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BILL ANALYSIS

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Senate Bills 397 and 401 through 403 (Substitute S-1 as passed by the Senate)
Senate Bills 399, 400, 404, and 405 (as passed by the Senate)
Sponsor: Senator Kevin Hertel (S.B. 397 & S.B. 400)
Senator Jeff Irwin (S.B. 399)
Senator Sylvia Santana (S.B. 401)
Senator Paul Wojno (S.B. 402)
Senator Sam Singh (S.B. 403)
Senator Darrin Camilleri (S.B. 404 & 405)
Committee: Health Policy

Date Completed: 8-27-25

RATIONALE

The bills focus on expanding access to treatment of opioid use disorder (OUD), alcohol use disorder (AUD), and other types of substance use disorders (SUDs). Generally, OUD and AUD are the chronic use of opioids or alcohol that causes significant distress or impairment and are prevalent in Michigan. The bills would expand access to OUD and AUD treatments by removing barriers to treatment models and preventative measures and by establishing policies for improved responses to OUD and AUD in specific settings, such as in marginalized communities. Recent State efforts to reduce the number of drug overdoses have worked, and the bills' efforts to streamline access to medication and strengthen harm reduction efforts could further reduce overdoses in Michigan.

CONTENT

Senate Bill 397 (S-1) would amend Section 109h of the Social Welfare Act to prohibit the Department of Health and Human Services (DHHS) from requiring prior authorization under Medicaid for a prescription drug that was recognized in a generally accepted standard medical reference for the treatment of and was being prescribed to a patient for the treatment of OUD. Also, the bill would prohibit the DHHS from requiring a dosage maximum for a prescription drug for the treatment of opioid withdrawal symptom management or OUD.

Senate Bill 399 would amend Part 74 (Offenses and Penalties) of the Public Health Code to specify that, as used in Sections 7453 to 7461 and Section 7521, "drug paraphernalia" would not include testing products used in determining whether a controlled substance contained chemicals, toxic substances, or hazardous compounds in quantities that could cause physical harm or death. "Testing products" would include fentanyl testing strips.

Senate Bill 400 would amend Chapter 34 (Disability Insurance Policies) of the Insurance Code to prohibit an insurer that delivered, issued for delivery, or renewed in the State a health insurance policy from requiring a prior authorization for coverage of a medication for the treatment of OUD or AUD.

Senate Bill 401 (S-1) would amend Part 177 (Pharmacy Practice and Drug Control) of the Public Health Code to require a prescriber who issued a prescription to a patient for an opioid to also offer the patient a prescription for an opioid antagonist under certain circumstances.

Senate Bill 402 (S-1) would amend Section 109 of the Social Welfare Act to allow a Medicaid-eligible individual to receive street medicine services, including prescriptions for OUD by an eligible provider.

Senate Bill 403 (S-1) would amend Part 73 (Manufacture, Distribution, and Dispensing) of the Public Health Code to require a pharmacist who received a lawful order from a prescriber for addiction medication to make a good-faith effort to fill the order for the addiction medication without undue delay to the ultimate user. Also, if the pharmacy did not have the addiction medication in stock, the pharmacist would have to offer certain solutions to the patient. Finally, the bill would require a pharmacist to return a prescription form to a patient on the patient's request if an additional medication were prescribed to the patient on a prescription form and was not filled at the pharmacy.

Senate Bill 404 would amend Part 15 (School Districts; Powers and Duties Generally) of the Revised School Code to do the following:

- **Require the board or board of directors of a school district, intermediate school district (ISD), or public school academy (PSA) that could receive opioid antagonists at no cost from the Department of Health and Human Services (DHHS) to ensure that one employee in each school had been trained in the appropriate use and administration of the opioid antagonist.**
- **Require the board or board of directors of a school district, ISD, or PSA that received opioid antagonists at no cost to develop and implement a policy concerning the administration of opioid antagonists in public schools, in consultation with the Department of Health and Human Services (DHHS).**
- **Exempt school employees who in good faith administered an opioid antagonist consistent with the policies of that school from liability in a criminal action or for civil damages as a result of an act or omission in the administration of the opioid antagonist, except for an act or omission amounting to willful or wanton misconduct.**

Senate Bill 405 would amend the Administration of Opioid Antagonists Act to exclude the board or board of directors of a school district, ISD, or PSA from the definition of "governmental agency".

