BILL ANALYSIS

H.B. 2250
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Insurance
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Current law requires health maintenance organizations (HMOs), preferred provider benefit plans (PPBPs) and entities contracting with these organizations for the processing or payment of claims, namely pharmacy benefit managers (PBMs), to pay health care providers promptly within specified time frames for paper and electronic claims. Current law also requires HMOs, PPBPs, and PBMs to adhere to certain procedures when auditing health care provider claims.

H.B. 2250 amends current law to reflect existing technology and the fact that the majority of pharmacy claims are filed electronically, with the pharmacy receiving feedback almost instantly from the HMO, PPBP, or PBM as to whether a claim is accepted or rejected. The pharmacy profession's use of electronic technology in its business operations saves money for employers, patients, and health care providers. This bill requires affirmatively adjudicated electronic claims to be paid to pharmacies via electronic funds transfer and shortens the payment period. The bill also allows a pharmacy a reasonable amount of time to make necessary staffing changes to maintain patient care while simultaneously accommodating an on-site audit by requiring an HMO, PPBP, or PBM to accommodate the pharmacy's schedule and provide notice of the audit. The bill establishes a specified complaint filing and resolution process with the Texas Department of Insurance for allegations of noncompliance with prompt pay and audit standards, including an appeals process with the State Office of Administrative Hearings.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

H.B. 2250 amends an Insurance Code provision that sets the deadline by which a health maintenance organization (HMO) that affirmatively adjudicates an electronically submitted pharmacy claim must pay the total amount of the claim to apply that deadline to a pharmacy benefit manager that administers pharmacy claims for the HMO. The bill shortens the deadline from the 21st day after the date the claim was affirmatively adjudicated to the 14th day after that date. The bill requires an HMO, or a pharmacy benefit manager that administers its pharmacy claims, that affirmatively adjudicates such a claim that is not electronically submitted to pay the total amount of the claim not later than the 21st day after the date on which the claim was affirmatively adjudicated.

H.B. 2250 prohibits an HMO or a pharmacy benefit manager that administers its pharmacy claims from using extrapolation to complete the audit of a provider who is a pharmacist or pharmacy, or from requiring extrapolation audits as a condition of participation in the HMO's contract, network, or program for a provider who is a pharmacist or pharmacy. The bill defines "extrapolation" as a mathematical process or technique used by an HMO or pharmacy benefit manager that administers its pharmacy claims in the audit of a pharmacy or pharmacist to estimate audit results or findings for a larger batch or group of claims not reviewed by the HMO

or pharmacy benefit manager. The bill requires an HMO or a pharmacy benefit manager that administers its pharmacy claims that performs an on-site audit of a provider who is a pharmacist or pharmacy to provide the provider reasonable notice of the audit and to accommodate the provider's schedule to the greatest extent possible. The bill requires this notice to be in writing and sent by certified mail to the provider not later than the 15th day before the date on which the on-site audit is scheduled to occur.

H.B. 2250 specifies that a pharmacy benefit manager is included in the application of provisions relating to a person with whom an HMO contracts to process or pay claims, obtain the services of physicians and providers to provide health care services to enrollees, or issue verifications or preauthorizations.

H.B. 2250 requires a dispute regarding payment of a claim to a provider who is a pharmacist or pharmacy to be resolved in accordance with the following provisions. The bill authorizes a provider who is a pharmacist or pharmacy to submit a complaint to the Texas Department of Insurance alleging noncompliance with these requirements by an HMO, a pharmacy benefit manager that administers its pharmacy claims, or another entity that contracts with the HMO. The bill requires a complaint to be submitted in writing or by submitting a completed complaint form delivered to the department and requires the department to maintain a complaint form on its Internet website and at its offices for use by a complainant. The bill requires the commissioner of insurance to determine the validity of the complaint and enter a written order that provides the HMO and the complainant with a summary of the investigation conducted by the department; written notice of the matters asserted, including a statement of the legal authority, jurisdiction, and alleged conduct under which an enforcement action is imposed or denied, with a reference to the statutes and rules involved, and that, on request to the department, the HMO and the complainant are entitled to a hearing conducted by the State Office of Administrative Hearings (SOAH) regarding the determinations made in the order; and a determination of the denial of the allegations or the imposition of penalties against the HMO. The bill establishes that such an order is final in the absence of a request by the complainant or HMO for a hearing by SOAH. The bill requires the commissioner, if the department investigation substantiates the allegations of noncompliance and after notice and an opportunity for a hearing by SOAH, to require the HMO to pay penalties as provided by state law.

H.B. 2250 requires SOAH to conduct a hearing regarding a written order of the commissioner on the request of the department. The bill provides that the hearing is subject to state laws governing administrative proceedings and must be conducted as a contested case hearing. The bill requires the commissioner to issue a final order after receipt of a proposal for decision issued by SOAH and, if it appears to the department, the complainant, or the HMO that a person or entity is engaging in or is about to engage in a violation of the final order, the department, the complainant, or the HMO is authorized to bring an action for judicial review in district court in Travis County to enjoin or restrain the continuation or commencement of the violation or to compel compliance with the final order. The bill authorizes the complainant or the HMO to also bring an action for judicial review of the final order. The bill provides that it is the intent of the legislature that the requirements regarding payment of claims to providers who are pharmacists or pharmacies apply to all HMOs and pharmacy benefit managers unless otherwise prohibited by federal law.

H.B. 2250 sets out provisions that are substantially similar to all of the above provisions relating to an HMO or a pharmacy benefit manager that administers its claims but that apply to an insurer under a preferred provider benefit plan or a pharmacy benefit manager that administers its claims. The bill includes a pharmacist and a pharmacy in the definition of the term "health care provider."

H.B. 2250 makes its provisions applicable only to a contract between a pharmacy benefit manager and an HMO or insurer entered into or renewed on or after January 1, 2010.

EFFECTIVE DATE

September 1, 2009.