By: Isett, et al. H.B. No. 1696

Substitute the following for H.B. No. 1696:

By: Isett C.S.H.B. No. 1696

A BILL TO BE ENTITLED

1 AN ACT

2 relating to the regulation of pharmacy benefit managers and to
3 payment of claims to pharmacies and pharmacists.
4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
5 SECTION 1. Subtitle D, Title 13, Insurance Code, is amended
6 by adding Chapter 4154 to read as follows:
7 CHAPTER 4154. PHARMACY BENEFIT MANAGERS
8 SUBCHAPTER A. GENERAL PROVISIONS
9 Sec. 4154.001. DEFINITIONS. In this chapter:
10 (1) "Covered entity" means a nonprofit hospital or
11 medical services corporation, a health insurer, a health benefit
12 plan, a health maintenance organization, a health program
13 administered by a state agency in the capacity of provider of health
14 coverage, or an employer, labor union, or other group of persons
15 organized in this state that provides health coverage. The term
16 does not include:
17 (A) a self-funded health coverage plan that is
18 exempt from state regulation under the Employee Retirement Income
19 Security Act of 1974 (29 U.S.C. Section 1001 et seq.);
20 (B) a plan issued for health coverage for federal
21 employees; or
22 (C) a health benefit plan that provides coverage
23 only for accidental injury or a specified disease, a hospital
24 indemnity plan, a Medicare supplement plan, a disability income

1 plan, a long-term care plan, or any other limited benefit health
2 insurance policy or contract.
3 (2) "Covered individual" means a member, participant,
4 enrollee, contract holder, policyholder, or beneficiary of a
5 covered entity who is provided health coverage by the covered
6 entity. The term includes a dependent or other individual who
7 receives health coverage through a policy, contract, or plan for a
8 covered individual.
9 (3) "Pharmacy benefit management" means
10 administration or management of prescription drug benefits
11 provided by a covered entity under the terms and conditions of a
12 contract between a pharmacy benefit manager and the covered entity.
13 (4) "Pharmacy benefit manager" has the meaning
14 assigned by Section 4151.151. The term includes a person acting on
15 behalf of a pharmacy benefit manager in a contractual or employment
16 relationship in the performance of pharmacy benefit management
17 services for a covered entity. The term does not include a public
18 self-funded pool or a private single employer self-funded plan that
19 provides pharmacy benefits or pharmacy benefit management services
20 directly to its beneficiaries.
21 Sec. 4154.002. RULES. The commissioner may adopt rules and
22 standards as necessary to implement this chapter.
23 [Sections 4154.003-4154.050 reserved for expansion]
24 SUBCHAPTER B. REGULATION OF PHARMACY BENEFIT MANAGERS
25 Sec. 4154.051. APPLICABILITY. This chapter applies to each
26 pharmacy benefit manager that provides claims processing services,
27 other prescription drug or device services, or both claims

1 processing services and other prescription drug or device services
2 to covered individuals who are residents of this state.
3 Sec. 4154.052. CERTIFICATE OF AUTHORITY AS ADMINISTRATOR
4 REQUIRED. (a) A person may not act as or represent that the person
5 is a pharmacy benefit manager in this state unless the person is
6 covered by and is engaging in business under a certificate of
7 authority as a third-party administrator issued under Chapter 4151.
8 (b) Chapter 4151 applies to a pharmacy benefit manager.
9 Sec. 4154.053. PERFORMANCE OF DUTIES; GOOD FAITH; CONFLICT
10 OF INTEREST. (a) In operating as a pharmacy benefit manager, a
11 pharmacy benefit manager shall exercise good faith and fair dealing
12 in the performance of contractual obligations toward a covered
13 entity.
14 (b) A pharmacy benefit manager shall notify a covered entity
15 in writing of any activity, policy, practice, ownership interest,
16 or affiliation of the pharmacy benefit manager that may present a
17 conflict of interest.
18 Sec. 4154.054. REQUIREMENTS REGARDING CONTACTING COVERED
19 INDIVIDUALS. Except as otherwise provided by the terms of the
20 contract with a covered entity, a pharmacy benefit manager may not
21 contact a covered individual without the express written permission
22 of the covered entity.
23 Sec. 4154.055. DISPENSING OF SUBSTITUTE PRESCRIPTION DRUG
24 FOR PRESCRIBED DRUG. (a) A pharmacy benefit manager may substitute
25 a lower priced generic and therapeutically equivalent drug for a
26 higher priced prescribed drug or request a therapeutic interchange
27 only as provided by Chapter 562, Occupations Code, and this

