BILL ANALYSIS

C.S.H.B. 1358
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Current law prescribes specific procedures for auditing a provider that is a pharmacist or pharmacy. Interested parties report that 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. Such parties assert that the current environment of the pharmacy claims process and the auditing transactions related to the post-adjudication evaluation of such claims needs to be addressed, as frequent and unreasonable audits of pharmacists and pharmacies are detracting from these providers' ability to efficiently and effectively operate their business and focus on patient care.

C.S.H.B. 1358 seeks to ensure that pharmacists and pharmacies have adequate time and resources to fully maintain patient care while simultaneously accommodating the need for reasonable audits by establishing practical procedures for the issuers of health plans and those entities with which they contract to perform the audit of pharmacy claims.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to commissioner of insurance in SECTION 1 of this bill.

ANALYSIS

C.S.H.B. 1358 amends the Insurance Code to revise procedures for certain audits of certain pharmacists or pharmacies. The bill sets out the health benefit plans to which the bill applies and exempts from its provisions an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under the state Medicaid program, the federal Medicare program, the state child health plan or health benefits plan for children, the TRICARE military health system, certain workers' compensation insurance policies, and a self-funded health benefit plan. The bill establishes that its provisions prevail in the event of a conflict with a provision of the Texas Health Maintenance Organization Act or with statutory provisions governing preferred provider benefit plans.

C.S.H.B. 1358 requires a health benefit plan issuer or pharmacy benefit manager performing an on-site audit of a pharmacist or pharmacy to provide the pharmacist or pharmacy reasonable notice of the audit in writing and to accommodate the pharmacist's or pharmacy's schedule to the greatest extent possible. The bill requires the notice to 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. The bill authorizes the pharmacist or pharmacy, not later than the seventh day after the date the pharmacist or pharmacy receives the notice, to request that an on-site audit be rescheduled to a mutually convenient date and requires such a request to be reasonably granted. The bill 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 before the 14th day after the date the pharmacist or pharmacy receives the

written notice; more than twice annually in connection with a particular payor; or during the first five calendar days of January and December.

C.S.H.B. 1358 does not require such a health benefit plan issuer or pharmacy benefit manager 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, 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. The bill prohibits the pharmacist or pharmacy from requesting that the audit be rescheduled in such an instance.

C.S.H.B. 1358 specifies that a pharmacist or pharmacy may 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. The bill requires a contract between a pharmacist or pharmacy and a health benefit plan issuer or pharmacy benefit manager to state detailed audit procedures and, 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, requires the plan issuer or pharmacy benefit manager to notify the pharmacist or pharmacy in writing of the change not later than the 60th day before the effective date of the change. The bill requires the list of the claims subject to an on-site audit to be provided in the notice to the pharmacist or pharmacy and to identify the claims only by the prescription numbers or a date range for prescriptions subject to the audit and authorizes omission of the last two digits of the provided prescription numbers. The bill prohibits the sample size used in an on-site or desk audit where the health benefit plan issuer or pharmacy benefit manager applies random sampling procedures to select claims for audit from exceeding 300 individual prescription claims. The bill requires an audit of a claim to 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.

C.S.H.B. 1358 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. The bill 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. The bill authorizes the validation of prescriptions using certain records by a pharmacist or pharmacy that is being audited.

C.S.H.B. 1358 prohibits a health benefit plan issuer or pharmacy benefit manager from calculating the amount of a recoupment based on an absence of documentation that the pharmacist or pharmacy is not required by applicable federal laws and regulations and state laws and rules to maintain or based on an error that does not result in actual financial harm to the patient or enrollee, the health benefit plan issuer, or to the pharmacy benefit manager. The bill 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 and 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. The bill requires the amount of a recoupment to be based on the actual overpayment or underpayment and prohibits the amount from being based on an extrapolation. The bill prohibits a health benefit plan issuer or pharmacy benefit manager from including a dispensing fee amount in the calculation of an overpayment unless the fee was a duplicate charge; unless the prescription for which the fee was charged either was not dispensed or was dispensed without the prescriber's authorization, to the wrong patient, or with the wrong instructions; or unless the wrong drug was dispensed.

C.S.H.B. 1358 establishes that an unintentional clerical or recordkeeping error found during an on-site or desk audit is not prima facie evidence of fraud or intentional misrepresentation and prohibits such an error 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. The bill requires a health benefit plan issuer or pharmacy benefit manager alleging that the pharmacist or pharmacy committed fraud or intentional misrepresentation to state the allegation in the final audit report. The bill authorizes a pharmacist or pharmacy, after an audit is initiated, to resubmit a claim containing an unintentional error if the deadline for submission of a claim under provisions of the Texas Health Maintenance Organization Act or provisions governing preferred provider benefit plans has not expired.

