Senate Bill 371

Sponsored by Senator BATES (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Imposes requirements related to audits by or on behalf of pharmacy benefit managers of pharmacy claims for reimbursement of cost of prescription drugs.

A BILL FOR AN ACT

Relating to audits of claims for reimbursement of costs of prescription drugs.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this 2013 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section:

(a)(A) "Audit" means a review of the records of a pharmacy by or on behalf of an entity that finances or reimburses the cost of health care services or pharmaceutical products.

(B) "Audit" does not include an investigative audit involving fraud or willful misrepresentation.

(b) "Entity" includes:

(A) A pharmacy benefit manager;

(B) A health benefit plan as defined in ORS 743.730;

(C) A state agency; or

(D) An entity that represents or is employed by one of the entities described in subparagraphs (A) to (C) of this paragraph.

(c)(A) "Pharmacy benefit manager" means a third party administrator that:

(i) Processes claims for prescription drugs or provides retail network management for pharmacies or pharmacists;

(ii) Makes payments for claims for prescription drugs to pharmacies or pharmacists;

(iii) Contracts with pharmacies or pharmacists for the procurement of prescription drugs; or

(iv) Negotiates rebates with prescription drug manufacturers for drugs paid for or procured as described in this subparagraph.

(B) "Pharmacy benefit manager" does not include an insurer that performs a service described in subparagraph (A) of this paragraph.

(2) An entity conducting an audit of a pharmacy:

(a) Must give at least two weeks' notice of an on-site audit;

(b) Must conduct the audit in consultation with a licensed pharmacist or the State Board of Pharmacy if the audit involves clinical or professional judgment;

(c) May not conduct an audit of a claim more than two years after the earlier of the date the claim was submitted to the entity for payment or the date the claim was adjudicated by

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

the entity;

(d) May not conduct the audit during the first seven days of any month without the pharmacy's consent;

(e) Must use the same standards and procedures for all pharmacies of a similar size and volume of business; and

(f) Must establish a written procedure for the appeal of a preliminary or final audit report that may be further contested by either party through mediation.

(3) An entity must make a finding of underpayment or overpayment of a claim based on identified transactions and not based on an estimate or projection of the number of claims or amounts that were underpaid or overpaid.

(4) The entity may not:

(a) Include dispensing fees or interest in the amount of any overpayment;

(b) Recoup costs associated with clerical or recordkeeping errors without proof that a pharmacy intended to commit fraud or unless the error results in financial harm to the entity or a consumer; or

(c) Charge a pharmacy for a denied or disputed claim or impose other penalties until the audit and the appeals process described in subsection (2)(f) of this section are final.

(5) An entity that contracts with a third party to conduct audits may not:

(a) Agree to pay the third party a commission or percentage of the amount of overpayment determined or recovered; or

(b) Permit the third party to calculate overpayments or penalties that are based on an estimate or projection of the number of claims or amounts that were overpaid.

(6) Information obtained during an audit is confidential and an entity may not disclose the information.

(7) For purposes of this section, a pharmacy may use the following records to validate a claim for a filling or refilling a prescription or making a change to a prescription:

(a) An electronic or physical copy of the prescription from the health care provider that prescribed the drug; or

(b) Any prescription that complies with ORS chapter 689.

(8)(a) After conducting an audit, an entity must provide the pharmacy that is the subject of the audit with a preliminary report of the audit. The preliminary report must be received by the pharmacy no later than 60 days after the date on which the audit was completed.

(b) An entity shall provide a pharmacy receiving a preliminary report under paragraph (a) of this subsection no less than 30 days after receiving the report to dispute the report and to provide additional documentation in support of the claim.

(9) If an audit results in a dispute or denial of a claim, the entity conducting the audit shall allow the pharmacy to resubmit the claim using any commercially reasonable method as long as the period of time that the claim may be submitted under the terms of the health care plan has not expired.

(10) An entity must provide the pharmacy that is the subject of the audit with a final report of the audit no later than 90 days after the date of the preliminary report or the date the appeal is concluded, whichever is earlier. The final report must include a final accounting of all moneys to be recovered by the entity.

(11) The entity must provide a copy of the final report to the policyholder or certificate holder.

SECTION 3. **Section 2 of this 2013 Act applies to audits conducted on or after the effective date of this 2013 Act.**