Legislative Analysis

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ALLOW ACCESS BY HEALTH INSURERS TO CONTROLLED SUBSTANCES DATA SYSTEM

House Bill 4369 as introduced
Sponsor: Rep. Lesia Liss
Committee: Health Policy

First Analysis (3-14-11)

BRIEF SUMMARY: The bill would allow the Department of Community Health to provide data relating to the dispensing and prescribing of certain controlled substances to health insurance carriers and similar entities.

FISCAL IMPACT: House Bill 4369 as introduced will result in administrative costs to the Department of Community Health to provide data or database access to requesting health insurance entities. The Department's costs will depend on the volume and nature of requests and the process established to provide data. There are no state Medicaid program savings related to the provisions of this bill.

THE APPARENT PROBLEM:

"Doctor shopping" refers to the practice of going to different doctors in different medical practices without the doctors' knowledge that other medical professionals are being consulted, all with the intent to obtain prescriptions for the same drug, usually narcotic painkillers such as OxyContin and Vicodin. Some "doctor shoppers" became addicted to painkillers when under treatment for an earlier injury or surgery. Others may be selling the drugs on the street. To avoid detection, doctor shoppers fill the prescriptions at multiple pharmacies, sometimes even in different towns.

Overdoses or dangerous drug interactions can occur when patients are able to obtain prescription drugs through doctor shopping. According to a study cited earlier in 2010 by CNN Health that had been published in the May edition of the *American Journal of Preventive Medicine*, hospitalizations for poisoning by prescription opioids, sedatives, and tranquilizers were estimated to have increased 65 percent from 1999 to 2006. In addition, approximately 20,000 people die each year from prescription drug overdoses. Doctor shopping also affects health care costs as patients seek treatment at multiple doctor offices, urgent care facilities, or pain clinics and/or undergo unnecessary or repeated diagnostic tests. For example, Blue Cross Blue Shield of Michigan reported in committee testimony that one patient ran up over $100,000 in medical costs associated with unnecessary medical tests and ER costs in an attempt to obtain unneeded prescription drugs.

To combat doctor shopping, Michigan enacted legislation in 2002 that created the Michigan Automated Prescription System (MAPS) - a database that collects data on controlled substance prescriptions dispensed from pharmacies in the state. Physicians

and pharmacists who suspect that a patient may be doctor shopping can access the database. Law enforcement agencies can also search the MAPS database when conducting drug investigations. In addition, the Public Health Code makes it a four-year felony offense, with a possible fine up to $30,000, to knowingly or intentionally obtain possession of a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge. Last year, Public Acts 354 and 355 of 2010 were enacted to make it a felony offense to fraudulently obtain or attempt to obtain from a health care provider a controlled substance or a prescription for a controlled substance.

Moreover, some people are engaging in a form of "doctor shopping" with health care plans. If part of a cafeteria plan, Medicaid, or Medicare, or if buying an individual policy, people can change enrollment in health care plans during open enrollment periods. Apparently, some are using these open enrollment periods to jump in and out of different health plans, engaging in doctor shopping conduct while in a health plan and then jumping to a different health plan at the next open enrollment before being detected. Due in part to the costs that doctor shopping imposes on health insurance carriers, the insurance carriers are requesting access to data in the MAPS database that could help them identify doctor shoppers when those individuals apply for enrollment in a health plan and while being covered.

THE CONTENT OF THE BILL:

The bill would allow the Department of Community Health to provide data relating to the dispensing and prescribing of certain controlled substances to health insurance carriers and similar entities.

The Department of Community Health (DCH) maintains an electronic system – the Michigan Automated Prescription System, or MAPS – for monitoring Schedule 2, 3, 4, and 5 controlled substances that are dispensed by veterinarians and licensed pharmacists and dispensing prescribers. The data collected includes patient identifiers, the name and quantity of the controlled substance dispensed, the date dispensed, and the name of the prescriber and dispenser. Notwithstanding any practitioner-patient privilege, the director of the DCH is permitted by statute to provide data obtained by the electronic monitoring system to the licensing boards of those authorized to prescribe, administer, or dispense controlled substances; departmental employees; law enforcement officials who enforce drug laws; a state-operated Medicaid program; governmental employees who hold a search warrant or subpoena for the records; a practitioner or pharmacist who requests information for the purpose of providing medical or pharmaceutical treatment to a current patient; or an individual under contract to administer the electronic monitoring system.

House Bill 4369 would amend the Public Health Code (MCL 333.7333a) to also permit the director of the DCH to provide data from the electronic monitoring system to a health care payment or benefit provider for the purposes of ensuring patient safety and investigating fraud and abuse.