C.S.H.B. 1358 restricts access of a health benefit plan issuer or pharmacy benefit manager to an audit report of a pharmacist or pharmacy to a report prepared in connection with an audit conducted by the health benefit plan issuer or pharmacy benefit manager. The bill authorizes a health benefit plan issuer or pharmacy benefit manager to have access to audit reports other than those reports if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, 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. The bill requires an auditor to conduct an on-site audit or a desk audit of similarly situated pharmacists or pharmacies under the same audit standards. The bill prohibits an individual performing an on-site or desk audit from directly or indirectly receiving compensation based on a percentage of the amount recovered as a result of the audit

C.S.H.B. 1358 requires the health benefit plan issuer or pharmacy benefit manager at the conclusion of an on-site or desk audit to provide to the pharmacist or pharmacy a summary of the audit findings and to allow the pharmacist or pharmacy to respond to questions and alleged discrepancies, if any, and comment on and clarify the findings. The bill 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 any documentation required to resolve any discrepancies found as a result of the audit. The bill authorizes the pharmacist or pharmacy to 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. The bill authorizes the pharmacist or pharmacy to request an extension to provide documentation supporting the challenge and requires the request to be reasonably granted. The bill does not subject a health benefit plan issuer or pharmacy benefit manager granting such an extension to the deadline for sending the final audit report.

C.S.H.B. 1358 requires the auditor, not later than the 120th day after the date the pharmacist or pharmacy receives the preliminary audit report, to send by a means that allows tracking of delivery to the pharmacist or pharmacy a final audit report stating the audit results after review of the pharmacist's or pharmacy's documentation submitted in response to the preliminary audit report and stating 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. The bill does not subject a health benefit plan issuer or pharmacy benefit manager to the deadlines for sending a report if, after reviewing claims data, written or oral statements of pharmacy staff, wholesalers, or others, or other investigative information, 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.

C.S.H.B. 1358 authorizes the health benefit plan issuer or pharmacy benefit manager to recoup from the pharmacist or pharmacy an amount based only on a final audit report and prohibits those entities from accruing or assessing interest on an amount due until the date the pharmacist or pharmacy receives the final audit report. The bill does not apply limitations on recoupment and interest accrual or assessment 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, suspects the audited pharmacist or pharmacy

committed fraud or made an intentional misrepresentation related to the pharmacy business.

C.S.H.B. 1358 prohibits the bill's provisions from being waived, voided, or nullified by contract or from being construed to waive a remedy at law available to a pharmacist or pharmacy. The bill authorizes the commissioner of insurance to enforce the bill's provisions and to adopt and enforce reasonable rules necessary to implement provisions regulating the audits of pharmacists and pharmacies.

C.S.H.B. 1358 repeals provisions governing audits of pharmacists or pharmacies made obsolete by the bill and repeals a redundant definition for "extrapolation," which the bill defines as a mathematical process or technique used by a health benefit plan issuer or pharmacy benefit manager that administers pharmacy claims for a health benefit plan issuer in the audit of a pharmacy or pharmacist to estimate audit results or findings for a larger batch or group of claims not reviewed by the plan issuer or pharmacy benefit manager.

C.S.H.B. 1358 reenacts and 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, to remove a redundant definition for "extrapolation."

C.S.H.B. 1358 repeals the following provisions of the Insurance Code:

- Section 843.002(9-a)
- Section 843.3401
- Section 1301.1041

EFFECTIVE DATE

September 1, 2013.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 1358 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and highlighted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1.	SECTION 1. *(part; see below)*
Chapter 843, Insurance Code, is amended by adding Subchapter O to read as follows: SUBCHAPTER O. AUDITS OF PHARMACISTS AND PHARMACIES Sec. 843.501. DEFINITIONS. In this subchapter: (1) "Auditor" means a health maintenance organization or a pharmacy benefit manager that provides pharmacy-related services for health maintenance organization enrollees that is performing an on-site audit or a desk audit of a pharmacist or pharmacy or another entity performing an on-site audit or a desk audit of a pharmacist or pharmacy on behalf of the organization or manager.	Chapter 1369, Insurance Code, is amended by adding Subchapter F to read as follows: SUBCHAPTER F. AUDITS OF PHARMACISTS AND PHARMACIES Sec. 1369.251. DEFINITIONS. In this subchapter:

(2) "Desk audit" means an audit conducted by an auditor at a location other than the location of the pharmacist or pharmacy. The term includes an audit performed at the auditor's offices during which the pharmacist or pharmacy provides requested documents for auditor review by hard copy or by microfiche, disk, or other electronic media.	(1) "Desk audit" means an audit conducted by a health benefit plan issuer or pharmacy benefit manager at a location other than the location of the pharmacist or pharmacy. The term includes an audit performed at the offices of the plan issuer or pharmacy benefit manager during which the pharmacist or pharmacy provides requested documents for review by hard copy or by microfiche, disk, or other electronic media. The term does not include a review conducted not later than the third business day after the date a claim is adjudicated provided recoupment is not demanded.
No equivalent provision.	(2) "Extrapolation" means a mathematical process or technique used by a health benefit plan issuer or pharmacy benefit manager that administers pharmacy claims for a health benefit plan issuer in the audit of a pharmacy or pharmacist to estimate audit results or findings for a larger batch or group of claims not reviewed by the plan issuer or pharmacy benefit manager.
No equivalent provision.	(3) "Health benefit plan" means a plan that provides benefits for medical, surgical, or other treatment expenses incurred as a result of a health condition, a mental health condition, an accident, sickness, or substance abuse, including: (A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is issued by: (i) an insurance company; (ii) a group hospital service corporation operating under Chapter 842; (iii) a health maintenance organization operating under Chapter 843; (iv) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; (v) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; (vi) a stipulated premium company operating under Chapter 884; (vii) a fraternal benefit society operating under Chapter 885; (viii) a Lloyd's plan operating under Chapter 941; or (ix) an exchange operating under Chapter

