

No. 150. An act relating to pharmacy audits, reimbursement for ambulance services, and the reporting requirements of health insurers.

(S.200)

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 18 V.S.A. § 9414a is added to read:

§ 9414a. ANNUAL REPORTING BY HEALTH INSURERS

(a) Health insurers with a minimum of 2,000 Vermont lives covered at the end of the preceding year or who offer insurance through the Vermont health benefit exchange pursuant to 33 V.S.A. chapter 18, subchapter 1 shall annually report the following information to the commissioner of financial regulation, 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 Vermont 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:

(A) 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;

(B) 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;

(C) 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:

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

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

(C) 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, or 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)(A) the titles and salaries of all corporate officers and board members during the preceding year;

(B) 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 Vermont-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 financial regulation 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 Vermont on the standardized form and shall indicate on the form where the reported information is not specific to Vermont.

(d)(1) The department of financial regulation shall post on its website the standardized form completed by each health insurer pursuant to this section.

(2) The department of Vermont health access shall post on the Vermont health benefit exchange established pursuant to 33 V.S.A. chapter 18, subchapter 1 an electronic link to the standardized forms posted by the department of financial regulation pursuant to subdivision (1) of this subsection.

(e) The commissioner of financial regulation may adopt rules pursuant to 3 V.S.A. chapter 25 to carry out the purposes of this act.

Sec. 2. INTERIM WORKING GROUP ON INSURANCE FILINGS

(a) The department of financial regulation shall convene a working group on consumer-oriented insurance filings for the purpose of assessing and

making recommendations to improve the accessibility and comprehensibility of filings required of health insurers by this act.

(b) The working group shall be composed of the following members:

(1) the commissioner of financial regulation or designee, who shall serve as facilitator;

(2) the state health care ombudsman;

(3) a representative of a consumer advocacy group, appointed by the commissioner of financial regulation; and

(4) two individuals representing the interests of Vermont's insurance industry, appointed by the commissioner of financial regulation.

(c)(1) The working group established by this section shall study the content and availability of filings required of health insurers by this act, including:

(A) the type of information currently disclosed, the format of such disclosures, and the accessibility of reported information to consumers; and

(B) the presentation of the reported information with regard to clarity and ease of consumer comprehension.

(2) The working group shall make recommendations for improving the format, content, accessibility, and delivery of filings required of health insurers by this act in a manner that enhances consumer comprehension and empowers informed decision-making.

(3) The working group shall submit a detailed report of its findings and recommendations to the senate committee on health and welfare and the house committee on health care on or before January 15, 2014. Where appropriate, the working group's recommendations shall include specific suggestions for administrative and legislative action, including additional information that should be reported by health insurers and how "lives covered," as used in 18 V.S.A. § 9414a(a)(2), should be defined.

(4) For the purposes of its study of these issues, the working group shall have administrative support from the department of financial regulation.

(d) The working group on consumer-oriented insurance filings shall cease to exist on January 31, 2014.

Sec. 3. 18 V.S.A. § 9421 is redesignated to read:

§ 9421. PHARMACY BENEFIT MANAGEMENT; REGISTRATION;
INSURER AUDIT OF PHARMACY BENEFIT MANAGER
ACTIVITIES

Sec. 4. 18 V.S.A. chapter 79 is added to read:

CHAPTER 79. PHARMACY AUDITS

§ 3801. DEFINITIONS

As used in this subchapter:

(1)(A) "Health insurer" shall have the same meaning as in section 9402 of this title and shall include:

(i) a health insurance company, a nonprofit hospital and medical service corporation, and health maintenance organizations;

(ii) an employer, a labor union, or another group of persons organized in Vermont that provides a health plan to beneficiaries who are employed or reside in Vermont; and

(iii) except as otherwise provided in section 3805 of this title, the state of Vermont and any agent or instrumentality of the state that offers, administers, or provides financial support to state government.

(B) The term “health insurer” shall not include Medicaid, the Vermont health access plan, Vermont Rx, or any other Vermont public health care assistance program.

(2) “Health plan” means a health benefit plan offered, administered, or issued by a health insurer doing business in Vermont.

(3) “Pharmacy” means any individual or entity licensed or registered under 26 V.S.A. chapter 36.

(4) “Pharmacy benefit management” means an arrangement for the procurement of prescription drugs at a negotiated rate for dispensation within this state to beneficiaries, the administration or management of prescription drug benefits provided by a health plan for the benefit of beneficiaries, or any of the following services provided with regard to the administration of pharmacy benefits:

(A) mail service pharmacy;

(B) claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to beneficiaries;

(C) clinical formulary development and management services;

(D) rebate contracting and administration;

(E) certain patient compliance, therapeutic intervention, and generic substitution programs; and

(F) disease or chronic care management programs.

(5) “Pharmacy benefit manager” means an entity that performs pharmacy benefit management. The term includes a person or entity in a contractual or employment relationship with an entity performing pharmacy benefit management for a health plan.

