Legislative Analysis

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ALLOW ACCESS BY HEALTH INSURERS TO CONTROLLED SUBSTANCES DATA SYSTEM

House Bill 4369 as enrolled
Public Act 44 of 2012
Sponsor: Rep. Lesia Liss
House Committee: Health Policy
Senate Committee: Health Policy

Second Analysis (7-18-13)

BRIEF SUMMARY: The bill would allow the Department of Licensing and Regulatory Affairs to provide data relating to the dispensing and prescribing of certain controlled substances to health insurance carriers and similar entities so to ensure patient safety and investigate fraud and abuse.

FISCAL IMPACT: House Bill 4369 as introduced will result in administrative costs to the Department of Licensing and Regulatory Affairs 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, with the intent of obtaining 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 this kind of 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 to confirm or refute that suspicion. Law enforcement agencies can also search the MAPS database when conducting drug investigations.

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. 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.

Despite these measures, the problem persists. Reportedly, some people are now engaging in a form of "doctor shopping" with health care plans. If enrolled in Medicaid or Medicare, part of an employer-sponsored cafeteria plan, or buying an individual policy, people can change enrollment in health care plans during annual 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 one health plan and then jumping to a different health plan during the next open enrollment to avoid 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 individuals apply for enrollment in a health plan and also during a plan's coverage.

THE CONTENT OF THE BILL:

The Department of Licensing and Regulatory Affairs (LARA) 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 (physicians). 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 LARA is <u>permitted</u> 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; an individual under contract to administer the electronic monitoring system; or to a practitioner for the purpose of determining whether prescriptions he or she had written have been dispensed.

House Bill 4369 would further amend the Public Health Code (MCL 333.7333a) to permit the director of LARA, until December 31, 2016, 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.

Beginning February 1, 2013, and through February 1, 2016, LARA could issue a written request to a health care payment or benefit provider to determine if the provider has accessed the electronic system as authorized under the bill in the previous calendar year, and if so, to determine the number of inquiries and any other information LARA requests in relation to the provider's access to the electronic system. The provider must respond to the written request on or before the March 31 following the request. Further, the bill requires LARA to collaborate with health care payment or benefit providers to develop a reasonable request and reporting form for use in facilitating the requests by LARA and responses by providers.

"Health care payment or benefit provider" 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.

(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:

The bill is needed to enable an insurance carrier to review the controlled substance history of a person before or after being accepted into one of its health plans. According to insurers, access to information compiled within the database is needed to scan potential enrollees or members before they come into a health plan, as well as new and current members. This is because some people 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/or fraud.

If an insurer could access the controlled substance history of specific patients, it may be able to spot a potential pattern of such abuse. The medical directors of the carrier's health plans (who are physicians) could then identify persons that may be abusing the system, need help with an addiction, or are illegally diverting pain killers. Such information

could be used by an insurer to develop policies regarding how to deal with an enrollee with a suspected problem; for instance, provisions of 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.

Importantly, the bill does not provide open access to health insurance carriers to the MAPS database; an insurer would have to request data on a specific enrollee or member, showing why the information is being requested and how the request relates to fraud and/or abuse of controlled substances. Any information received by an insurer under the bill would fall under confidentiality requirements imposed on other recipients. This should not raise concerns since health plans already have access to patient information needed to pay claims, and are subject to other state and federal confidentiality rules and regulations.

Further, including a sunset provision gives an opportunity for LARA to assess whether the bill is working in the manner intended. 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 aid in the attempts by all to reduce health care costs and keep accessibility affordable.

Against:

There may be legitimate reasons why people seek 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 these patients 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" 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 identify patterns that are typical of abuse situations, not the occasional time that a different pain medication is needed or a vacationer forgets to pack medicine. For instance, an insurer found that in reviewing claims data, one physician wrote three prescriptions for a particular patient 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 or she is not receiving adequate pain relief from a 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 this internal review process still results in a denial, the patient can request the Department of Insurance and Financial Services (DIFS), the agency that regulates health insurance carriers, to do an independent, external review. There simply is no reason for a person in pain to be refused appropriate relief. Moreover, 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.

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