BILL ANALYSIS

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H.B. 1358
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State Affiars
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Current law requires certain specific procedures when auditing a provider that is a pharmacist or pharmacy. The majority of pharmacy claims are filed and adjudicated electronically, allowing a pharmacist or pharmacy and the entity processing the pharmacy claim to almost instantly exchange feedback regarding the claim's acceptance or rejection. Legislation is necessary to address the current environment of the pharmacy claims process and the auditing transactions that are related to the post-adjudication evaluation of these claims. Frequent, unreasonable, abusive, and unfair audits of pharmacists and pharmacies are detracting from these providers' ability to efficiently and effectively operate their business and focus on patient care. This legislation is necessary to ensure that pharmacists and pharmacies have adequate time and resources to fully maintain patient care while simultaneously accommodating the need for reasonable audits. The bill establishes reasonable procedures for the issuers of health plans and those entities that they contract with to perform the audit of pharmacy claims, namely pharmacy benefit managers, to abide by when conducting an audit of a pharmacist or pharmacy.

H.B. 1358 amends current law relating to procedures for certain audits of pharmacists and pharmacies.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Section 1369.269, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 1369, Insurance Code, by adding Subchapter F, as follows:

SUBCHAPTER F. AUDITS OF PHARMACISTS AND PHARMACIES

Sec. 1369.251. DEFINITIONS. Defines "desk audit," "extrapolation," "health benefit plan," "on-site audit," and "pharmacy benefit manager" in this subchapter.

Sec. 1369.252. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER. Provides that this subchapter does not apply to an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under:

(1) the state Medicaid program;

(2) the federal Medicare program;

(3) the state child health plan or health benefits plan for children under Chapter 62 (Child Health Plan for Certain Low-Income Children) or 63 (Health Benefits Plan for Certain Children), Health and Safety Code;

(4) the TRICARE military health system;

(5) a workers' compensation insurance policy or other form of providing medical benefits under Title 5 (Workers' Compensation), Labor Code; or

(6) a self-funded health benefit plan as defined by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

Sec. 1369.253. CONFLICT WITH OTHER LAWS. Provides that if there is a conflict between this subchapter and a provision of Chapter 843 (Health Maintenance Organizations) or 1301 (Preferred Provider Benefit Plans) related to a pharmacy benefit manager, this subchapter prevails.

Sec. 1369.254. AUDIT OF PHARMACIST OR PHARMACY; NOTICE; GENERAL PROVISIONS. (a) Requires a health benefit plan issuer or pharmacy benefit manager that performs an on-site audit under this subchapter of a pharmacist or pharmacy, except as provided by Subsection (d), to provide the pharmacist or pharmacy reasonable notice of the audit and accommodate the pharmacist's or pharmacy's schedule to the greatest extent possible. Requires that the notice required under this subsection be in writing and be sent by a means that allows tracking of delivery to the pharmacist or pharmacy not later than the 14th day before the date on which the on-site audit is scheduled to occur.

(b) Authorizes the pharmacist or pharmacy, not later than the seventh day after the date a pharmacist or pharmacy receives notice under Subsection (a), to request that an on-site audit be rescheduled to a mutually convenient date. Requires that the request be reasonably granted.

(c) Prohibits a health benefit plan issuer or pharmacy benefit manager, unless the pharmacist or pharmacy consents in writing, from scheduling or having an on-site audit conducted:

(1) except as provided by Subsection (d), before the 14th day after the date the pharmacist or pharmacy receives notice under Subsection (a), if applicable;

(2) more than twice annually in connection with a particular payor; or

(3) during the first five calendar days of January and December.

(d) Provides that a health benefit plan issuer or pharmacy benefit manager is not required to provide notice before conducting an audit if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, the plan issuer or pharmacy benefit manager suspects the pharmacist or pharmacy subject to the audit committed fraud or made an intentional misrepresentation related to the pharmacy business. Prohibits the pharmacist or pharmacy from requesting that the audit be rescheduled under Subsection (b).

(e) Authorizes a pharmacist or pharmacy to be required to submit documents in response to a desk audit not earlier than the 20th day after the date the health benefit plan issuer or pharmacy benefit manager requests the documents.

(f) Requires that a contract between a pharmacist or pharmacy and a health benefit plan issuer or pharmacy benefit manager state detailed audit procedures. Requires the plan issuer or pharmacy benefit manager, if a health benefit plan issuer or pharmacy benefit manager proposes a change to the audit procedures for an on-site audit or a desk audit, to notify the pharmacist or pharmacy in writing of a change in an audit procedure not later than the 60th day before the effective date of the change.

(g) Requires that the list of the claims subject to an on-site audit be provided in the notice under Subsection (a) to the pharmacist or pharmacy and identify the claims only by the prescription numbers or a date range for prescriptions subject

to the audit. Authorizes the last two digits of the prescription numbers provided to be omitted.