(6) “Responsible party” means the entity, including a health insurer or pharmacy benefit manager, responsible for payment of claims for health care services other than:

(A) the individual to whom the health care services were rendered;

(B) that individual’s guardian or legal representative; or

(C) the agency of human services, its agents, and contractors.

§ 3802. PHARMACY RIGHTS DURING AN AUDIT

Notwithstanding any provision of law to the contrary, whenever a health insurer, a third-party payer, or an entity representing a responsible party

conducts an audit of the records of a pharmacy, the pharmacy shall have a right to all of the following:

(1) To have an audit involving clinical or professional judgment be conducted by a pharmacist licensed to practice pharmacy in one or more states, who has at least a familiarity with Vermont pharmacy statutes and rules and who is employed by or working with an auditing entity.

(2) If an audit is to be conducted on-site at a pharmacy, the entity conducting the audit:

(A) shall give the pharmacy at least 14 days' advance written notice of the audit and the specific prescriptions to be included in the audit; and

(B) may not audit a pharmacy on Mondays or on weeks containing a federal holiday, unless the pharmacy agrees to alternative timing for the audit.

(3) Not to have an entity audit claims that:

(A) were submitted to the pharmacy benefit manager more than 18 months prior to the date of the audit, unless:

(i) required by federal law; or

(ii) the originating prescription was dated within the 24-month period preceding the date of the audit; or

(B) exceed 200 selected prescription claims.

(4) To have auditors enter the prescription department only when accompanied by or authorized by a member of the pharmacy staff, and not to have auditors disrupt the provision of services to the pharmacy's customers.

(5) Not to have clerical or recordkeeping errors, including typographical errors, scrivener's errors, and computer errors, on a required document or record deemed fraudulent in the absence of any financial harm or other evidence; provided that this subdivision shall not be construed to prohibit recoupment of actual fraudulent payments.

(6) If required under the terms of the contract, to have the auditing entity provide to the pharmacy, upon request, all records related to the audit in an electronic or digital media format.

(7) In order to validate a pharmacy record with respect to a prescription or refill, to have the properly documented records of a hospital or of any person authorized by law to prescribe medication transmitted by any means of communication.

(8) To use any prescription that meets the requirements to be a legal prescription under Vermont law, including prescriber notations such as "as directed" and "as needed" which require the professional judgment of the pharmacist to determine that the dose dispensed is within normal guidelines, to validate claims submitted for reimbursement for dispensing of original and refill prescriptions, or changes made to prescriptions.

(9) To dispense and receive reimbursement for the full quantity of the smallest commonly available commercially packaged product, including eye drops, insulin, and topical products, that contains the total amount required to be dispensed to meet the days' supply ordered by the prescriber, even if the full quantity of the commercially prepared package exceeds the maximum days' supply allowed.

(10) To determine the days' supply using the highest daily total dose that may be utilized by the patient pursuant to the prescriber's directions, and for prescriptions with a titrated dose schedule, to use the schedule to determine the days' supply.

(11) To be subject to recoupment only following the correction of a claim and to have recoupment limited to amounts paid in excess of amounts payable under the corrected claim.

(12) Not to have a demand for recoupment, repayment, or offset against future reimbursement for overpayment of a claim for dispensing of an original or refill prescription include the dispensing fee, unless the prescription that is the subject of the claim was not actually dispensed, was not valid, was fraudulent, or was outside the provisions of the contract; provided that this subdivision shall not apply if a pharmacy is required to correct an error in a claim submitted in good faith.

(13) Unless otherwise agreed to by contract, not to have an audit finding or demand for recoupment, repayment, or offset against future reimbursement made for any claim for dispensing of an original or refill prescription due to information missing from a prescription or to information not placed in a particular location when the information or location is not required or specified by state or federal law. The pharmacy shall be allowed 30 days to document and correct the missing information.

(14) In the event the actual quantity dispensed on a valid prescription for a covered beneficiary exceeded the allowable maximum days' supply of the product as defined in the contract, to have the amount to be recouped, repaid, or offset against future reimbursement limited to an amount calculated based on the quantity of the product dispensed found to be in excess of the allowed days' supply quantity and using the cost of the product as reflected on the original claim.

(15) Not to have the accounting practice of extrapolation used in calculating any recoupment or penalty, unless otherwise required by federal law or by federal health plans.

(16) Except for cases of federal Food and Drug Administration regulation or drug manufacturer safety programs, to be free of recoupments based on either:

(A) documentation requirements in addition to or in excess of state board of pharmacy documentation creation or maintenance requirements; or

(B) a requirement that a pharmacy or pharmacist perform a professional duty in addition to or in excess of state board of pharmacy professional duty requirements.

(17) Except for Medicare claims, to be subject to reversals of approval for drug, prescriber, or patient eligibility upon adjudication of a claim only in cases in which the pharmacy obtained the adjudication by fraud or misrepresentation of claim elements.

