction outreach programs and public health offices. Naloxone is also available over the counter without a prescription at all Walgreens pharmacies in the state. Additionally, in 2016, a standing order was issued for all *registered* pharmacies in New Mexico to dispense Naloxone to any person who requests the opioid antagonist[5]. However, many medical professionals, including pharmacists, are reported to associate Naloxone with individuals who inject illicit opioids despite the fact that the majority of all opioid overdoses involve a prescription opioid. The New Mexico Prescription Drug Misuse and Overdose Prevention and Pain Advisory Council has included Naloxone use and the CDC guidelines in its priority work.

References

1. Centers for Disease Control and Prevention (CDC). CDC grand rounds: Prescription drug overdoses — A U.S. epidemic. Morbidity and Mortality Weekly Report (MMWR) 2012;61(1):10–13.
2. Centers for Disease Control and Prevention (CDC). Drug Overdose Death Data. 2016. Available at https://www.cdc.gov/drugoverdose/data/statedeaths.html

3. Centers for Disease Control and Prevention (CDC). Drug Overdose Death Data. 2016. Available at https://www.cdc.gov/drugoverdose/data/statedeaths.html and NM Department of Health Emergency and Response Division.
4. U. S. Department of Health and Human Services Centers for Disease Control and Prevention, *Guidelines for Prescribing Opioids for Chronic Pain*. 2016. Available at https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
5. New Mexico Statewide Standing Order for Naloxone, March 2016. Available at https://nmhealth.org/publication/view/regulation/2126/

The Department of Health reports New Mexico had the eighth highest drug overdose death rate among all states in 2015, down from second in 2014. Most drug overdose deaths are unintentional and many are attributed to prescription opioid analgesics. Data from the New Mexico Department of Health (NMDOH) Substance Abuse Epidemiology Section show that one out of three individuals who die from drug overdose have current prescriptions for the drugs involved in their death.

Prescription opioids taken for long-term treatment of chronic non-cancer pain can be highly addictive. A review found that the prevalence of addiction varies from 0% to 50% among long-term opioid patients (Hojsted and Sjogren, 2007). Furthermore, prescription opioid use is a strong risk factor for heroin use (Mars *et al.*, 2014, Compton *et al.*, 2016).

Overdose education and Naloxone distribution have been shown to reduce opioid overdose death rates (http://www.bmj.com/content/346/bmj.f174.full). The Substance Abuse and Mental Health Services Administration (SAMHSA) has released an Opioid Overdose Toolkit for prescribers which recommends that: 1) prescribers educate patients on the risks and benefits of opioid therapy; and 2) prescribers provide opioid patients with prescriptions for Naloxone (http://store.samhsa.gov/shin/content/SMA13-4742/Toolkit_Prescribers.pdf).

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