Senate Bills 404 and 405 are tie-barred.

Senate Bill 397 (S-1)

Section 109h of the Social Welfare Act requires the DHHS to exempt certain prescription drugs from any prior authorization the DHHS develops under Medicaid.

"Prior authorization" means a process implemented by the DHHS that conditions, delays, or denies the delivery of particular pharmaceutical services to Medicaid beneficiaries upon application of predetermined criteria by the DHHS or the DHHS's agent for those pharmaceutical services covered by the DHHS on a fee-for-service basis or according to a contract for those services.

Among other drugs exempt from prior authorization, the Act currently exempts a prescription drug that is recognized in a generally accepted standard medical reference for the treatment of and is being prescribed to a patient for the treatment of opioid withdrawal symptom management. The bill also would exempt a prescription drug that was recognized in a

generally accepted standard medical reference for the treatment of and was being prescribed to a patient for the treatment of OUD. The bill would prohibit the DHHS from requiring a dosage maximum for a prescription drug for the treatment of opioid withdrawal symptom management or OUD.

Senate Bill 399

The bill would specify that, as used in Sections 7453 to 7461 and Section 7521, "drug paraphernalia" would not include testing products used in determining whether a controlled substance contained chemicals, toxic substances, or hazardous compounds in quantities that could cause physical harm or death. "Testing products" would include fentanyl testing strips.

Generally, "drug paraphernalia" currently means any equipment, product, or material specifically used for producing, testing, storing, or consuming a controlled substance, such as testing equipment designed for use in identifying strength or purity of a controlled substance. Sections 7453 to 7461 prescribe requirements that restrict the sale of, penalize, provide exceptions for, and set rules for prosecution in cases regarding, drug paraphernalia. Section 7521 prescribes requirements for what kinds of property are subject to forfeiture, including drug paraphernalia.

Senate Bill 400

The bill would prohibit an insurer that delivered, issued for delivery, or renewed in the State a health insurance policy from requiring a prior authorization for coverage of a medication for the treatment of OUD or AUD.

"Prior authorization" would mean a determination by an insurer or utilization review organization that a requested health care benefit has been reviewed and, based on the information provided, satisfies the insurer or utilization review organization requirements for medical necessity and appropriateness.

Senate Bill 401 (S-1)

The bill would require a prescriber who issued a prescription to a patient for an opioid to also offer the patient a prescription for an opioid antagonist if any of the following applied:

-- The prescription for the opioid was for a dosage that was equal to or greater than 50 morphine milligram equivalents per day.
-- The opioid was prescribed concurrently with a prescription for a benzodiazepine.
-- The patient was at an increased risk of experiencing an opioid-related overdose.

A patient would be considered to be at an increased risk of experiencing an opioid-related overdose if the patient had a known history of opioid-related overdose or SUD or the patient was at risk of returning to a high dose of an opioid to which the patient was no longer tolerant.

"Opioid antagonist" means naloxone hydrochloride or any other similarly acting and equally safe drug approved by the Federal Food and Drug Administration for the treatment of drug overdose.

Senate Bill 402 (S-1)

The bill would allow a Medicaid-eligible individual to receive street medicine services, including prescriptions for OUD by an eligible provider.

"Street medicine services" would mean health and social care provided directly to a homeless individual in the individual's environment. "Eligible provider" would mean a nurse practitioner, licensed physician's assistant, licensed physician, or peer recovery coach.

"Nurse practitioner" would mean an individual who is licensed as a registered professional nurse under Part 172 (Nursing) of the Public Health Code who has been granted a specialty certification as a nurse practitioner by the Board of Nursing. "Peer recovery coach" would mean an individual who has lived experience of recovery, has received training and supervision to assist other individuals in initiating and maintaining recovery, and is either of the following:

-- A certified peer recovery mentor certified by the Michigan Certification Board for Addiction Professionals.
-- A certified peer recovery coach certified by the DHHS.

