SUBJECT: Paying and auditing pharmacy claims

COMMITTEE: Insurance — committee substitute recommended

VOTE: 9 ayes — Smithee, Eiland, Hancock, Nash, Sheets, L. Taylor, Torres, Vo, Walle

0 nays

WITNESSES: For — Richard Beck, Texas Pharmacy Business Council; William Moore, Moore's Pharmacy; Michael Smith, Walgreens; (*Registered, but did not testify:* Barbara Waldon, HEB; Michael Wright, Texas Pharmacy Association)

Against — (*Registered, but did not testify:* David Dederichs, Express Scripts)

On — (*Registered, but did not testify:* Douglas Danzeiser, Texas Department of Insurance)

BACKGROUND: Health plans contract with pharmacy benefit managers (PBMs) to conduct an array of services related to providing and administering pharmacy benefits, such as claims adjudication, formulary development and maintenance, and providing drug utilization monitoring reports to plan administrators.

DIGEST: CSHB 2292 would add requirements related to the payment and auditing of pharmacies by health maintenance organizations (HMOs), preferred provider plans (PPPs), and PBMs that administered benefits for HMOs and PPPs. The bill would state as legislative intent that the changes related to claims payment and auditing would apply to all HMOs, PPPs, and PBMs unless otherwise prohibited by federal law.

The bill would require HMOs, PPPs, and their PBMs to pay all affirmatively adjudicated electronically submitted pharmacy claims within 18 days of adjudication through an electronic funds transfer (EFT). HMOs, PPPs, and PBMs would be required to pay paper claims within 21 days.

HMOs, PPPs, and their PBMs could not use extrapolation when auditing pharmacy claims or require extrapolation audits as a condition of network participation. They also would be required to provide the pharmacy with written notice within 15 days of an onsite audit and accommodate the pharmacy's schedule to the greatest possible extent. Extrapolation would be defined as a mathematical process or technique that estimated audit results or findings for a group of claims without reviewing every claim.

The bill would take effect September 1, 2011. The changes in this bill related to claims payments would apply only to claims paid under contracts entered into or renewed on or after September 1, 2011, and to claims paid without contracts on or after September 1, 2011. The changes in this bill related to audits would apply only to audits conducted under contracts entered into or renewed on or after September 1, 2011.

SUPPORTERS SAY:

CSHB 2292 is needed to clarify that pharmacies are to be paid promptly and specify the terms regarding prompt payment and claims auditing. A government solution is needed because a single pharmacy has no negotiating power against a PBM or health plan, and groups of pharmacies are prevented by antitrust laws from banding together to negotiate contracts. Two of the largest PBMs in the U.S., Medco and Caremark/CVS, have agreed to this bill.

Most pharmacy claims are electronically submitted, meaning that the health plan or PBM determines within split seconds whether the claim is complete and meets all plan, formulary, and clinical requirements for dispensing the prescription. There is no reason for pharmacies to wait longer than 18 days to get paid for prescriptions that already have left the store. If the Texas Vendor Drug Program, covering Medicaid and Children's Health Insurance Program (CHIP) pharmacy benefits, can pay within a couple of weeks, so too can private insurers and PBMs.

PBMs unfairly profit through interest income secured by delaying payments to pharmacies. The pharmacy business relies on a timely cash flow, and many pharmacies cannot sustain long delays in payment, particularly when medication suppliers enforce penalties on pharmacies for delayed payments.

Delayed payments particularly affect independent pharmacies, who do not have the revenue streams that chain drug stores and large retailers enjoy. An independent pharmacy typically pays between $100,000 and $200,000

per month on drug supplies, and most cannot sustain prolonged periods without payment for prescriptions they have dispensed.

Requiring electronic fund transfer (EFT) payments also would be appropriate, given today's technology, and should *reduce*, not increase, business costs. EFT is a common form of payment. Today, many large employers, including Texas, save costs by paying employees using EFTs. Pharmacies typically receive payments for a batch of prescriptions by mail, often ranging in the thousands of dollars. Payments lost or delivered to the wrong address can financially stress the pharmacy and take time away from patient care to recoup.

Extrapolation should not be used for auditing pharmacy claims, and has been abused by PBMs to deny payment on groups of claims based on a single-instance error, even administrative errors that did not alter the validity of dispensing the drug. Extrapolation audits use a sampling of claims data to determine payment accuracy, and the sample is projected onto a total group or period of claims to determine a total expected payment error. Extrapolation may be an appropriate audit technique in other more systematic business operations, but is inappropriate for auditing highly individualized pharmacy prescriptions.

Since audits are paper-intensive endeavors and require a considerable investment of a pharmacist's time, it is only reasonable to ask for advance notice of an onsite audit. Given the thousands of diverse claims a pharmacy would have handled, there is no way an advance notice would allow a pharmacist to selectively alter a prescription or claim information before the arrival of the auditor, or to determine which claims the auditor would select to review.

OPPONENTS SAY:

This bill unnecessarily would infringe on free-market contract negotiations and business decisions and would increase pharmacy costs related to waste and fraud. Pharmacies can choose to participate in networks and can negotiate contract terms that they do not like.

Claim adjudication may be quick, but claims must go through other processes prior to payment to ensure accuracy and protect against fraud and waste. In most states, the payment standard is 30 days. A study by Grant Thornton in 2007 on the costs of dispensing prescriptions found that surveyed pharmacies reported non-Medicaid third-party claims payment to only average about 24 days. Texas Vendor Drug, which covers Medicaid

and CHIP pharmacy benefits, does not have to process millions of pharmacy claims from multiple employer plans with varying pharmacy coverage, and therefore can reimburse pharmacies relatively quickly. Texas already has a low claims payment period requirement of 21 days, and PBMs and plans should not be held to a uniform and even lower time period.

Auditing pharmacy claims helps ensure patient safety and conformity with plan requirements and is the prudent way to verify accuracy and protect against fraud. While extrapolation is not used by all PBMs, it still is a valid way of auditing claims, given the expanse of claims submitted by pharmacies and the effort and cost that would be involved in reviewing each individual prescription.

These requirements would raise the cost of doing business, which would be passed on to employers and beneficiaries. If pharmacies are having problems with PBMs adhering to current claims payment or other requirements, they should report the bad actors to the Texas Department of Insurance for enforcement, instead of making the law more restrictive for all PBMs.

NOTES:

The companion bill, SB 1211 by Van de Putte, was referred to the Senate State Affairs Committee on March 16.