(h) Prohibits the sample size, if the health benefit plan issuer or pharmacy benefit manager in an on-site audit or a desk audit applies random sampling procedures to select claims for audit, from being greater than 300 individual prescription claims.

Sec. 1369.255. COMPLETION OF AUDIT. Requires that an audit of a claim under Section 1369.254 be completed on or before the one-year anniversary of the date the claim is received by the health benefit plan issuer or pharmacy benefit manager.

Sec. 1369.256. AUDIT REQUIRING PROFESSIONAL JUDGMENT. Requires a health benefit plan issuer or pharmacy benefit manager that conducts an on-site audit or a desk audit involving a pharmacist's clinical or professional judgment to conduct the audit in consultation with a licensed pharmacist.

Sec. 1369.257. ACCESS TO PHARMACY AREA. Prohibits a health benefit plan issuer or pharmacy benefit manager that conducts an on-site audit from entering the pharmacy area unless escorted by an individual authorized by the pharmacist or pharmacy.

Sec. 1369.258. VALIDATION USING CERTAIN RECORDS AUTHORIZED. Authorizes a pharmacist or pharmacy that is being audited to:

(1) validate a prescription, refill of a prescription, or change in a prescription with a prescription that complies with applicable federal laws and regulations and state laws and rules adopted under Section 554.051 (Rulemaking: General Powers and Duties), Occupations Code; and

(2) validate the delivery of a prescription with a written record of a hospital, physician, or other authorized practitioner of the healing arts.

Sec. 1369.259. CALCULATION OF RECOUPMENT; USE OF EXTRAPOLATION PROHIBITED. (a) Prohibits a health benefit plan issuer or pharmacy benefit manager from calculating the amount of a recoupment based on:

(1) an absence of documentation the pharmacist or pharmacy is not required by applicable federal laws and regulations and state laws and rules to maintain; or

(2) an error that does not result in actual financial harm to the patient or enrollee, the health benefit plan issuer, or the pharmacy benefit manager.

(b) Prohibits a health benefit plan issuer or pharmacy benefit manager from requiring extrapolation audits as a condition of participation in a contract, network, or program for a pharmacist or pharmacy.

(c) Prohibits a health benefit plan issuer or pharmacy benefit manager from using extrapolation to complete an on-site audit or a desk audit of a pharmacist or pharmacy. Requires that the amount of a recoupment, notwithstanding Subsection (a)(2), be based on the actual overpayment or underpayment and may not be based on an extrapolation.

(d) Prohibits a health benefit plan issuer or pharmacy benefit manager from including a dispensing fee amount in the calculation of an overpayment unless:

(1) the fee was a duplicate charge;

(2) the prescription for which the fee was charged was not dispensed, or was dispensed without the prescriber's authorization, to the wrong patient, or with the wrong instructions; or

(3) the wrong drug was dispensed.

Sec. 1369.260. CLERICAL OR RECORDKEEPING ERROR; FRAUD ALLEGATION. (a) Provides that an unintentional clerical or recordkeeping error, such as a typographical error, scrivener's error, or computer error, found during an on-site audit or a desk audit:

(1) is not prima facie evidence of fraud or intentional misrepresentation; and

(2) is prohibited from being the basis of a recoupment unless the error results in actual financial harm to a patient or enrollee, health benefit plan issuer, or pharmacy benefit manager.

(b) Requires the health benefit plan issuer or pharmacy benefit manager, if the health benefit plan issuer or pharmacy benefit manager alleges that the pharmacist or pharmacy committed fraud or intentional misrepresentation described by Subsection (a), to state the allegation in the final audit report required by Section 1369.264.

(c) Authorizes a pharmacist or pharmacy, after an audit is initiated, to resubmit a claim described by Subsection (a) if the deadline for submission of a claim under Section 843.337 (Time for Submission of Claim; Duplicate Claims; Acknowledgement of Receipt of Claim) or 1301.102 (Submission of Claim) has not expired.

Sec. 1369.261. ACCESS TO PREVIOUS AUDIT REPORTS; UNIFORM AUDIT STANDARDS. (a) Authorizes a health benefit plan issuer or pharmacy benefit manager, except as provided by Subsection (b), to have access to an audit report of a pharmacist or pharmacy only if the report was prepared in connection with an audit conducted by the health benefit plan issuer or pharmacy benefit manager.

(b) Authorizes a health benefit plan issuer or pharmacy benefit manager to have access to audit reports other than the reports described by Subsection (a) if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, the plan issuer or the pharmacy benefit manager suspects the audited pharmacist or pharmacy committed fraud or made an intentional misrepresentation related to the pharmacy business.

(c) Requires an auditor to conduct an on-site audit or a desk audit of similarly situated pharmacists or pharmacies under the same audit standards.

Sec. 1369.262. COMPENSATION OF AUDITOR. Prohibits an individual performing an on-site audit or a desk audit from directly or indirectly receiving compensation based on a percentage of the amount recovered as a result of the audit.