Senate Bill 403 (S-1)

The bill would require a pharmacist who received a lawful order from a prescriber for addiction medication to make a good-faith effort to fill the order for the addiction medication without undue. If the pharmacy did not have the addiction medication in stock, the pharmacist would have to offer to do one or more of the following for the patient:

-- Obtain the addiction medication using the pharmacy's standard expedited ordering procedure.
-- Locate a pharmacy that was reasonably accessible to the patient that had the addiction medication in stock and transfer the order to that pharmacy using the transferring pharmacy's standard transfer procedure.

"Addiction medication" would mean a controlled substance to treat or manage an OUD.

"Undue delay" would mean a delay intended to obstruct a patient's access to the addiction medication or that is not a valid delay. "Valid delay" would mean a delay caused by fulfilling the requirements of Article 7 (Controlled Substances), Part 177 (Pharmacy Practice and Drug Control), or a rule promulgated under either, or any other delay commonly associated with the practice of pharmacy.

The bill also would require a pharmacist to return a prescription form to a patient on the patient's request if an additional medication were prescribed to the patient on a prescription form and was not filled at the pharmacy.

Senate Bill 404

School Policy Concerning the Administration of an Opioid Antagonist

Under the bill, if the DHHS could supply a school district, ISD, or PSA with opioid antagonists at no cost, the board or board of directors of that district, ISD, or PSA would have to ensure that each school operated by the board or board of directors had at least one employee who had been trained in the appropriate use and administration of an opioid antagonist.

The board of a school district or intermediate school district or board of directors of a PSA that received opioid antagonists would have to, in consultation with the DHHS, develop and implement a policy concerning the administration of opioid antagonists in public schools that did at least the following:

-- Required school personnel to notify the parent or legal guardian of a pupil to whom an opioid antagonist had been administered.
-- Required school personnel to call 9-1-1 if a pupil were believed to be having an opioid-related overdose.

"Opioid antagonist" would mean naloxone hydrochloride or other similarly acting and equally safe drug approved by the United States Food and Drug Administration (FDA) for the treatment of drug overdose.

"Opioid-related overdose" would mean a condition, including extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death that results from the consumption or use of an opioid or another substance with which an opioid was combined or that an individual who has received training under the bill would believe to be an opioid-related overdose that requires medical assistance.

Exemption from Civil and Criminal Liability

The Revised School Code exempts from civil and criminal liability a school employee who in good faith administers epinephrine to an individual consistent with policies for epinephrine currently required under the Code and similar to those proposed for the administration of opioid antagonists as described above.

Under the bill, a school employee who in good faith administered an opioid antagonist to an individual consistent with the policies above would not be liable in a criminal action or for civil damages as a result of an act or omission in the administration of the opioid antagonist, except for an act or omission amounting to willful or wanton misconduct.

The Code also exempts from civil and criminal liability a school administrator, teacher, or other designated school employee who in good faith administers medication to a pupil in the presence of another adult or in an emergency that threatens the pupil's life or health pursuant to instruction of a medical professional and written permission of a parent or guardian, except for an act or omission amounting to gross negligence or willful or wanton misconduct. The Code specifies that a school employee who is a licensed registered professional nurse does not need another adult present to be exempt from civil or criminal liability when administering a medication in good faith. Under the bill, a school employee who was a licensed registered professional nurse and who administered an opioid antagonist without the presence of another adult also would be exempt from civil or criminal liability.

Senate Bill 405

The Administration of Opioid Antagonists Act allows a governmental agency to purchase and possess an opioid antagonist and distribute the antagonist to its employees. The Act exempts a government agency from civil and criminal liability for possessing or administering in good faith an opioid antagonist.

Currently, "governmental agency" means the State or a political subdivision but does not include a person licensed under Part 209 (Emergency Medical Services) of the Public Health Code. Under the bill, the term also would not include the board or board of directors of a school district, ISD, or PSA.

"Intermediate school district" would mean a corporate body established under Part 7 (Intermediate School Districts) of the Revised School Code.

"Public school academy" would mean a public school academy established under Part 6a (Public School Academies) and, except as used in Part 6a, also includes an urban high school academy established under Part 6c (Urban High School Academies), a school of excellence established under Part 6e (Schools of Excellence), and a strict discipline academy established under Sections 1311b to 1311m.[1]

"School district" would mean a general powers school district organized under the Revised School Code, regardless of previous classification, a community district, or a school district of the first class.

