2018 -- H 7684

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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2018

A N A C T

RELATING TO HEALTH AND SAFETY

Introduced By: Representatives Hull, Lombardi, Messier, Morin, and Kazarian

Date Introduced: February 15, 2018

Referred To: House Health, Education & Welfare

It is enacted by the General Assembly as follows:

SECTION 1. Chapter 5-19.1 of the General Laws entitled "Pharmacies" is hereby amended by adding thereto the following section:

5-19.1-33. Audits.

(a) When an on-site audit of the records of a pharmacy is conducted by a pharmacy benefits manager, the audit must be conducted in accordance with the following criteria:

(1) A finding of overpayment or underpayment must be based on the actual overpayment or underpayment, and not a projection based on the number of patients served having a similar diagnosis, or on the number of similar orders or refills for similar drugs, unless the projected overpayment or denial is a part of a settlement agreed to by the pharmacy or pharmacist.

(2) The auditor may not use extrapolation in calculating recoupments or penalties.

(3) Any audit that involves clinical or professional judgment must be conducted by, or in consultation with a pharmacist.

(4) Each entity conducting an audit shall establish an appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity.

(5) This section does not apply to any audit, review or investigation that is initiated based on or involving suspected or alleged fraud, willful misrepresentation or abuse.

(6) Prior to an audit, the entity conducting an audit shall give the pharmacy thirty (30) days' advance written notice of the audit, and the range of prescription numbers and the range of dates included in the audit. Additionally, the number of prescriptions shall not exceed one

hundred (100) selected prescription claims which also includes all associated refills. Time allotted must be adequate to collect all samples. Signature logs shall not exceed twenty-five (25).

(7) A pharmacy has the right to request mediation by a private mediator, agreed upon by the pharmacy and the pharmacy benefits manager, to resolve any disagreements. A request for mediation does not waive any existing rights of appeal available to a pharmacy under this section.

(8) A preliminary audit report must be delivered to the pharmacy within fifteen (15) days after the conclusion of the audit. A pharmacy must be allowed at least thirty (30) days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit. A final audit report must be delivered to the pharmacy within sixty (60) days after receipt of the preliminary audit report or final appeal, whichever is later. A charge-back, recoupment or other penalty may not be assessed until the appeal process provided by the pharmacy benefits manager has been exhausted and the final report issued. Except as provided by state or federal law, audit information may not be shared. Auditors may have access only to previous audit reports on a particular pharmacy conducted by that same entity. Auditors may initiate a desk audit prior to an on-site audit unless otherwise specified in the law.

(9) Contracted auditors cannot be paid based on the findings within an audit.

(10) Scanned images of all prescriptions including all scheduled controlled substances are allowed to be used by the pharmacist for an audit. Verbally received prescriptions must be accepted and applicable for desk, on-site and follow up appeal documentation.

(11) Any clerical error, typographical error, scrivener's error or computer error regarding a document or record required under the Medicaid program does not constitute a willful violation, and is not subject to criminal penalties without proof of intent to commit fraud.

(12) Pharmacists are allowed at minimum one opportunity to reschedule with the auditor if the scheduled audit presents a scheduling conflict for the pharmacist.

(13) The period covered by an audit may not exceed one year.

SECTION 2. Title 27 of the General Laws entitled "INSURANCE" is hereby amended by adding thereto the following chapter:

CHAPTER 1.3

HEALTH INSURER ANNUAL REPORTING

27-1.3-1. Pharmacy benefit manager transparency.

(a) Health insurers with a minimum of two thousand (2,000) Rhode Island lives covered at the end of the preceding year, or who offer insurance through the Rhode Island health benefit exchange, shall annually report the following information to the department of health, in plain language, as an addendum to the health insurer's annual statement:

(1) The health insurer's state of domicile and the total number of states in which the insurer operates;

(2) The total number of Rhode Island lives covered by the health insurer;

(3) The total number of claims submitted to the health insurer;

(4) The total number of claims denied by the health insurer;

(5) The total number of denials of service by the health insurer at the preauthorization level, including:

(i) The total number of denials of service at the preauthorization level appealed to the health insurer at the first-level grievance and, of those, the total number overturned;

(ii) The total number of denials of service at the preauthorization level appealed to the health insurer at any second-level grievance and, of those, the total number overturned; and

(ii) The total number of denials of service at the preauthorization level for which external review was sought and, of those, the total number overturned;

(6) The total number of adverse benefit determinations made by the health insurer, including:

(i) The total number of adverse benefit determinations appealed to the health insurer at the first-level grievance and, of those, the total number overturned;

(ii) The total number of adverse benefit determinations appealed to the health insurer at any second-level grievance and, of those, the total number overturned;

(iii) The total number of adverse benefit determinations for which external review was sought and, of those, the total number overturned;

(7) The total number of claims denied by the health insurer because the service was experimental, investigational, an off-label use of a drug, was not medically necessary, involved access to a provider that is inconsistent with the limitations imposed by the plan, or was subject to a preexisting condition exclusion;

(8) The total number of claims denied by the health insurer as duplicate claims, as coding errors, or for services or providers not covered;

(9) The titles and salaries of all corporate officers and board members during the preceding year, and the bonuses and compensatory benefits of all corporate officers and board members during the preceding year;

(10) The health insurer's marketing and advertising expenses during the preceding year;

(11) The health insurer's federal and Rhode Island-specific lobbying expenses during the preceding year;

(12) The amount and recipient of each political contribution made by the health insurer

during the preceding year;

(13) The amount and recipient of dues paid during the preceding year by the health insurer to trade groups that engage in lobbying efforts, or that make political contributions;

(14) The health insurer's legal expenses related to claims or service denials during the preceding year; and

(15) The amount and recipient of charitable contributions made by the health insurer during the preceding year.

(b) Health insurers may indicate the extent of overlap or duplication in reporting the information described in subsection (a) of this section.

(c) The department of health shall create a standardized form using terms with uniform, industry-standard meanings for the purpose of collecting the information described in subsection (a) of this section, and each health insurer shall use the standardized form for reporting the required information as an addendum to its annual statement. To the extent possible, health insurers shall report information specific to Rhode Island on the standardized form, and shall indicate on the form where the reported information is not specific to Rhode Island.

(d) The department of health shall post on its website the standardized form to be completed by each health insurer pursuant to this section, and shall post on the Rhode Island health benefit exchange an electronic link to the standardized forms posted by the department of health.

(e) The director of the department of health may issue such rules, regulations, and orders as shall be necessary to carry out the provisions of this chapter.

SECTION 3. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HEALTH AND SAFETY

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This act would establish audit requirements for pharmacy benefit managers, and would also establish annual reporting requirements for health insurers.

This act would take effect upon passage.

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