"Health care payment or benefit providers" would mean a person providing health benefits, coverage, or insurance in the state. The term would include a health insurance company, a nonprofit health care corporation (Blue Cross and Blue Shield of Michigan), an HMO, a multiple employer welfare arrangement, a Medicaid contracted health plan, or any other person providing a plan of health benefits, coverage, or insurance subject to state insurance regulation.

The bill would also delete an obsolete provision requiring a report by October 1, 2002 on the need for a paper prescription form that would minimize the potential for forgery.

(Note: The health code prohibits a person who receives data or any report from the DCH containing any patient identifiers of the electronic system from providing it to any other person or entity except by a court order.)

BACKGROUND INFORMATION:

A similar bill was introduced last session. That bill, House Bill 5735 of 2010, was passed by the House but died on the Senate floor.

ARGUMENTS:

For:

According to insurance carriers, access to information compiled within the MAPS database is needed to scan potential new enrollees or members before they come into a health plan. This is because some have found ways to use the open enrollment periods to jump in and out of different health plans before anyone can detect their patterns of abuse and fraud. If the medical directors of health plans (who are physicians) could access the controlled substance history of specific patients, they may be able to spot a potential for abuse. A health plan could adopt a policy regarding how to deal with a new enrollee with a suspected problem; for instance, the health plan could limit that person to obtaining controlled substance prescriptions from only one physician or physician office and fill those prescriptions at a designated pharmacy.

Currently, health plans have access to patient information needed to pay claims, and they must abide by state and federal confidentiality rules and regulations. The bill, however, would enable a carrier to review the controlled substance history of a person before being accepted by the carrier into one of its health plans. Thus, they could identify persons that could be abusing the system, need help with an addiction, or are illegally diverting pain killers. Getting the appropriate medications to those who have a legitimate need for prescription pain killers while identifying those engaging in illicit or illegal activities could further add in the attempts by all to reduce health care costs and keep accessibility affordable.

Against:

There may be legitimate reasons why a person seeks prescriptions for pain killers from multiple doctors, and why they want to switch to a different health plan. Some people

complain that many doctors still don't "get it" in regards to the severity of pain experienced by many non-terminal pain patients and don't prescribe adequate strengths or dosages of pain medications. Such a patient may feel the only alternative is to try to get more of the needed pain killers from an urgent care facility or hospital emergency room, or even another physician practice. That could be the very reason that they try a different health plan at each new open enrollment – to see if the physicians in the new plan understand how to treat chronic pain conditions. It seems the bill would disadvantage those patients and lump them in with those purposefully engaging in criminal activities.

In addition, what would happen if someone left town without their prescription medicines? Would they be tagged as "doctor shoppers" also and denied enrollment in a health plan or told "you can only get a prescription from this one doctor and fill it at only this one pharmacy?"

Response:

According to industry members, the goal of the legislation is to get information sufficient to identity patterns that are typical of abuse situations, not the occasional time that a different pain medication is needed or a vacationer forgets to pack his or her medicine. For instance, an insurer found that in reviewing claims data, one physician wrote three prescriptions for a controlled substance for one week each in a short period of time. The insurer contacted the doctor, who looked up the patient's name, and found that it was a bogus patient. A further investigation revealed that one of the doctor's prescription pads had been stolen. The physician was grateful that the stolen pad had been revealed so soon. Thus, insurers maintain they are trying only to identify abuse and fraud, not micromanage how pain patients get needed medications.

As to any pain patient who believes he is she is not receiving adequate pain relief from his or her doctor, the state insurance laws allow a patient to appeal the physician's denial of pain medication (or any medical treatment the patient believes is warranted) through the insurer's internal appeals process. It is not uncommon for the insurer to overrule a physician's treatment plan and order tests or medications previously denied. If the health plan's internal review process still results in a denial, the patient can request the Office of Financial and Insurance Regulation (OFIR), the agency that regulates health insurance carriers, to do an independent review. There simply is no reason for a person in pain to be refused appropriate relief. Just changing doctors would probably not result in a red flag going up under the bill's provisions. Instead, the health plans would be looking for a pattern of going to many doctors at the same time and filling prescriptions at many different pharmacies in an attempt to avoid detection.

Insurers believe that being allowed access to data relating to a patient's controlled substance prescription history will enable them to crack down on abuse and eliminate waste, all the while protecting patients' confidential information under confidentiality laws.

POSITIONS:

Representatives of the Michigan Association of Health Plans (MAHP) testified in support of the bill. (3-3-11)

Blue Cross Blue Shield of Michigan indicated support for the bill. (3-3-11)

The Michigan Osteopathic Association indicated support for the bill. (3-3-11)

The Michigan Pharmacists Association indicated support for the bill. (3-3-11)

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■ This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.