Individual State Agency Fiscal Note

Bill Number: 2105 E HB	Title: Workers' comp/prescriptions	Agency: 235-Department of Labor and Industries

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

FUND					
Total $					

Estimated Expenditures from:

	FY 2008	FY 2009	2007-09	2009-11	2011-13
Fund					
Medical Aid Account-State 609-1	12,800	0	12,800	0	0
Total $	12,800	0	12,800	0	0

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☐ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☒ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☒ Requires new rule making, complete Part V.

Legislative Contact:		Phone:	Date: 03/22/2007
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Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Briefly describe, by section number, the significant provisions of the bill, and any related workload or policy assumptions, that have revenue or expenditure impact on the responding agency.

See attached.

II. B - Cash receipts Impact

Briefly describe and quantify the cash receipts impact of the legislation on the responding agency, identifying the cash receipts provisions by section number and when appropriate the detail of the revenue sources. Briefly describe the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explain how workload assumptions translate into estimates. Distinguish between one time and ongoing functions.

None.

II. C - Expenditures

Briefly describe the agency expenditures necessary to implement this legislation (or savings resulting from this legislation), identifying by section number the provisions of the legislation that result in the expenditures (or savings). Briefly describe the factual basis of the assumptions and the method by which the expenditure impact is derived. Explain how workload assumptions translate into cost estimates. Distinguish between one time and ongoing functions.

See attached.

Part III: Expenditure Detail

III. A - Expenditures by Object Or Purpose

	FY 2008	FY 2009	2007-09	2009-11	2011-13
FTE Staff Years					
A-Salaries and Wages					
B-Employee Benefits					
C-Personal Service Contracts					
E-Goods and Services	12,800		12,800		
G-Travel					
J-Capital Outlays					
M-Inter Agency/Fund Transfers					
N-Grants, Benefits & Client Services					
P-Debt Service					
S-Interagency Reimbursements					
T-Intra-Agency Reimbursements					
Total:	$12,800	$0	$12,800	$0	$0

Part IV: Capital Budget Impact

None.

Part V: New Rule Making Required

Identify provisions of the measure that require the agency to adopt new administrative rules or repeal/revise existing rules.

See attached.

Part II: Explanation

This bill requires the department, on state fund claims **only,** where the worker files a claim for benefits**,** to pay according to the L&I fee schedule for any prescription drugs provided in relation to the initial visit. This is regardless of whether the claim is allowed or not.

The bill adds language stating that limitations in treatment duration are related to accepted claims.

II. A – Brief Description of What the Measure Does that Has Fiscal Impact

Section 1 - Requires that on state fund claims **only,** the department will pay, according to the fee schedule, for initial prescription drugs provided in relation to the initial visit, regardless whether the claim is allowed.

Section 2 –Requires that L&I, by December 1, 2009 make a report to the legislature on the implementation of the bill.

Section 3 –Makes the act effective January 1, 2008.

This bill differs from HB 2105 by adding Sections 2 and 3 requiring that L&I report on the bill's implementation to the legislature by December 1, 2009 and specifying that the effective date of the bill is January 1, 2008.

The fiscal impact decreases from HB 2105 due to a reevaluation of the assumptions used in HB 2105 which erroneously attributed increased claims to the bill.

II. B – Cash Receipt Impact

None

II. C – Expenditures

The fiscal impact is estimated in two parts. The first will be the increase in annual payments and a one time reserve for rejected prescription claims. The second will be the effect of removing the $2.75 pharmacy dispensing fee incentive payments on the accepted claims.

We will continue to pay the normal dispensing fee to pharmacies. However, there is a new $2.75 incentive fee program that will be implemented in April. These new incentive fees will be paid to pharmacies who are willing to submit the initial pharmacy bills to us and willing to wait until the claim is accepted before receiving payment. This program is designed to help us pay the initial pharmacy bills for claims--right now some of these bills are rejected because the claim has not been allowed at the time the bill is presented.

If EHB 2105 passes, the department intends to stop the $2.75 incentive dispensing fee payments upon implementation of the guaranteed payments. Under EHB 2105 the pharmacy will not have to wait for the claim to be accepted, and risk non-payment if the claim is rejected, because the department will pay for the initial prescriptions on almost all claims. Therefore, there will not be any need to provide incentives to the pharmacies. It is the savings on these $2.75 incentive dispensing fees that are shown in the analysis for accepted claims.

1) Rejected Claims

The following assumptions were used to estimate the cost of prescriptions resulting from an injured worker's first visit to the doctor:

- In Fiscal Year 2005 prescription payments on rejected claims were $37,485 at 2005 cost levels.

- This bill does not apply to the claims of self insurers, which were approximately 18.1 percent of the rejected claims. Therefore, the state fund portion of these amounts is approximately $31,000 (=$37,485 x (100% - 18.1%)).

- The department paid $433,344,000 in medical payments during Calendar Year 2005. The increase to this amount as a result of State Fund rejected claims now being paid will be 0.007 percent (=31,000 / 443,344,000).

Annual Claim Payments
For injuries occurring during 2005 the department incurred medical costs of $634,903,000 (at 2007 cost levels). Applying an exposure growth of 2 percent per year for 2.5 years and medical inflation of 5.5 percent per year for 0.5 years this cost increases to $685,226,000 (=$634,903,000 x $1.02^{2.5}$ x $1.055^{0.5}$) for injuries incurred during Fiscal Year 2008. Payment of rejected prescription claims would be an annual cost increase or **$48,000** (=685,226,000 x 0.007%).