(18) To be audited under the same standards and parameters as other similarly situated pharmacies audited by the same entity.

(19) To have the preliminary audit report delivered to the pharmacy within 60 days following the conclusion of the audit.

(20) To have at least 30 days following receipt of the preliminary audit report to produce documentation to address any discrepancy found during the audit.

(21) To have a final audit report delivered to the pharmacy within 120 days after the end of the appeals period, as required by section 3803 of this title.

(22) Except for audits initiated to address an identified problem, to be subject to no more than one audit per calendar year, unless fraud or misrepresentation is reasonably suspected.

(23) Not to have audit information from an audit conducted by one auditing entity shared with or utilized by another auditing entity, except as required by state or federal law.

§ 3803. APPEALS

(a) An entity that audits a pharmacy shall provide the pharmacy with a preliminary audit report, which shall be delivered to the pharmacy or to its corporate office of record within 60 days following completion of the audit.

(b) A pharmacy shall have 30 days following receipt of the preliminary audit report in which to respond to questions, provide additional documentation, and comment on and clarify audit findings. Receipt of the report shall be based on the date postmarked on the envelope or the date of a computer transmission, if transferred electronically.

(c) If an audit results in the dispute or denial of a claim, the entity conducting the audit shall allow the pharmacy to resubmit the claim using any commercially reasonable method, including U.S. mail, facsimile, or electronic claims submission, as long as the period of time during which a claim may be resubmitted has not expired.

(d) Within 120 days after the completion of the appeals process established by this section, a final audit report shall be delivered to the pharmacy or to its corporate office of record. The final audit report shall include a disclosure of any funds recovered by the entity that conducted the audit.

(e) An entity that audits a pharmacy shall have in place a written appeals process by which a pharmacy may appeal the preliminary audit report and the final audit report, and shall provide the pharmacy with notice of the appeals process.

(f) A pharmacy shall be entitled to request a mediator agreed upon by both parties to resolve any disagreements; such request shall not be deemed to waive any existing rights of appeal.

§ 3804. PHARMACY AUDIT RECOUPMENTS

(a) Recoupment of any disputed funds shall occur only after the final internal disposition of an audit, including the appeals process set forth in section 3803 of this title.

(b) An entity conducting an audit may not:

(1) Include dispensing fees in calculations of overpayments unless the prescription is determined to have been dispensed in error.

(2) Recoup funds for clerical or recordkeeping errors, including typographical errors, scribes' errors, and computer errors on a required document or record unless the error resulted in overpayment or the entity

conducting the audit has evidence that the pharmacy's actions reasonably indicate fraud or other intentional or willful misrepresentation.

(3) Collect any funds, charge-backs, or penalties until the audit and all appeals are final, unless the entity conducting the audit is alleging fraud or other intentional or willful misrepresentation.

(4) Recoup an amount in excess of the actual overpayment.

(c) Recoupment on an audit shall be refunded to the responsible party as contractually agreed upon by the parties.

(d) The entity conducting the audit may charge or assess the responsible party, directly or indirectly, based on amounts recouped if both of the following conditions are met:

(1) the responsible party and the entity conducting the audit have entered into a contract that explicitly states the percentage charge or assessment to the responsible party; and

(2) a commission or other payment to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

§ 3805. APPLICABILITY

The provisions of this chapter shall not apply to any audit or investigation undertaken by any state agency, including the office of the attorney general or the agency of human services, to a fiscal agent of the state, or to any audit,

review, or investigation that involves alleged Medicaid fraud, Medicaid waste, Medicaid abuse, insurance fraud, or criminal fraud or misrepresentation.

Sec. 5. 24 V.S.A. § 2689 is added to read:

§ 2689. REIMBURSEMENT FOR AMBULANCE SERVICE PROVIDERS

(a) When an ambulance service provides emergency medical treatment to a person who is insured by a health insurance policy, plan, or contract that provides benefits for emergency medical treatment, the health insurer shall reimburse the ambulance service directly, subject to the terms and conditions of the health insurance policy, plan, or contract.

(b) Nothing in this section shall be construed to interfere with coordination of benefits or to require a health insurer to provide coverage for services not otherwise covered under the insured's policy, plan, or contract.

(c) Nothing in this section shall preclude an insurer from negotiating with and subsequently entering into a contract with a nonparticipating ambulance service to establish rates of reimbursement for emergency medical treatment.

Sec. 6. EFFECTIVE DATES

(a) Secs. 1 and 2 of this act and this section shall take effect on July 1, 2012, and reporting by health insurers shall begin with the annual statement due under Title 8 for calendar year 2012.

(b) Secs. 3 and 4 of this act shall take effect on July 1, 2012 and shall apply to contracts entered into or renewed on and after that date.

(c) Sec. 5 of this act shall take effect on July 1, 2012.

Approved: May 16, 2012