MCL 400. 109h (S.B. 397); 333.6230 & 333.6234 (S.B. 398); 333.7451 (S.B. 399)
Proposed MCL 500.3406ww (S.B. 400); MCL 333.17744b (S.B. 401); 400.109 (S.B. 402)
Proposed MCL 333.7333c (S.B. 403)
MCL 380.1178 et al. (S.B. 404); 15.671 (S.B. 405)

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

Requiring prior authorization, the process by which a health insurer permits the issuance of specific medication before the medication's delivery, on doses of buprenorphine-naloxone larger than 32 mg is a barrier to accessing life-saving medication that does not align with evidence. Buprenorphine-naloxone is the most commonly prescribed formulation of buprenorphine, an opioid antagonist often used to treat OUD. Research indicates that doses of buprenorphine higher than 32 mg are safe and effective, eliminating the need for prior authorizations.[2] Additionally, research indicates that higher doses of buprenorphine-naloxone are associated with improved retention rates, reduced department or inpatient healthcare visits from patients, and improved effectiveness against high potency synthetic opioids like fentanyl.[3] Finally, delays in treatment due to prior authorization increase the likelihood of withdrawal, relapse, or overdose. The 32 mg dosage maximum interferes with clinical decision-making for no effective medical benefit, and so a requirement for a dosage maximum should be eliminated by passing Senate Bill 397 (S-1).

Supporting Argument

Synthetic opioids like fentanyl and xylazine were involved in over 60% of overdose deaths nationally in the 12-month period ending in October 2024.[4] This is in part because synthetic opioids have been found in drugs other than opioids. In response to this, fentanyl testing kits have become more common and have reportedly been proven effective at reducing

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[1] Sections 1311b to 1311m of the Revised School Code establish, describe the powers and duties of, and describe the administration of, a strict discipline academy. Broadly speaking, a strict discipline academy is a public school that educates pupils who have been expelled or suspended from other educational institutions, or who have been ordered by a court to attend due to behavioral issues.

[2] Lei, Feitong, et al., Journal of Addiction Medication, "Higher First 30-Day Dose of Buprenorphine for Opioid Use Disorder Treatment Is Associated with Decreased Mortality", April 2024.

[3] Kennedy, Amy, et al., Journal of General Internal Medicine, "Factors Associated with Long-Term Retention in Buprenorphine-Based Addiction Treatment Programs: A Systematic Review", February 2022; Axeen, Sarah, et al, JAMA Network Open, "Association of Daily Doses of Buprenorphine With Urgent Health Care Utilization", September 2024; Weimer, Melissa, et al, Journal of Addiction Medicine, "ASAM Clinical Considerations: Buprenorphine Treatment of Opioid Use Disorder for Individuals Using High-potency Synthetic Opioids", December 2023.

[4] Ahmad, FB, et al., National Center for Health Statistics, "Provisional drug overdose death counts", 2025.

overdoses.[5] Test strips can help individuals who use drugs make informed choices, like whether to take a drug, reduce a dosage, consume a drug slower, or only do the drug in settings with other individuals present.[6] Senate Bill 399 would specify that prohibited drug paraphernalia would not include fentanyl testing strips and so expand access to them, leading to reductions in the risk of opioid overdose.

Supporting Argument

Senate Bill 400 would prohibit commercial insurance plans in Michigan from maintaining a prior authorization on medications used to treat OUD or AUD. Prior authorization is a process by which a health insurer permits the issuance of specific medication before that medication's delivery. According to testimony submitted to the Senate Committee on Health Policy, prior authorization has been justified in the past as a cost-saving measure; however, studies indicate that prior authorization for buprenorphine does not decrease costs.[7] Instead, prior authorization's delays in medication initiation have been linked to increased likelihood for overdose and death, particularly among individuals who stop using illicit opioids to prepare for treatment.[8] Studies also indicate that prior authorization for buprenorphine can significantly reduce treatment retention.[9] Finally, prior authorization requirements are often circumvented by those who need immediate OUD or AUD treatment, resulting in individuals using emergency departments instead of preventative care. This process is costly and inefficient in an already resource-constrained health care environment.