	942; (B) a small employer health benefit plan written under Chapter 1501; or (C) a health benefit plan issued under Chapter 1551, 1575, 1579, or 1601.
(3) "On-site audit" means an audit that is conducted at: (A) the location of the pharmacist or pharmacy; or (B) another location at which the records under review are stored.	(4) "On-site audit" means an audit that is conducted at: (A) the location of the pharmacist or pharmacy; or (B) another location at which the records under review are stored.
No equivalent provision.	(5) "Pharmacy benefit manager" has the meaning assigned by Section 4151.151.
No equivalent provision.	Sec. 1369.252. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER. 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 or 63, 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, 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.).
No equivalent provision.	Sec. 1369.253. CONFLICT WITH OTHER LAWS. If there is a conflict between this subchapter and a provision of Chapter 843 or 1301 related to a pharmacy benefit manager, this subchapter prevails.
(See SECTION 4 below for Sec. 1301.252, Insurance Code, Audit Of Pharmacist Or Pharmacy; Notice; General Provisions.)	*(See SECTION 1 (part) below for Sec. 1369.254, Insurance Code, Audit Of Pharmacist Or Pharmacy; Notice; General Provisions.)*
No equivalent provision.	Sec. 1369.255. COMPLETION OF AUDIT. An audit of a claim under Section 1369.254 must 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. 843.503. AUDIT REQUIRING	Sec. 1369.256. AUDIT REQUIRING

PROFESSIONAL JUDGMENT.

An on-site audit or a desk audit involving a pharmacist's clinical or professional judgment must be conducted in consultation with a pharmacist licensed by the Texas State Board of Pharmacy.

Sec. 843.504. ACCESS TO PHARMACY AREA.

An auditor may not enter the pharmacy area unless escorted by the pharmacist-in-charge as defined by Section 551.003(29), Occupations Code.

Sec. 843.505. VALIDATION USING CERTAIN RECORDS AUTHORIZED. A pharmacist or pharmacy that is being audited may:

(1) validate a prescription, refill, or change in a prescription with a prescription that complies with rules adopted under Section 554.051, 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. 843.506. CALCULATION OF RECOUPMENT; USE OF EXTRAPOLATION PROHIBITED.

(a) An auditor may not calculate the amount of a recoupment based on:

(1) an absence of documentation the pharmacist or pharmacy is not required by law to maintain; or

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

(b) A health maintenance organization or pharmacy benefit manager may not require extrapolation audits as a condition of participation in a contract, network, or program for a pharmacist or pharmacy.

(c) An auditor may not use extrapolation to complete an on-site audit or a desk audit of a pharmacist or pharmacy. Notwithstanding Subsection (a)(2), the amount of a recoupment must be based on the actual

PROFESSIONAL JUDGMENT. 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 must conduct the audit in consultation with a licensed pharmacist.

Sec. 1369.257. ACCESS TO PHARMACY AREA. A health benefit plan issuer or pharmacy benefit manager that conducts an on-site audit may not enter the pharmacy area unless escorted by an individual authorized by the pharmacist or pharmacy.

Sec. 1369.258. VALIDATION USING CERTAIN RECORDS AUTHORIZED. A pharmacist or pharmacy that is being audited may:

(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, 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) A health benefit plan issuer or pharmacy benefit manager may not calculate 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) A health benefit plan issuer or pharmacy benefit manager may not require extrapolation audits as a condition of participation in a contract, network, or program for a pharmacist or pharmacy.

(c) A health benefit plan issuer or pharmacy benefit manager may not use extrapolation to complete an on-site audit or a desk audit of a pharmacist or pharmacy. Notwithstanding Subsection (a)(2), the

