HOUSE BILL No. 5981

December 2, 2014, Introduced by Rep. Cavanagh and referred to the Committee on Insurance.

A bill to amend 1978 PA 368, entitled

"Public health code,"

(MCL 333.1101 to 333.25211) by adding section 17771.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

SEC. 17771. (1) SUBJECT TO THIS SECTION, A HEALTH BENEFIT PAYER MAY CONDUCT AN AUDIT OF A PHARMACY IN THIS STATE. A HEALTH BENEFIT PAYER THAT CONDUCTS AN AUDIT OF A PHARMACY IN THIS STATE SHALL DO ALL OF THE FOLLOWING:

(A) IN ITS PHARMACY CONTRACT, IDENTIFY AND DESCRIBE IN DETAIL THE AUDIT PROCEDURES. A HEALTH BENEFIT PAYER SHALL UPDATE ITS PHARMACY CONTRACT AND COMMUNICATE ANY CHANGES TO THE PHARMACY AS CHANGES TO THE CONTRACT OCCUR.

(B) PROVIDE WRITTEN NOTICE TO THE PHARMACY AT LEAST 14

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CALENDAR DAYS BEFORE INITIATING AND SCHEDULING THE INITIAL ON-SITE AUDIT FOR EACH AUDIT CYCLE. A HEALTH BENEFIT PAYER SHALL NOT INITIATE OR SCHEDULE AN ON-SITE AUDIT DURING THE FIRST 5 CALENDAR DAYS OF A MONTH UNLESS OTHERWISE CONSENTED TO BY THE PHARMACIST.

(C) CONDUCT AN AUDIT THAT INVOLVES CLINICAL OR PROFESSIONAL JUDGMENT BY OR IN CONSULTATION WITH A PHARMACIST.

(D) SUBJECT TO THE REQUIREMENTS OF THIS ARTICLE, FOR THE PURPOSE OF VALIDATING A PHARMACY RECORD WITH RESPECT TO ORDERS, REFILLS, OR CHANGES IN PRESCRIPTIONS, ALLOW THE USE OF EITHER OF THE FOLLOWING:

(*i*) HOSPITAL OR PHYSICIAN RECORDS THAT ARE WRITTEN OR THAT ARE TRANSMITTED OR STORED ELECTRONICALLY, INCLUDING FILE ANNOTATIONS, DOCUMENT IMAGES, AND OTHER SUPPORTING DOCUMENTATION THAT ARE DATE- AND TIME-STAMPED.

(*ii*) A PRESCRIPTION THAT COMPLIES WITH BOARD REQUIREMENTS AND STATE AND FEDERAL LAW.

(E) BASE A FINDING OF AN OVERPAYMENT OR UNDERPAYMENT ON THE ACTUAL OVERPAYMENT OR UNDERPAYMENT OF A CLAIM.

(F) BASE A RECOUPMENT OR PAYMENT ADJUSTMENT OF A CLAIM ON A CALCULATION THAT IS REASONABLE AND PROPORTIONAL IN RELATION TO THE TYPE OF ERROR DETECTED.

(G) IF THERE IS A FINDING OF AN UNDERPAYMENT, REIMBURSE THE PHARMACY WITHIN 30 BUSINESS DAYS AFTER THE FINAL WRITTEN AUDIT REPORT IS DELIVERED TO THE PHARMACY UNDER SUBSECTION (2)(C).

(H) AUDIT ONLY CLAIMS SUBMITTED OR ADJUDICATED WITHIN THE 2-YEAR PERIOD IMMEDIATELY PRECEDING THE INITIATION OF THE AUDIT UNLESS A LONGER PERIOD IS PERMITTED UNDER FEDERAL OR STATE LAW.

(2) UPON COMPLETION OF AN AUDIT OF A PHARMACY, THE HEALTH BENEFIT PAYER SHALL DO ALL OF THE FOLLOWING:

(A) DELIVER A PRELIMINARY WRITTEN AUDIT REPORT TO THE PHARMACY BEFORE THE EXPIRATION OF 120 CALENDAR DAYS AFTER THE COMPLETION OF THE AUDIT, WITH REASONABLE EXTENSIONS ALLOWED. THE PRELIMINARY WRITTEN AUDIT REPORT MUST INCLUDE CONTACT INFORMATION FOR THE AUDITING ENTITY.

(B) ALLOW THE PHARMACY AT LEAST 30 BUSINESS DAYS AFTER ITS RECEIPT OF THE PRELIMINARY REPORT UNDER SUBDIVISION (A) TO PRODUCE DOCUMENTATION TO ADDRESS ANY DISCREPANCY FOUND DURING THE AUDIT.