Removing prior authorization requirements in other states has had a positive effect on access to care; a linked increase in the use of buprenorphine-naloxone and a decrease in overall health care use costs, including hospitalization and emergency department use.[10] One study found that when Illinois removed prior authorization for buprenorphine for Medicaid, there was a statistically significant increase in buprenorphine subscriptions.[11] Senate Bill 400's removal of prior authorization requirements for OUD and AUD medication could help to eliminate unnecessary delays in care and expand access to the medication.

Supporting Argument

Naloxone is an opioid antagonist that is effective at reducing opioid overdose risk and infectious disease transmission. Due to how effective naloxone is as a treatment method, the

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[5] Quijano, Thomas, et al., International Journal of Drug Policy, "Xylazine in the drug supply: Emerging threats and lessons learned in areas with high levels of adulteration", October 2023.

[6] United States Centers for Disease Control and Prevention, "What You Can Do to Test for Fentanyl", April 2024; Peiper, Nicholas, et al, International Journal of Drug Policy, "Fentanyl Test Strips as an Opioid Overdose Prevention Strategy: Findings from a Syringe Services Program in the Southeastern United States", January 2019; Park, Ju Nyeong, et al, International Journal of Drug Policy, "Evaluation of Fentanyl Test Strip Distribution in Two Mid-Atlantic Syringe Services Programs", August 2021; Krieger, Maxwell, et al, International Journal of Drug Policy, "Use of Rapid Fentanyl Test Strips among Young Adults Who Use Drugs", November 2018.

[7] Mark, Tamil, et al, JAMA Network Open, "Association of Formulary Prior Authorization Policies with Buprenorphine-Naloxone Prescriptions and Hospital and Emergency Department Use Among Medicare Beneficiaries", April 2020.

[8] Sigmon, Stacey, et al., International Society of Addiction Journal Editors, "Bridging waitlist delays with interim buprenorphine treatment: Initial feasibility", December 2015.

[9] Landis, Rachel, et al., International Society of Addiction Journal Editors, "Buprenorphine treatment episode duration, dosage, and concurrent prescribing of benzodiazepines and opioid analgesics: The effects of Medicaid prior authorization policies", December 2022.

[10] Mark, Tamil, et al., JAMA Network Open, "Association of Formulary Prior Authorization Policies with Buprenorphine-Naloxone Prescriptions and Hospital and Emergency Department Use Among Medicare Beneficiaries", April 2020.

[11] Keshwani, Shailina, et al., JAMA Health Forum, "Buprenorphine Use Trends Following Removal of Prior Authorization Policies for the Treatment of Opioid Use Disorder in 2 State Medicaid Programs", June 2022.

practice of co-prescribing naloxone is recommended by the U.S. Centers for Disease Control and Prevention (CDC).[12] According to the CDC, for every 100 high-dose opioid prescriptions, primary care providers prescribe only two naloxone prescriptions;[13] however, the figure for naloxone prescriptions is much higher in states with co-prescribing laws than in states without them. In 2017, Vermont and Virginia became the first two states to pass naloxone co-prescribing laws. One study found that in the first full month after these laws went into effect, 111 naloxone prescriptions per 100,000 were dispensed in Vermont and 88 naloxone prescriptions per 100,000 were dispensed in Virginia.[14] In contrast, the 10 states (including Washington D.C.) with the highest overdose death rates only dispensed 16 per 100,000 and the remaining 39 states averaged six per 100,000.[15] Another study examining the impact of naloxone co-prescribing found that patients who received naloxone through co-prescribing may reduce the risk of opioid overdose death and opioid-related emergency department visits than those who were not co-prescribed naloxone.[16] Senate Bill 401 (S-1) would create co-prescribing laws for opioid antagonists in Michigan to increase access to naloxone and decrease opioid overdose and death.

Supporting Argument

Only around 24% of individuals who require treatment for an SUD receive treatment.[17] This can be attributed to a number of factors, such as a lack of healthcare providers, stigma surrounding an SUD, and affordability issues, among others. Individuals experiencing homelessness often experience many of these factors and so are less likely to receive or seek care. Research suggests that low-threshold treatment is effective at treating SUD for marginalized populations, including individuals experiencing homelessness.[18] Generally, low-threshold treatment is treatment without concurrent service requirements, treatment that does not terminate because of a relapse, and treatment that has a low-or no-cost initiation of medication. Street medicine services are a form of low-threshold treatment that may prove more effective than traditional methods of treating SUD in homeless populations. Senate Bill 402 (S-1) would allow providers to bill Medicaid for street medicine services, which could expand access to care, reduce emergency room use, and support continuous treatment for the riskiest populations. This could have a significant impact on reducing rates of SUD overdose in Michigan among marginalized populations.