overpayment or underpayment and may not be based on an extrapolation.	amount of a recoupment must be based on the actual overpayment or underpayment and may not be based on an extrapolation.
(d) An auditor may not include a dispensing fee amount in the calculation of an overpayment unless:	(d) A health benefit plan issuer or pharmacy benefit manager may not include a dispensing fee amount in the calculation of an overpayment unless:
(1) the fee was a duplicate charge; or	(1) the fee was a duplicate charge;
(2) the prescription for which the fee was charged:	(2) the prescription for which the fee was charged:
(A) was not dispensed; or	(A) was not dispensed; or
(B) was dispensed without the prescriber's authorization.	(B) was dispensed:
	(i) without the prescriber's authorization;
	(ii) to the wrong patient; or
	(iii) with the wrong instructions; or
	(3) the wrong drug was dispensed.
Sec. 843.507. CLERICAL OR RECORDKEEPING ERROR.	Sec. 1369.260. CLERICAL OR RECORDKEEPING ERROR; FRAUD ALLEGATION. (a) 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:
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
(1) is not prima facie evidence of fraud; and	(2) may not be 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.
(2) may not be the basis of a recoupment from a pharmacist or pharmacy without proof of intent to commit fraud.	
	(b) 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), the health benefit plan issuer or pharmacy benefit manager must state the allegation in the final audit report required by Section 1369.264.
	(c) After an audit is initiated, a pharmacist or pharmacy may resubmit a claim described by Subsection (a) if the deadline for submission of a claim under Section 843.337 or 1301.102 has not expired.
No equivalent provision.	Sec. 1369.261. ACCESS TO PREVIOUS AUDIT REPORTS; UNIFORM AUDIT STANDARDS. (a) Except as provided by Subsection (b), a health benefit plan issuer or pharmacy benefit manager may 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) A health benefit plan issuer or pharmacy benefit manager may 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.
Sec. 843.508. UNIFORM STANDARDS REQUIRED. An auditor must conduct an on-site audit or a desk audit of similarly situated pharmacists or pharmacies under the same audit standards.	(c) An auditor must conduct an on-site audit or a desk audit of similarly situated pharmacists or pharmacies under the same audit standards.
Sec. 843.509. ACCESS TO PREVIOUS AUDIT REPORTS. An auditor may have access to audit reports of a pharmacist or pharmacy that were prepared only for the health maintenance organization or pharmacy benefit manager for which the auditor is conducting an audit.	No equivalent provision.
Sec. 843.510. COMPENSATION OF AUDITOR. A health maintenance organization, pharmacy benefit manager, or other auditor may not base compensation paid to the individual or entity performing an on-site audit or a desk audit on a percentage of the amount the health maintenance organization, pharmacy benefit manager, or other auditor is entitled to recover as the result of the audit.	Sec. 1369.262. COMPENSATION OF AUDITOR. An individual performing an on-site audit or a desk audit may not directly or indirectly receive compensation based on a percentage of the amount recovered as a result of the audit.
Sec. 843.511. CONCLUSION OF AUDIT; SUMMARY; PRELIMINARY AUDIT REPORT. (a) At the conclusion of an on-site audit or a desk audit, the auditor shall: (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) Not later than the 30th day after the date the audit is concluded, the auditor shall send by certified mail, return receipt requested, to	Sec. 1369.263. CONCLUSION OF AUDIT; SUMMARY; PRELIMINARY AUDIT REPORT. (a) At the conclusion of an on-site audit or a desk audit, the health benefit plan issuer or pharmacy benefit manager shall: (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) Not later than the 60th day after the date the audit is concluded, the health benefit plan issuer or pharmacy benefit manager

