Economic Impact Analysis
Virginia Department of Planning and Budget

18 VAC 76-20 – Regulations Governing the Prescription Monitoring Program
Department of Health Professions
July 29, 2004

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with Section 2.2-4007.G of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007.G requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the Proposed Regulation

The Prescription Monitoring Program (program) requires pharmacies to send reports to the Department of Health Professions (department) on the prescriptions they fill that have a very high potential for abuse. Dispensers[1] send reports to the department on the Schedule II prescriptions[2] they fill on a semi-monthly basis. The program is aimed at giving police better ways to investigate "doctor shopping," a practice in which drug abusers fake illness or injury to obtain prescriptions from multiple physicians. It is also intended to help identify the doctors who keep abusers in supply.

[1] § 54.1-2519 of the Code of Virginia: "'Dispenser' means a person or entity that (i) is authorized by law to dispense a covered substance or to maintain a stock of covered substances for the purpose of dispensing, and (ii) dispenses the covered substance to a citizen of the Commonwealth regardless of the location of the dispenser, or who dispenses such covered substance from a location in Virginia regardless of the location of the recipient.
[2] Schedule II drugs are those considered highly addictive, such as morphine, OxyContin and methadone. The U.S. Food and Drug Administration maintains the list of Schedule II drugs.

The program regulations specify criteria for discretionary disclosure of information from the program database. Under the current regulations, the Director of the department may disclose information from the database to a prescriber for the purpose of establishing a treatment history, provided the request is accompanied by the prescriber's license number, the prescriber's signature, and a copy of written consent obtained from the recipient. According to the department, the requirement to submit a copy of the written consent for disclosure has been viewed as burdensome and unnecessary. The department proposes to allow prescribers to attest that they have obtained written consent in lieu of providing a copy of the written consent in order to receive information on a patient's prescription history for Schedule II drugs. The prescriber must keep the written consent separate and distinct from any other consent documents required by the practitioner and shall maintain it as part of the patient record.

Estimated Economic Impact

Allowing prescribers to attest to having obtained written consent rather than sending a copy of the written consent will save the prescribers and their staff a small amount of time since they can just send a standard form saying they have consent instead of spending the time to search for the original consent form, copying it, and sending the copy. It is standard for new patients to give consent when they fill out new patient forms. Reducing the staff time needed to request a prescription history from the program may encourage prescribers to request prescription histories more often. More frequent requests may increase the number of times that prescribers find out that a prospective patient has had Schedule II drugs proscribed recently and repeatedly, indicating abuse. In these cases the prescriber can make a more appropriate decision as to what if any drug to prescribe.

On the other hand, allowing prescribers to attest to having obtained written consent rather than sending a copy of the written consent will increase the probability that prescribers will mistakenly believe and claim that the patient has given consent when he actually has not. With the requirement that the prescriber provide a copy of written consent, the prescriber or his staff must actually find and see the written consent. Under the proposed requirement that the prescriber attest to having received written consent, she may mistakenly believe that written consent was obtained and wrongly attest to its having been received. The cost associated with

the increased probability that prescribers will mistakenly believe and claim that the patient has given consent when he actually has not depends on three factors:

1. First, how much patients are injured by their prescription history being distributed against their wishes. Having one's legal rights violated does produce some difficult to measure cost for affected individuals.

2. Second, how much the public may benefit from the distribution of the prescription history. If by obtaining a prescription history the prescriber determines that the patient has misrepresented his prescription history, the prescriber may be able to make a more appropriate decision as to what if any drug to prescribe.

3. and third, the magnitude of the increased probability.

Information is not readily available for any of the three factors. Thus, an accurate comparison cannot be made between the magnitude of the benefit of the proposed amendment (reduced staff time and prescribers perhaps making better-informed decisions) with the cost of an increased probability of prescribers mistakenly believing and claiming that the patient has given consent when he actually has not. In any case, since the time saved from sending a standard form indicating that consent has been received rather than sending a copy of the original consent form is quite small, the proposed amendment will not likely result in a large increase in prescription history requests.

Businesses and Entities Affected

The proposed regulations affect prescribers of Schedule II drugs, such as the 29,106 doctors of Medicine, 1,085 doctors of osteopathic medicine, 488 doctors of podiatry, 2,750 interns, and residents, and 5,338 dentists in the Commonwealth.[3]

Localities Particularly Affected

The proposed regulations particularly affect the part of Virginia where there has been an epidemic of abuse of the prescription painkiller OxyContin. According to department, this been in State Health Planning Region III which consists of the following localities: Lee County, Scott County, Wise County, City of Norton, Dickenson County, Buchanan County, Russell County,

Tazewell County, Washington County, Smyth County, Grayson County, Carroll County, Wythe County, Bland County, City of Bristol, City of Galax, Giles County, Pulaski County, Floyd County, Montgomery County, City of Radford, Alleghany County, Craig County, Botetourt County, Roanoke County, City of Clifton Forge, City of Covington, City of Salem, Roanoke City, Bedford County, Bedford County, Amherst County, Campbell County, Appomattox County, City of Lynchburg, City of Bedford, Amherst County, Campbell County, Appomattox County, City of Lynchburg, City of Bedford, Franklin County, Patrick County, Henry County, Pittsylvania County, City of Martinsville, and City of Danville.

Projected Impact on Employment

The proposed regulations will not significantly affect employment levels.

Effects on the Use and Value of Private Property

The proposal to allow prescribers to attest that they have obtained written consent in lieu of providing a copy of the written consent in order to receive information on a patient's prescription history for Schedule II drugs will save prescribers and their staff a small amount of labor time. This will increase the value of prescribers' practices by a very small amount.

[3] Source: Department of Health Professions