(C) IF AN APPEAL IS NOT FILED, DELIVER A FINAL WRITTEN AUDIT REPORT TO THE PHARMACY WITHIN 6 MONTHS AFTER THE TIME DESCRIBED IN SUBDIVISION (B) HAS ELAPSED. IF AN APPEAL IS FILED, DELIVER A FINAL WRITTEN AUDIT REPORT TO THE PHARMACY WITHIN 30 CALENDAR DAYS AFTER THE CONCLUSION OF THE APPEAL.

(D) EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, ONLY RECOUP DISPUTED FUNDS OR OVERPAYMENTS OR RESTORE UNDERPAYMENTS AT LEAST 30 BUSINESS DAYS AFTER THE FINAL WRITTEN AUDIT REPORT IS DELIVERED TO THE PHARMACY UNDER SUBDIVISION (C). IF THE PRELIMINARY WRITTEN AUDIT REPORT UNDER SUBDIVISION (A) DISCLOSES A DISCREPANCY THAT EXCEEDS $20,000.00 IN OVERPAYMENT, A HEALTH BENEFIT PAYER MAY WITHHOLD FUTURE PAYMENTS TO THE PHARMACY DURING THE PERIOD BEGINNING ON THE DATE THE PRELIMINARY AUDIT REPORT IS DELIVERED TO THE PHARMACY UNDER SUBDIVISION (A) THROUGH THE DATE THE AUDIT IS FINALIZED UNDER SUBDIVISION (C).

(E) UPON REQUEST, PROVIDE TO THE SPONSOR OF THE HEALTH CARE PAYMENT OR BENEFITS PROGRAM A COPY OF THE FINAL WRITTEN AUDIT

REPORT DELIVERED TO THE PHARMACY UNDER SUBDIVISION (C).

(3) A HEALTH BENEFIT PAYER SHALL NOT CONDUCT AN EXTRAPOLATION AUDIT IN CALCULATING RECOUPMENTS, RESTORATION, OR PENALTIES FOR AN AUDIT UNDER THIS SECTION. FOR THE PURPOSES OF THIS SUBSECTION, AN EXTRAPOLATION AUDIT IS AN AUDIT OF A SAMPLE OF PRESCRIPTION DRUG BENEFIT CLAIMS SUBMITTED BY A PHARMACY TO THE HEALTH BENEFIT PAYER THAT IS THEN USED TO ESTIMATE AUDIT RESULTS FOR A LARGER BATCH OR GROUP OF CLAIMS NOT REVIEWED DURING THE AUDIT.

(4) THIS SECTION DOES NOT APPLY TO ANY OF THE FOLLOWING:

(A) A HEALTH BENEFIT PAYER PHARMACY AUDIT OR INVESTIGATIVE AUDIT CONDUCTED BY OR ON BEHALF OF A STATE AGENCY THAT INVOLVES FRAUD, WILLFUL MISREPRESENTATION, OR ABUSE, INCLUDING, BUT NOT LIMITED TO, INVESTIGATIVE AUDITS OR AUDITS CONDUCTED UNDER ANY OTHER STATUTORY PROVISION THAT AUTHORIZES INVESTIGATION RELATING TO INSURANCE FRAUD.

(B) AN AUDIT BASED ON A CRIMINAL INVESTIGATION.

(5) THIS SECTION DOES NOT IMPAIR OR SUPERSEDE A PROVISION REGARDING HEALTH BENEFIT PAYER PHARMACY AUDITS IN THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.100 TO 500.8302. IF ANY PROVISION OF THIS SECTION CONFLICTS WITH A PROVISION OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.100 TO 500.8302, WITH REGARD TO HEALTH BENEFIT PAYER PHARMACY AUDITS, THE PROVISION IN THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.100 TO 500.8302, CONTROLS.

(6) AS USED IN THIS SECTION:

(A) "CLAIM" MEANS ANY ATTEMPT TO CAUSE AN ENTITY TO MAKE A PAYMENT TO COVER A HEALTH CARE BENEFIT UNDER A HEALTH CARE PAYMENT

OR BENEFITS PROGRAM.

(B) "HEALTH BENEFIT PAYER" MEANS A PUBLIC OR PRIVATE ENTITY THAT OFFERS, PROVIDES, ADMINISTERS, OR MANAGES A HEALTH CARE PAYMENT OR BENEFITS PROGRAM, INCLUDING, BUT NOT LIMITED TO, ALL OF THE FOLLOWING:

(*i*) A HEALTH INSURER OR AN INSURANCE COMPANY AUTHORIZED TO PROVIDE HEALTH INSURANCE IN THIS STATE.