the pharmacist or pharmacy a preliminary audit report stating the results of the audit, including explanations for and the amount of recoupment claimed.	shall 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) The pharmacist or pharmacy may, 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.	(c) The pharmacist or pharmacy may, 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) The pharmacist or pharmacy may request an extension to provide documentation supporting a challenge. The request shall be reasonably granted. 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. 843.512. FINAL AUDIT REPORT. Not later than the 90th day after the date the pharmacist or pharmacy receives a preliminary audit report under Section 843.511, the auditor shall send by certified mail, return receipt requested, to the pharmacist or pharmacy a final audit report that states:	Sec. 1369.264. FINAL AUDIT REPORT. Not later than the 120th day after the date the pharmacist or pharmacy receives a preliminary audit report under Section 1369.263, the health benefit plan issuer or pharmacy benefit manager shall send by a means that allows tracking of delivery to the pharmacist or pharmacy a final audit report that states:
(1) a summary of the pharmacist's or pharmacy's explanation and documentation, if any, submitted in response to the preliminary audit report; and	(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.	(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.
No equivalent provision.	Sec. 1369.265. CERTAIN AUDITS EXEMPT FROM DEADLINES. 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. 843.513. APPEAL OF FINAL AUDIT REPORT; AUDIT OUTCOME REPORT. (a) An auditor shall establish a process for a pharmacist or pharmacy to wholly or partly appeal a final audit report. (b) An auditor shall use the National Council for Prescription Drug Programs' data interchange standards for pharmacy claim submission to evaluate audited claims and appeals under the process established under Subsection (a). (c) On the date a final audit report is found wholly or partly unsubstantiated after an appeal under the process established under Subsection (a), the auditor shall reject the report, wholly or partly, as applicable. (d) Not later than the 30th day after the date an appeal under the process established under Subsection (a) is concluded, the auditor shall send by certified mail, return receipt requested, to the pharmacist or pharmacy an audit outcome report that includes: (1) a summary of the pharmacist's or pharmacy's arguments and documentation, if any, submitted in response to the final audit report; and (2) the audit results and recoupments claimed after consideration of the pharmacist's or pharmacy's response to the final audit report.	No equivalent provision.
Sec. 843.514. RECOUPMENT AND INTEREST CHARGED AFTER AUDIT. If an audit under this subchapter is conducted, the health maintenance organization or pharmacy benefit manager: (1) may recoup from the pharmacist or pharmacy an amount based only on a final audit report or, if appealed under the process established under Section 843.513(a), an audit outcome report; and (2) may not accrue or assess interest on an amount due until the later of the date the pharmacist or pharmacy receives the final audit report or, if appealed under the process established under Section 843.513(a), the date of the audit outcome report.	Sec. 1369.266. RECOUPMENT AND INTEREST CHARGED AFTER AUDIT. (a) If an audit under this subchapter is conducted, the health benefit plan issuer or pharmacy benefit manager: (1) may recoup from the pharmacist or pharmacy an amount based only on a final audit report; and (2) may not accrue or assess interest on an amount due until the date the pharmacist or pharmacy receives the final audit report under Section 1369.264. (b) 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. 843.515. MEDIATION. (a) A pharmacist or pharmacy aggrieved by an audit outcome report may require an auditor to participate in mediation under Chapter 154, Civil Practice and Remedies Code. (b) The pharmacist or pharmacy must elect mediation and notify the auditor not later than the 30th day after the date the pharmacist or pharmacy receives the audit outcome report. The mediation must be completed not later than the 90th day after the date the pharmacist or pharmacy receives the audit outcome report. (c) The mediation must be conducted by a person qualified as an impartial third party under Section 154.052, Civil Practice and Remedies Code.	No equivalent provision.
Sec. 843.516. REMEDIES NOT EXCLUSIVE.	Sec. 1369.268. REMEDIES NOT EXCLUSIVE.
Sec. 843.517. WAIVER PROHIBITED.	Sec. 1369.267. WAIVER PROHIBITED.
No equivalent provision.	Sec. 1369.269. ENFORCEMENT; RULES. The commissioner may enforce this subchapter and adopt and enforce reasonable rules necessary to accomplish the purposes of this subchapter.
Sec. 843.518. LEGISLATIVE DECLARATION. It is the intent of the legislature that the requirements contained in this subchapter regarding audit of claims to providers who are pharmacists or pharmacies apply to all health maintenance organizations and pharmacy benefit managers unless otherwise prohibited by federal law.	Sec. 1369.270. LEGISLATIVE DECLARATION. Except as provided by Section 1369.252, it is the intent of the legislature 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. Section 843.3401, Insurance Code, is transferred to Subchapter O, Chapter 843, Insurance Code, as added by this Act, redesignated as Section 843.502,	*(See SECTION 1 (part) below for comparison.)*

Insurance Code, and amended to read as follows:

Sec. 843.502 [~~843.3401~~]. AUDIT OF PHARMACIST OR PHARMACY; NOTICE; GENERAL PROVISIONS.

(a) An auditor [~~A health maintenance organization or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization may not use extrapolation to complete the audit of a provider who is a pharmacist or pharmacy. A health maintenance organization may not require extrapolation audits as a condition of participation in the health maintenance organization's contract, network, or program for a provider who is a pharmacist or pharmacy.~~

[~~(b) A health maintenance organization or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization~~] that performs an on-site audit or a desk audit under this chapter of a provider who is a pharmacist or pharmacy shall provide the provider reasonable notice of the audit and accommodate the provider's schedule to the greatest extent possible. The notice required under this subsection must be in writing and must be sent by certified mail to the provider not later than the 15th day before the date on which the on-site audit is scheduled to occur.

(See SECTION 1 (part) below for comparison.)

(b) Not later than the seventh day after the date a pharmacist or pharmacy receives notice under Subsection (a), the pharmacist or pharmacy may reschedule an on-site audit or a desk audit to a date not later than the 14th day after the date the audit is initially scheduled. On agreement of the pharmacist or pharmacy and the auditor, the audit may be rescheduled to a date after the 14th day after the date the audit is initially scheduled.

(See SECTION 1 (part) below for comparison.)

(c) Unless the pharmacist or pharmacy consents in writing, an auditor may not schedule or have an on-site audit or a desk audit conducted:

(1) before the 30th day after the date the pharmacist or pharmacy receives notice under Subsection (a);

(2) more than once annually; or

(3) during the first seven calendar days of a month.

(See SECTION 1 (part) below for comparison.)

(d) A pharmacist or pharmacy may be required to submit documents in response to a desk audit not earlier than the 30th day after the date the auditor requests the documents.

(See SECTION 1 (part) below for comparison.)

(e) A contract between a pharmacist or pharmacy and a health maintenance organization or a pharmacy benefit manager must state detailed audit procedures. If a health maintenance organization or pharmacy benefit manager proposes a change to the audit procedures for an on-site audit or a desk audit, the organization or manager must 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.