One-Time Reserves (Unpaid Medical Costs On Existing Injuries)
As of 6/30/2006 it is estimated there are approximately 21,307 claims that are still unreported and that will ultimately be accepted on injuries that occurred prior to 6/30/2006. Assuming, based on 2005 data, that 88 percent of the reported claims are eventually accepted, we estimate that 24,212 (=21,307 / 88%) claims are unreported, and that 2,905 (=24,212 x 12%) of those claims will ultimately be rejected. Assuming 18.1 percent of these claims will be self insured claims, there are estimated to be 2,379 (=2,905 x (100% - 18.1%)) unreported claims on injuries that have occurred through 6/30/2006 that will ultimately be rejected for reasons other than self insurance.

As estimated above, in 2005 the department would have paid an additional $31,000 for the initial prescription costs for non self insured rejected claims. There were 13,676 (=16,703 – 3,027) such claims in 2005 for an average amount per claim of $2.27 (=31,000 / 13,676) at 2005 levels. With 2.5 years of medical inflation at 5.5 percent per year this is equivalent to $2.60 (=2.27 x $1.055^{2.5}$) per claim at Fiscal Year 2008 levels. Therefore the reserve for unpaid medical payments would increase by approximately **$6,000** (=2.60 x 2,379) when the department paid for the initial prescription on rejected

state fund claims. This amount is shown as a one-time accrued liability reserve in Fiscal Year 2008.

2) Accepted Claims

This bill will increase the initial pharmacy reimbursements on claims that were accepted after an initial pharmacy bill was submitted but rejected because L&I had not received a notice of the claim being filed. Currently many of these pharmacy bills are never resubmitted and we assume the worker's private health insurance pays the cost. We expect that the new pharmacy dispensing fee incentive program will also result in reimbursement for the initial prescriptions for these claims. Therefore this bill has no expected impact on the prescription costs or regular dispensing fees on claims that are eventually accepted. However the dispensing fee incentive payment of $2.75 will be discontinued if this bill takes effect, resulting in the savings estimated below.

Annual Claim Payments
It is estimated that approximately 25,500 dispensing fee incentive payments would have been paid in 2005 if the program had been in place. Assuming 2.5 years of medical inflation at 5.5% per annum, the $2.75 incentive fee payments are equivalent to $2.41 (= $2.75 / 1.055^2.5) at 2005 cost levels. Therefore at 2005 cost levels, the savings from discontinuing the incentive fees are approximately $61,000 (=25,500 x $2.41), or 0.014% (=61,000 / $443,344,000) of the calendar year 2005 medical payments. As calculated above the Fiscal Year 2008 incurred losses are estimated to be $685,226,000, so the annual savings are estimated to be **$96,000** (=0.014% x $685,226,000).

One-Time Reserves (Unpaid Medical Costs On Existing Injuries)
There were 122,505 allowed claims filed in calendar year 2005. As calculated above, the discontinuation of the incentive fee payments is estimated to reduce the medical payments by $61,000 at 2005 levels, or $0.50 (=$61,000 / 122,505) per allowed claim at 2005 levels. Assuming 2.5 years of medical inflation at 5.5% per annum, this is equivalent to $0.57 (= $0.50 x 1.055^2.5) per allowed claim at fiscal year 2008 levels. As of 6/30/2006 it is estimated there are approximately 21,307 claims that are still unreported and that will ultimately be accepted on injuries that occurred prior to 6/30/2006. Therefore, discontinuing the incentive fees is estimated to result in a reserve reduction of approximately $12,000 (=21,307 x $0.57) at 6/30/2007.

Totals
Note that these estimates assume no change in claimant or provider behavior. There is a risk that the frequency of invalid claims would increase, as the department would automatically pay for the initial prescriptions. We assume that the frequency of rejected claims will double. Therefore, the annual costs will be a net **$0** (=48,000 x 2 – 96,000) and the one-time reserve increase will be a net **$0** (=6,000 x 2 – 12,000). The additional costs for rejected claims are anticipated to be offset by the reduction in the incentive fee payments.

IT Systems Changes Needed

The department will require logic modifications to the Point of Sale (POS) system and Medical Payment System (MIPS) system to determine if the submitted bills meet the initial visit criteria. This criterion includes pharmacy billings that are received prior to the report of accident (ROA) as well as both pharmacy and non-pharmacy billing received after the ROA. If the billing is identified as related to the initial visit, then system edits controlling eligibility that would normally deny the billing will be overridden allowing the bill to be paid. This override will be automated.

Making these system modifications will take 160 contract programming hours at $80 an hour = $12,800

Summary of All Cost Estimates

	FY 08	FY 09	FY 10	FY 11	FY 12
Annual prescription cost	$0	$0	$0	$0	$0
One-time Accrued Reserves	$0				
IT System Changes	$12,800				
Total All Funds	$12,800	$0	$0	$0	$0

Part IV: Capital Budget Impact

None

Part V: New Rule Making Required

Rule making would be required to WAC 296-20-124 Medical Aid Rules for Rejected and Closed claims. – No payment will be made for medication on rejected claims.