1 section. The pharmacy benefit manager must disclose information as
2 required by Subsection (b) and obtain the approval of the
3 prescribing practitioner before requesting any therapeutic
4 interchange under this section.
5 (b) The pharmacy benefit manager must disclose the
6 following information to the prescribing practitioner:
7 (1) the difference, if any, in copayments or other
8 out-of-pocket costs to the covered individual;
9 (2) whether the drug originally prescribed has a
10 generic equivalent and the drug proposed for substitution does not;
11 and
12 (3) any known clinically significant differences
13 between the prescribed drug and the drug proposed for substitution,
14 including any side effects and other potential effects on the
15 covered individual's health.
16 (c) If the net cost to the covered individual or covered
17 entity of the substituted drug exceeds the cost of the prescribed
18 drug, the substitution may be made only for medical reasons that
19 benefit the covered individual.
20 (d) A pharmacy benefit manager may not substitute an
21 equivalent prescribed drug contrary to a prescription drug order
22 that prohibits a substitution.
23 (e) If the therapeutic interchange is approved by the
24 prescribing practitioner, the pharmacy benefit manager must notify
25 the covered individual of the change from the originally prescribed
26 drug to the substituted drug.
27 Sec. 4154.056. DUTIES TO PHARMACY NETWORK PROVIDER. (a) A

1 pharmacy benefit manager may not require a pharmacy network
2 provider to comply with recordkeeping provisions more stringent
3 than those required by other state law or rule or by federal law or
4 regulation.

5 (b) If a pharmacy benefit manager receives notice from a
6 covered entity of termination of the covered entity's contract, the
7 pharmacy benefit manager shall notify, not later than the 10th
8 business day after the date of the notice, each pharmacy network
9 provider affected by the termination of the effective date of the
10 termination.

11 (c) Not later than the third business day after the date of a
12 price increase notification by a manufacturer or supplier, a
13 pharmacy benefit manager shall adjust its payment to the pharmacy
14 network provider in a manner consistent with the price increase.

15 SECTION 2. Section 843.002, Insurance Code, is amended by
16 adding Subdivision (9-a) to read as follows:

17 (9-a) "Extrapolation" means a mathematical process or
18 technique used by a health maintenance organization or pharmacy
19 benefit manager that administers pharmacy claims for a health
20 maintenance organization in the audit of a pharmacy or pharmacist
21 to estimate audit results or findings for a larger batch or group of
22 claims not reviewed by the health maintenance organization or
23 pharmacy benefit manager.

24 SECTION 3. Section 843.338, Insurance Code, is amended to
25 read as follows:

26 Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except
27 as provided by Sections [~~Section~~] 843.3385 and 843.339, not later

than the 45th day after the date on which a health maintenance organization receives a clean claim from a participating physician or provider in a nonelectronic format or the 30th day after the date the health maintenance organization receives a clean claim from a participating physician or provider that is electronically submitted, the health maintenance organization shall make a determination of whether the claim is payable and:

(1) if the health maintenance organization determines the entire claim is payable, pay the total amount of the claim in accordance with the contract between the physician or provider and the health maintenance organization;

(2) if the health maintenance organization determines a portion of the claim is payable, pay the portion of the claim that is not in dispute and notify the physician or provider in writing why the remaining portion of the claim will not be paid; or

(3) if the health maintenance organization determines that the claim is not payable, notify the physician or provider in writing why the claim will not be paid.

SECTION 4. Section 843.339, Insurance Code, is amended to read as follows:

Sec. 843.339. DEADLINE FOR ACTION ON [~~CERTAIN~~] PRESCRIPTION CLAIMS; PAYMENT. (a) A [~~Not later than the 21st day after the date a~~] health maintenance organization, or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization, that affirmatively adjudicates a pharmacy claim that is electronically submitted, [~~the health maintenance organization~~] shall pay the total amount of the claim through electronic funds

1 transfer not later than the 14th day after the date on which the
2 claim was affirmatively adjudicated.
3 (b) A health maintenance organization, or a pharmacy
4 benefit manager that administers pharmacy claims for the health
5 maintenance organization, that affirmatively adjudicates a
6 pharmacy claim that is not electronically submitted, shall pay the
7 total amount of the claim not later than the 21st day after the date
8 on which the claim was affirmatively adjudicated.
9 SECTION 5. Section 843.340, Insurance Code, is amended by
10 adding Subsections (f) and (g) to read as follows:
11 (f) A health maintenance organization or a pharmacy benefit
12 manager that administers pharmacy claims for the health maintenance
13 organization may not use extrapolation to complete the audit of a
14 provider who is a pharmacist or pharmacy. A health maintenance
15 organization or a pharmacy benefit manager that administers
16 pharmacy claims for the health maintenance organization may not
17 require extrapolation audits as a condition of participation in the
18 health maintenance organization's contract, network, or program
19 for a provider who is a pharmacist or pharmacy.
20 (g) A health maintenance organization or a pharmacy benefit
21 manager that administers pharmacy claims for the health maintenance
22 organization that performs an on-site audit under this chapter of a
23 provider who is a pharmacist or pharmacy shall provide the provider
24 reasonable notice of the audit and accommodate the provider's
25 schedule to the greatest extent possible. The notice required
26 under this subsection must be in writing and must be sent by
27 certified mail to the provider not later than the 15th day before