(See SECTION 1 (part) below for comparison.)

(f) The list of the claims subject to audit must be provided in the notice under Subsection (a) to the pharmacist or pharmacy and may identify the claims only by the prescription numbers or a date range for prescriptions subject to the audit.

(See SECTION 1 (part) below for comparison.)

(g) If the auditor:
(1) in an on-site audit or a desk audit applies random sampling procedures to select claims for audit, the sample size may not be greater than 50 individual prescription claims; or
(2) conducts an on-site audit or a desk audit related to a specific issue, the number of individual prescription claims subject to the audit may not be greater than 50 and, notwithstanding Subsection (f), may be identified only by prescription number.

(See SECTION 1 (part) below for comparison.)

(h) After an audit is initiated, a pharmacist or pharmacy may electronically resubmit a disputed claim if the deadline for submission of a claim under Section 843.337 has not expired.

(See SECTION 1 (part) below for comparison.)

SECTION 3. Chapter 1301, Insurance Code, is amended by adding Subchapter F to read as follows:
SUBCHAPTER F. AUDITS OF PHARMACISTS AND PHARMACIES

(See SECTION 1 (part) above for comparison.)

Sec. 1301.251. DEFINITIONS. In this subchapter:
(1) "Auditor" means an insurer or a

(See SECTION 1 (part) above for comparison.)

pharmacy benefit manager that provides pharmacy-related services for the insurer's insureds that is performing an on-site audit or a desk audit of a preferred provider that is a pharmacist or pharmacy or another entity performing an on-site audit or a desk audit of a preferred provider that is a pharmacist or pharmacy on behalf of the insurer or manager.

(2) "Desk audit" means an audit conducted by an auditor at a location other than the location of the pharmacist or pharmacy. The term includes an audit performed at the auditor's offices during which the pharmacist or pharmacy provides requested documents for auditor review by hard copy or by microfiche, disk, or other electronic media.

(3) "On-site audit" means an audit that is conducted at:

(A) the location of the pharmacist or pharmacy; or

(B) another location at which the records under review are stored.

Sec. 1301.253. AUDIT REQUIRING PROFESSIONAL JUDGMENT. An on-site audit or a desk audit involving a pharmacist's clinical or professional judgment must be conducted in consultation with a pharmacist licensed by the Texas State Board of Pharmacy.

(See SECTION 1 (part) above for comparison.)

Sec. 1301.254. ACCESS TO PHARMACY AREA. An auditor may not enter the pharmacy area unless escorted by the pharmacist-in-charge as defined by Section 551.003(29), Occupations Code.

(See SECTION 1 (part) above for comparison.)

Sec. 1301.255. VALIDATION USING CERTAIN RECORDS AUTHORIZED. A pharmacist or pharmacy that is being audited may:

(1) validate a prescription, refill, or change in a prescription with a prescription that complies with rules adopted under Section 554.051, 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.

(See SECTION 1 (part) above for comparison.)

Sec. 1301.256. CALCULATION OF RECOUPMENT; EXTRAPOLATION PROHIBITED. (a) An auditor may not

(See SECTION 1 (part) above for comparison.)

calculate the amount of a recoupment based on:
(1) an absence of documentation the pharmacist or pharmacy is not required by law to maintain; or
(2) an error that does not result in actual financial harm to the insured, insurer, or pharmacy benefit manager.
(b) An insurer or pharmacy benefit manager may not require extrapolation audits as a condition of participation in a contract, network, or program for a pharmacist or pharmacy.
(c) An auditor may not use extrapolation to complete an on-site audit or a desk audit of a pharmacist or pharmacy. Notwithstanding Subsection (a)(2), the amount of a recoupment must be based on the actual overpayment or underpayment and may not be based on an extrapolation.
(d) An auditor may not include a dispensing fee amount in the calculation of an overpayment unless:
(1) the fee was a duplicate charge; or
(2) the prescription for which the fee was charged:
(A) was not dispensed; or
(B) was dispensed without the prescriber's authorization.

Sec. 1301.257. CLERICAL OR RECORDKEEPING ERROR. 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; and
(2) may not be the basis of a recoupment from a pharmacist or pharmacy without proof of intent to commit fraud.

(See SECTION 1 (part) above for comparison.)

Sec. 1301.258. UNIFORM STANDARDS REQUIRED. An auditor must conduct an on-site audit or a desk audit of similarly situated pharmacists or pharmacies under the same audit standards.

(See SECTION 1 (part) above for comparison.)

Sec. 1301.259. ACCESS TO PREVIOUS AUDIT REPORTS. An auditor may have access to audit reports of a pharmacist or pharmacy that were prepared only for the insurer or pharmacy benefit manager for which the auditor is conducting an audit.

(See SECTION 1 (part) above for comparison.)