Supporting Argument

Timely access to medication is critical to preventing OUD withdrawal and overdose. A recent study examining 586 Michigan pharmacies found that only 52.8% of these pharmacies have buprenorphine in stock.[19] This leads to delays in treatment for opioid withdrawal, particularly for Michigan residents who must drive long distances to a pharmacy with a supply. Residents of Michigan's northern Lower Peninsula and Michigan's Upper Peninsula experience the most extreme delays in care because of a lack of buprenorphine stock. Senate Bill 403 (S-1) would

[12] CDC, "CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022", November 2022.
[13] United States Centers for Disease Control and Prevention, Vital Signs, "Life-Saving Naloxone from Pharmacies", August 2019.
[14] Sohn, Minji, et al, JAMA Network Open, "Association of Naloxone Coprescription Laws with Naloxone Prescription Dispensing in the United States", June 2019.
[15] *Id*.
[16] National Institute on Drug Abuse, "Naloxone DrugFacts", January 2022.
[17] Substance Abuse and Mental Health Services Administration, ""Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health", July 2024.
[18] Carter, Jamie, et al, Addiction Science and Clinical Practice 14, "Low barrier buprenorphine treatment for persons experiencing homelessness and injecting heroin in San Francisco", May 2019.
[19] Weiner, Scott, et al, JAMA Network Open, "Pharmacy Availability of Buprenorphine for Opioid Use Disorder Treatment in the US", May 2023.

require pharmacies to stock and dispense opioid antagonists without undue delay to ensure continuity of care and protect patients from potentially fatal withdrawal symptoms.

Supporting Argument
Between 2019 and 2020, opioid overdose deaths among adolescents doubled, with drug overdose and poisoning becoming the third leading cause of death among children and adolescents in 2020.[20] According to the CDC, between July 2019 and December 2021, there was evidence of naloxone administration in only 30% of cases where overdose deaths occurred among people ages 10 to 19.[21] According to testimony submitted to the Senate Committee on Health Policy, past resistance to naloxone availability in schools has been centered around the idea that adolescents do more drugs if they have access to naloxone because the negative symptoms associated with drug use can be counteracted; however, several studies suggest drug use does not increase when naloxone is available.[22] Making naloxone available in schools could decrease opioid overdose and death among youth. Senate Bills 404 and 405 should be passed to protect students, staff, and community members.

Legislative Analyst: Alex Krabill

FISCAL IMPACT

Senate Bill 397 (S-1)

The bill could have an indeterminate but likely minimal fiscal impact on the DHHS through the State's Medicaid program and no fiscal impact on local units of government. Currently, Medicaid policy restricts buprenorphine/naloxone to a 32-milligram equivalent limit per day under the State's Single Preferred Drug List.

The bill would eliminate the need for prior authorization for buprenorphine/naloxone tablets exceeding 32 milligrams per day. Fiscal implications for the DHHS would result from the removal of the existing 32 milligrams/day cap. The exact fiscal impact to the State Medicaid program is uncertain. It is not known how many recipients would exceed the current daily limit.

Senate Bill 399

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

Senate Bill 400

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

Senate Bill 401 (S-1)

The bill could have an uncertain but potentially significant fiscal impact on the State and local units of government. The bill would require that any prescriber issuing an opioid prescription to a patient also would have to offer a prescription for an opioid antagonist. Offering a prescription for an opioid antagonist would likely lead to an increase in filled prescriptions for opioid antagonists. The resulting additional prescription costs could affect the State's Medicaid

[20] Friedman, Joseph, et al, JAMA Network, "Trends in Drug Overdose Deaths Among US Adolescents, January 2010 to June 2021", April 2022.
[21] United States Centers for Disease Control and Prevention, "Drug Overdose Deaths Among Persons Aged 10-19 Years – United States, July 2019-December 2021", December 2022.
[22] Bruzelius, Emilie, et al, International Journal of Drug Policy, "Naloxone expansion is not associated with increases in adolescent heroin use and injection drug use: Evidence from 44 US states", April 2023.