(*ii*) A HEALTH MAINTENANCE ORGANIZATION.

(*iii*) A PREFERRED PROVIDER ORGANIZATION.

(*iv*) A NONPROFIT DENTAL CARE CORPORATION.

(*v*) THE MEDICAL SERVICES ADMINISTRATION IN THE DEPARTMENT OF COMMUNITY HEALTH.

(*vi*) A PHARMACY BENEFIT MANAGER.

(*vii*) A LEGAL ENTITY THAT IS SELF-INSURED AND PROVIDING HEALTH CARE BENEFITS TO ITS EMPLOYEES.

(*viii*) A RESPONSIBLE PARTY.

(*ix*) A PERSON ACTING FOR AN ENTITY DESCRIBED IN SUBPARAGRAPHS (*i*) TO (*viii*) IN A CONTRACTUAL RELATIONSHIP IN THE PERFORMANCE OF ANY ACTIVITY ON BEHALF OF THE ENTITY DESCRIBED IN SUBPARAGRAPHS (*i*) TO (*viii*).

(C) "HEALTH CARE BENEFIT" MEANS THE RIGHT UNDER A HEALTH CARE PAYMENT OR BENEFITS PROGRAM TO HAVE A PAYMENT MADE BY A HEALTH BENEFIT PAYER FOR A SPECIFIED HEALTH CARE SERVICE.

(D) "HEALTH CARE PAYMENT OR BENEFITS PROGRAM" MEANS AN EXPENSE-INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICY OR CERTIFICATE, HEALTH MAINTENANCE ORGANIZATION CONTRACT, AND ANY OTHER PLAN OR PROGRAM OF HEALTH CARE BENEFITS THAT PROVIDES

COVERAGE FOR OR ADMINISTERS COVERAGE FOR PRESCRIPTION DRUGS OR DEVICES.

(E) "PHARMACY BENEFIT MANAGER" MEANS AN ENTITY THAT CONTRACTS WITH A PHARMACY ON BEHALF OF A HEALTH CARE PAYMENT OR BENEFITS PROGRAM FOR THE PHARMACY TO PROVIDE PHARMACY SERVICES TO INDIVIDUALS COVERED BY THE HEALTH CARE PAYMENT OR BENEFITS PROGRAM AND THAT DETERMINES REIMBURSEMENT TO THE PHARMACY FOR THE PHARMACY SERVICES PROVIDED TO INDIVIDUALS COVERED BY THE HEALTH CARE PAYMENT OR BENEFITS PROGRAM. AN ENTITY THAT ENGAGES IN, OR SUBCONTRACTS FOR, 3 OR MORE OF THE FOLLOWING ACTIVITIES IS CONSIDERED A PHARMACY BENEFIT MANAGER UNDER THIS SECTION:

(*i*) CLAIMS PROCESSING.

(*ii*) PHARMACY NETWORK MANAGEMENT.

(*iii*) PHARMACY DISCOUNT CARD MANAGEMENT.

(*iv*) THE PAYMENT OF CLAIMS TO PHARMACIES FOR PRESCRIPTION DRUGS DISPENSED TO INDIVIDUALS COVERED BY THE HEALTH CARE PAYMENT OR BENEFITS PROGRAM.

(*v*) CLINICAL FORMULARY DEVELOPMENT AND MANAGEMENT SERVICES INCLUDING, BUT NOT LIMITED TO, UTILIZATION MANAGEMENT AND QUALITY ASSURANCE PROGRAMS.

(*vi*) REBATE CONTRACTING AND ADMINISTRATION.

(*vii*) THE CONDUCTING OF AUDITS OF NETWORK PHARMACIES.

(*viii*) THE SETTING OF PHARMACY REIMBURSEMENT PRICING AND METHODOLOGIES, INCLUDING MAXIMUM ALLOWABLE COST PRICE, AND DETERMINING SINGLE SOURCE DRUGS OR MULTIPLE SOURCE DRUGS.

(*ix*) THE RETENTION OF ANY SPREAD OR DIFFERENTIAL BETWEEN WHAT IS RECEIVED FROM HEALTH CARE PAYMENT OR BENEFITS PROGRAMS AS

REIMBURSEMENT FOR PRESCRIPTION DRUGS AND WHAT IS PAID TO PHARMACIES BY THE PHARMACY BENEFIT MANAGER FOR THE DRUGS.

(F) "RESPONSIBLE PARTY" MEANS AN ENTITY THAT IS RESPONSIBLE FOR THE PAYMENT OF CLAIMS FOR HEALTH CARE BENEFITS UNDER A HEALTH CARE PAYMENT OR BENEFITS PROGRAM.