BILL ANALYSIS

S.B. 1106
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Insurance
Committee Report (Amended)

BACKGROUND AND PURPOSE

Current law requires a health maintenance organization (HMO), preferred provider benefit plan, and an entity, such as a pharmacy benefit manager contracting with these organizations for the processing or payment of claims, to pay health care providers promptly within specified time frames for paper and electronic claims. Current law also requires an HMO, a preferred provider benefit plan, and a pharmacy benefit manager to adhere to certain procedures when auditing health care provider claims. This bill seeks to amend 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 as to whether a claim is accepted or rejected and to allow a pharmacy a reasonable amount of time to make necessary staffing changes to maintain patient care while simultaneously accommodating an on-site audit.

S.B. 1106 requires affirmatively adjudicated electronic claims to be paid to pharmacies via electronic funds transfer and shortens the deadline for payment. The bill requires an HMO, a preferred provider benefit plan, or a pharmacy benefit manager to accommodate the pharmacy's schedule and provide notice of an on-site 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

S.B. 1106 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 and requires the claim to be paid through electronic funds transfer. 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.

S.B. 1106 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.

S.B. 1106 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.

S.B. 1106 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 (TDI) 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 TDI and requires TDI 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 TDI; 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 TDI, 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 TDI 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.

S.B. 1106 requires SOAH to conduct a hearing regarding a written order of the commissioner on the request of TDI. 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 TDI, 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, TDI, 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 also to 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.

S.B. 1106 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."

S.B. 1106 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.

EXPLANATION OF AMENDMENTS

Committee Amendment No. 1

S.B. 1106 is amended to increase from the 14th day after the date a claim was affirmatively adjudicated to the 18th day after that date the deadline by which a health maintenance organization (HMO), an insurer under a preferred provider benefit plan, or a pharmacy benefit manager that administers pharmacy claims for the HMO or insurer that affirmatively adjudicates an electronically submitted pharmacy claim is required to pay the total amount of the claim through electronic funds transfer.