Sec. 1369.263. CONCLUSION OF AUDIT; SUMMARY; PRELIMINARY AUDIT REPORT. (a) Requires the health benefit plan issuer or pharmacy benefit manager, at the conclusion of an on-site audit or a desk audit, to:

(1) provide to the pharmacist or pharmacy a summary of the audit findings; and

(2) allow the pharmacist or pharmacy to respond to questions and alleged discrepancies, if any, and comment on and clarify the findings.

(b) Requires the health benefit plan issuer or pharmacy benefit manager, not later than the 60th day after the date the audit is concluded, to send by a means that allows tracking of delivery to the pharmacist or pharmacy a preliminary audit report stating the results of the audit and a list identifying documentation, if any, required to resolve discrepancies, if any, found as a result of the audit.

(c) Authorizes the pharmacist or pharmacy to, by providing documentation or otherwise, challenge a result or remedy a discrepancy stated in the preliminary audit report not later than the 30th day after the date the pharmacist or pharmacy receives the report.

(d) Authorizes the pharmacist or pharmacy to request an extension to provide documentation supporting a challenge. Requires that the request be reasonably granted. Provides that a health benefit plan issuer or pharmacy benefit manager that grants an extension is not subject to the deadline to send the final audit report under Section 1369.264.

Sec. 1369.264. FINAL AUDIT REPORT. Requires the health benefit plan issuer or pharmacy benefit manager, not later than the 120th day after the date the pharmacist or pharmacy receives a preliminary audit report under Section 1369.263, to send by a means that allows tracking of delivery to the pharmacist or pharmacy a final audit report that states:

(1) the audit results after review of the documentation submitted by the pharmacist or pharmacy in response to the preliminary audit report; and

(2) the audit results, including a description of all alleged discrepancies and explanations for and the amount of recoupments claimed after consideration of the pharmacist's or pharmacy's response to the preliminary audit report.

Sec. 1369.265. CERTAIN AUDITS EXEMPT FROM DEADLINES. Provides that a health benefit plan issuer or pharmacy benefit manager is not subject to the deadlines for sending a report under Sections 1369.263 and 1369.264 if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, the plan issuer or pharmacy benefit manager suspects the audited pharmacist or pharmacy committed fraud or made an intentional misrepresentation related to the pharmacy business.

Sec. 1369.266. RECOUPMENT AND INTEREST CHARGED AFTER AUDIT. (a) Provides that if an audit under this subchapter is conducted, the health benefit plan issuer or pharmacy benefit manager:

(1) is authorized to recoup from the pharmacist or pharmacy an amount based only on a final audit report; and

(2) is prohibited from accruing or assessing interest on an amount due until the date the pharmacist or pharmacy receives the final audit report under Section 1369.264.

(b) Provides that the limitations on recoupment and interest accrual or assessment under Subsection (a) do not apply to a health benefit plan issuer or pharmacy benefit manager that, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, including patient referrals, anonymous reports, or postings on Internet websites, suspects the audited pharmacist or pharmacy committed fraud or made an intentional misrepresentation related to the pharmacy business.

Sec. 1369.267. WAIVER PROHIBITED. Prohibits the provisions of this subchapter from being waived, voided, or nullified by contract.

Sec. 1369.268. REMEDIES NOT EXCLUSIVE. Prohibits this subchapter from being construed to waive a remedy at law available to a pharmacist or pharmacy.

Sec. 1369.269. ENFORCEMENT; RULES. Authorizes the commissioner of insurance to enforce this subchapter and adopt and enforce reasonable rules necessary to accomplish the purposes of this subchapter.

Sec. 1369.270. LEGISLATIVE DECLARATION. Provides that it is the intent of the legislature, except as provided by Section 1369.252, that the requirements contained in this subchapter regarding the audit of claims to providers who are pharmacists or pharmacies apply to all health benefit plan issuers and pharmacy benefit managers unless otherwise prohibited by federal law.

SECTION 2. Amends Section 1301.001, Insurance Code, as amended by Chapters 288 (H.B. 1772) and 798 (H.B. 2292), Acts of the 82nd Legislature, Regular Session, 2011, by reenacting and amending Subdivision (1) and reenacting Subdivision (1-a), to delete existing text defining "extrapolation," and to make no further change to these subdivisions.

SECTION 3. Repealers: Sections 843.002(9-a) (defining "extrapolation"), 843.3401 (Audit of Pharmacist or Pharmacy), and 1301.1041 (Audit of Pharmacist or Pharmacy).

SECTION 4. Provides that the changes in law made by this Act apply only to contracts between a pharmacist or pharmacy and a health benefit plan issuer or pharmacy benefit manager executed or renewed, and audits conducted under those contracts, on or after the effective date of this Act. Provides that contracts entered into or renewed, and audits conducted under those contracts, before the effective date of this Act are governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 5. Effective date: September 1, 2013.