Sec. 1301.260. COMPENSATION OF

(See SECTION 1 (part) above for

AUDITOR. An insurer, pharmacy benefit manager, or other auditor may not base compensation paid to the individual or entity performing an on-site audit or a desk audit on a percentage of the amount the insurer, pharmacy benefit manager, or other auditor is entitled to recover as the result of the audit.

comparison.)

Sec. 1301.261. CONCLUSION OF AUDIT; SUMMARY; PRELIMINARY AUDIT REPORT. (a) At the conclusion of an on-site audit or a desk audit, the auditor shall:

(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) Not later than the 30th day after the date the audit is concluded, the auditor shall send by certified mail, return receipt requested, to the pharmacist or pharmacy a preliminary audit report stating the results of the audit, including explanations for and the amount of recoupment claimed.

(c) The pharmacist or pharmacy may, 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.

(See SECTION 1 (part) above for comparison.)

Sec. 1301.262. FINAL AUDIT REPORT. Not later than the 90th day after the date the pharmacist or pharmacy receives a preliminary audit report under Section 1301.261, the auditor shall send by certified mail, return receipt requested, to the pharmacist or pharmacy a final audit report that states:

(1) a summary of the pharmacist's or pharmacy's explanation and documentation, if any, submitted 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.

(See SECTION 1 (part) above for comparison.)

Sec. 1301.263. APPEAL OF FINAL AUDIT REPORT; AUDIT OUTCOME

(See SECTION 1 (part) above for comparison.)

REPORT. (a) An auditor shall establish a process for a pharmacist or pharmacy to wholly or partly appeal a final audit report.

(b) An auditor shall use the National Council for Prescription Drug Programs' data interchange standards for pharmacy claim submission to evaluate audited claims and appeals under the process established under Subsection (a).

(c) On the date a final audit report is found wholly or partly unsubstantiated after an appeal under the process established under Subsection (a), the auditor shall reject the report, wholly or partly, as applicable.

(d) Not later than the 30th day after the date an appeal under the process established under Subsection (a) is concluded, the auditor shall send by certified mail, return receipt requested, to the pharmacist or pharmacy an audit outcome report that includes:

(1) a summary of the pharmacist's or pharmacy's arguments and documentation, if any, submitted in response to the final audit report; and

(2) the audit results and recoupments claimed after consideration of the pharmacist's or pharmacy's response to the final audit report.

Sec. 1301.264. RECOUPMENT AND INTEREST CHARGED AFTER AUDIT. If an audit under this subchapter is conducted, the insurer or pharmacy benefit manager:

(1) may recoup from the pharmacist or pharmacy an amount based only on a final audit report or, if appealed under the process established under Section 1301.263(a), an audit outcome report; and

(2) may not accrue or assess interest on an amount due until the later of the date the pharmacist or pharmacy receives the final audit report or, if appealed under the process established under Section 1301.263(a), the date of the audit outcome report.

(See SECTION 1 (part) above for comparison.)

Sec. 1301.265. MEDIATION. (a) A pharmacist or pharmacy aggrieved by an audit outcome report may require an auditor to participate in mediation under Chapter 154, Civil Practice and Remedies Code.

(b) The pharmacist or pharmacy must elect mediation and notify the auditor not later than the 30th day after the date the

(See SECTION 1 (part) above for comparison.)

pharmacist or pharmacy receives the audit outcome report. The mediation must be completed not later than the 90th day after the date the pharmacist or pharmacy receives the audit outcome report.

(c) The mediation must be conducted by a person qualified as an impartial third party under Section 154.052, Civil Practice and Remedies Code.

Sec. 1301.266. REMEDIES NOT EXCLUSIVE. This section may not be construed to waive a remedy at law available to a pharmacist or pharmacy.

(See SECTION 1 (part) above for comparison.)

Sec. 1301.267. WAIVER PROHIBITED. The provisions of this subchapter may not be waived, voided, or nullified by contract.

(See SECTION 1 (part) above for comparison.)

Sec. 1301.268. LEGISLATIVE DECLARATION. It is the intent of the legislature that the requirements contained in this subchapter regarding audit of claims to preferred providers who are pharmacists or pharmacies apply to all insurers and pharmacy benefit managers unless otherwise prohibited by federal law.

(See SECTION 1 (part) above for comparison.)

SECTION 4. Section 1301.1041, Insurance Code, is transferred to Subchapter F, Chapter 1301, Insurance Code, as added by this Act, redesignated as Section 1301.252, Insurance Code, and amended to read as follows:

SECTION 1. *(part)*

Sec. 1301.252 [~~1301.1041~~]. AUDIT OF PHARMACIST OR PHARMACY; NOTICE; GENERAL PROVISIONS.

Sec. 1369.254. AUDIT OF PHARMACIST OR PHARMACY; NOTICE; GENERAL PROVISIONS.