program through fee-for-service payments and increases to Medicaid health plan managed care rates, as well as the State's employee and retiree healthcare expenses. Local government units would experience cost increases through public employee and retiree healthcare programs as well as through local jail/correctional health care costs. The fiscal impact to the State for the State employee self-funded health insurance plans could be approximately $11.5 million General Fund/General Purpose (GF/GP). According to the Michigan Civil Service Commission, in calendar year 2024, the State's health plans filled roughly 88,600 opioid prescriptions and the average cost for opioid antagonists to the State's health plans was $130. Assuming that future years have similar numbers of opioid prescriptions with a 100% fill rate for the automatic opioid antagonists, 88,600 opioid antagonist prescriptions at $130/prescription is around $11.5 million. The fiscal impact to the State's Medicaid program could be approximately $44.9 million gross and $10.9 million GF/GP. In Fiscal Year (FY) 2023-24, there were approximately 781,700 opioid prescriptions filled under the State's Medicaid program. In FY 2023-24, the average cost to the State's Medicaid program for an opioid antagonist was $57.40 per unit. Assuming that future years have similar numbers of opioid prescriptions with a 100% fill rate for the automatic opioid antagonists, 781,700 opioid antagonist prescriptions at $57.40/prescription is around $44.9 million gross. The estimated match rate between Traditional Medicaid and the Healthy Michigan Plan is approximately 24.25% meaning that of the $44.9 million, the GF/GP share would be $10.9 million.

Senate Bill 402 (S-1)

The bill could have a fiscal impact on the Michigan Department of Health and Human Services and no fiscal impact on local units of government. The proposed changes to the Social Welfare Act under the bill would require Michigan's Medicaid program to cover street medicine services, including prescriptions for opioid use disorder, by eligible providers.

Michigan's Medicaid program already covers prescriptions for opioid use disorder, so the fiscal impact from the addition of providing prescriptions for opioid use disorder to unsheltered homeless individuals would be minimal.

The section of the bill that could have an uncertain fiscal impact would be the definition of "street medicine services". According to the bill, "street medicine services" would mean health and social care provided directly to a homeless individual in their environment. The bill does not specify the exact nature of "health and social care", allowing for a broad interpretation that could mandate extensive provisions of such services. Depending on the scope and types of health and social care that would have to be provided, this definition would have the potential to result in a significant fiscal impact.

According to the 2024 United States Department of Housing and Urban Development Annual Homelessness Assessment Report, there were 9,739 homeless people in Michigan, Depending on the interpretation of "health and social care", providing care to approximately 9,700 individuals in their own environment, instead of in a facility or mobile health clinic setting, could result in significant costs for the Medicaid program.

Senate Bill 403 (S-1)

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

Senate Bills 404 & 405

The bills would have a minor negative fiscal impact on the DHHS and no impact on local units of government. Although the bill wouldn't require the DHHS to provide opioid antagonists to a school district, ISD, or PSA, an initial cost to provide a two dose unit of naloxone, specifically

Narcan, would range from $36,203 to $135,751.2 The lower amount would provide a single two dose unit to each school district, while the higher amount would provide a single two dose unit to each school.3 Currently, the DHHS operates Narcan Direct, a Naloxone distribution portal, which uses Opioid Healing and Recovery Fund revenue and Federal grants to distribute opioid antagonists to either a person, organization, or governmental entity free of charge upon submission and approval of an online request form. If districts or individual schools were already using Narcan Direct to receive Narcan, this would offset a portion of the initial costs.

The bills would have an indeterminate, though likely small, fiscal impact on districts, ISDs, and PSAs. If the DHHS were able to supply a district, ISD, or PSA with opioid antagonists at no cost, the district, ISD, or PSA would incur some administrative cost to ensure at least one employee of each school had been trained in the appropriate use and administration of an opioid antagonist. Senate Bill 404's immunity provisions could reduce the number of prosecutions and convictions for possession or administration of controlled substances by employees or agents, thus potentially reducing court and corrections costs and costs of litigation for affected districts, ISDs, and PSAs.

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