(a) An auditor [~~insurer or a pharmacy benefit manager that administers pharmacy claims for the insurer may not use extrapolation to complete the audit of a preferred provider that is a pharmacist or pharmacy. An insurer may not require extrapolation audits as a condition of participation in the insurer's contract, network, or program for a preferred provider that is a pharmacist or pharmacy.~~

[~~(b) An insurer or a pharmacy benefit manager that administers pharmacy claims for the insurer~~] that performs an on-site audit or a desk audit of a preferred provider who is a pharmacist or pharmacy shall provide the provider reasonable notice of the audit and accommodate the provider's

(a) Except as provided by Subsection (d), a health benefit plan issuer or pharmacy benefit manager

that performs an on-site audit under this subchapter of a pharmacist or pharmacy shall provide the pharmacist or pharmacy reasonable notice of the audit and accommodate the pharmacist's or

schedule to the greatest extent possible. The notice required under this subsection must be in writing and must be sent by certified mail to the preferred provider not later than the 15th day before the date on which the on-site audit is scheduled to occur.

pharmacy's schedule to the greatest extent possible. The notice required under this subsection must be in writing and must 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) Not later than the seventh day after the date a pharmacist or pharmacy receives notice under Subsection (a), the pharmacist or pharmacy may reschedule an on-site audit or a desk audit to a date not later than the 14th day after the date the audit is initially scheduled. On agreement of the pharmacist or pharmacy and the auditor, the audit may be rescheduled to a date after the 14th day after the date the audit is initially scheduled.

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

(c) Unless the pharmacist or pharmacy consents in writing, an auditor may not schedule or have an on-site audit or a desk audit conducted:

(1) before the 30th day after the date the pharmacist or pharmacy receives notice under Subsection (a);

(2) more than once annually; or

(3) during the first seven calendar days of a month.

(c) Unless the pharmacist or pharmacy consents in writing, a health benefit plan issuer or pharmacy benefit manager may not schedule or have 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) 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. The pharmacist or pharmacy may not request that the audit be rescheduled under Subsection (b).

(d) A pharmacist or pharmacy may be required to submit documents in response to a desk audit not earlier than the 30th day after the date the auditor requests the

(e) A pharmacist or pharmacy may 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

documents.

(e) A contract between a pharmacist or pharmacy and an insurer or a pharmacy benefit manager must state detailed audit procedures. If an insurer or pharmacy benefit manager proposes a change to the audit procedures for an on-site audit or a desk audit, the insurer or pharmacy benefit manager must 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.

(f) The list of the claims subject to audit must be provided in the notice under Subsection (a) to the pharmacist or pharmacy and may identify the claims only by the prescription numbers or a date range for prescriptions subject to the audit.

(g) If the auditor:
(1) in an on-site audit or a desk audit applies random sampling procedures to select claims for audit, the sample size may not be greater than 50 individual prescription claims; or
(2) conducts an on-site audit or a desk audit related to a specific issue, the number of individual prescription claims subject to the audit may not be greater than 50 and, notwithstanding Subsection (f), may be identified only by prescription number.

(h) After an audit is initiated, a pharmacist or pharmacy may electronically resubmit a disputed claim if the deadline for submission of a claim under Section 1301.102 has not expired.

SECTION 5. The changes in law made by this Act apply only to contracts between a pharmacist or pharmacy and a health maintenance organization, an insurer, or a pharmacy benefit manager executed or renewed, and audits conducted under those contracts, on or after the effective date of this Act. A contract entered into or renewed, and audits conducted under those

or pharmacy benefit manager requests the documents.

(f) A contract between a pharmacist or pharmacy and a health benefit plan issuer or pharmacy benefit manager must state detailed audit procedures. 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, the plan issuer or pharmacy benefit manager must 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) The list of the claims subject to an on-site audit must be provided in the notice under Subsection (a) to the pharmacist or pharmacy and must identify the claims only by the prescription numbers or a date range for prescriptions subject to the audit. The last two digits of the prescription numbers provided may be omitted.

(h) 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, the sample size may not be greater than 300 individual prescription claims.

SECTION 4. 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. Contracts entered into or renewed, and audits conducted under those contracts, before the effective date of

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.	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.
No equivalent provision.	SECTION 2. 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, is amended by reenacting and amending Subdivision (1) and reenacting Subdivision (1-a) to read as follows: (1) "Exclusive provider benefit plan" means a benefit plan in which an insurer excludes benefits to an insured for some or all services, other than emergency care services required under Section 1301.155, provided by a physician or health care provider who is not a preferred provider. [~~"Extrapolation" means a mathematical process or technique used by an insurer or pharmacy benefit manager that administers pharmacy claims for an insurer in the audit of a pharmacy or pharmacist to estimate audit results or findings for a larger batch or group of claims not reviewed by the insurer or pharmacy benefit manager.~~] (1-a) "Health care provider" means a practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state. The term includes a pharmacist and a pharmacy. The term does not include a physician.
No equivalent provision.	SECTION 3. The following provisions of the Insurance Code are repealed: (1) Section 843.002(9-a); (2) Section 843.3401; and (3) Section 1301.1041.
SECTION 6. This Act takes effect September 1, 2013.	SECTION 5. Same as introduced version.