1 the date on which the on-site audit is scheduled to occur.
2 SECTION 6. Section 843.344, Insurance Code, is amended to
3 read as follows:
4 Sec. 843.344. APPLICABILITY OF SUBCHAPTER TO ENTITIES
5 CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. This subchapter
6 applies to a person, including a pharmacy benefit manager, with
7 whom a health maintenance organization contracts to:
8 (1) process or pay claims;
9 (2) obtain the services of physicians and providers to
10 provide health care services to enrollees; or
11 (3) issue verifications or preauthorizations.
12 SECTION 7. Subchapter J, Chapter 843, Insurance Code, is
13 amended by adding Sections 843.354, 843.355, and 843.356 to read as
14 follows:
15 Sec. 843.354. DEPARTMENT ENFORCEMENT OF PHARMACY CLAIMS.
16 (a) Notwithstanding any other provision of this subchapter, a
17 dispute regarding payment of a claim to a provider who is a
18 pharmacist or pharmacy shall be resolved as provided by this
19 section.
20 (b) A provider who is a pharmacist or pharmacy may submit a
21 complaint to the department alleging noncompliance with the
22 requirements of this subchapter by a health maintenance
23 organization, a pharmacy benefit manager that administers pharmacy
24 claims for the health maintenance organization, or another entity
25 that contracts with the health maintenance organization as provided
26 by Section 843.344. A complaint must be submitted in writing or by
27 submitting a completed complaint form to the department by mail or

through another delivery method. The department shall maintain a complaint form on the department's Internet website and at the department's offices for use by a complainant.

(c) After investigation of the complaint by the department, the commissioner shall determine the validity of the complaint and shall enter a written order. In the order, the commissioner shall provide the health maintenance organization and the complainant with:

(1) a summary of the investigation conducted by the department;

(2) written notice of the matters asserted, including a statement:

(A) 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

(B) that, on request to the department, the health maintenance organization and the complainant are entitled to a hearing conducted by the State Office of Administrative Hearings in the manner prescribed by Section 843.355 regarding the determinations made in the order; and

(3) a determination of the denial of the allegations or the imposition of penalties against the health maintenance organization.

(d) An order issued under Subsection (c) is final in the absence of a request by the complainant or health maintenance organization for a hearing under Section 843.355.

(e) If the department investigation substantiates the

1 allegations of noncompliance made under Subsection (b), the
2 commissioner, after notice and an opportunity for a hearing as
3 described by Subsection (c), shall require the health maintenance
4 organization to pay penalties as provided by Section 843.342.
5 Sec. 843.355. HEARING BY STATE OFFICE OF ADMINISTRATIVE
6 HEARINGS; FINAL ORDER. (a) The State Office of Administrative
7 Hearings shall conduct a hearing regarding a written order of the
8 commissioner under Section 843.354 on the request of the
9 department. A hearing under this section is subject to Chapter
10 2001, Government Code, and shall be conducted as a contested case
11 hearing.
12 (b) After receipt of a proposal for decision issued by the
13 State Office of Administrative Hearings after a hearing conducted
14 under Subsection (a), the commissioner shall issue a final order.
15 (c) If it appears to the department, the complainant, or the
16 health maintenance organization that a person or entity is engaging
17 in or is about to engage in a violation of a final order issued under
18 Subsection (b), the department, the complainant, or the health
19 maintenance organization may bring an action for judicial review in
20 district court in Travis County to enjoin or restrain the
21 continuation or commencement of the violation or to compel
22 compliance with the final order. The complainant or the health
23 maintenance organization may also bring an action for judicial
24 review of the final order.
25 Sec. 843.356. LEGISLATIVE DECLARATION. It is the intent of
26 the legislature that the requirements contained in this subchapter
27 regarding payment of claims to providers who are pharmacists or

pharmacies apply to all health maintenance organizations and pharmacy benefit managers unless otherwise prohibited by federal law.

SECTION 8. Section 1301.001, Insurance Code, is amended by amending Subdivision (1) and adding Subdivision (1-a) to read as follows:

(1) "Extrapolation" means a mathematical process or technique used by an insurer or pharmacy benefit manager that administers pharmacy claims for an insurer 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 insurer or pharmacy benefit manager.

(1-a) "Health care provider" means a practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state. The term includes a pharmacist and a pharmacy. The term does not include a physician.

SECTION 9. Section 1301.103, Insurance Code, is amended to read as follows:

Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except as provided by Sections 1301.104 and [~~Section~~] 1301.1054, not later than the 45th day after the date an insurer receives a clean claim from a preferred provider in a nonelectronic format or the 30th day after the date an insurer receives a clean claim from a preferred provider that is electronically submitted, the insurer shall make a determination of whether the claim is payable and:

(1) if the insurer determines the entire claim is

payable, pay the total amount of the claim in accordance with the contract between the preferred provider and the insurer;

(2) if the insurer determines a portion of the claim is payable, pay the portion of the claim that is not in dispute and notify the preferred provider in writing why the remaining portion of the claim will not be paid; or

(3) if the insurer determines that the claim is not payable, notify the preferred provider in writing why the claim will not be paid.

SECTION 10. Section 1301.104, Insurance Code, is amended to read as follows:

Sec. 1301.104. DEADLINE FOR ACTION ON CERTAIN PHARMACY CLAIMS; PAYMENT. (a) An [~~Not later than the 21st day after the date an~~] insurer, or a pharmacy benefit manager that administers pharmacy claims for the insurer under a preferred provider benefit plan, that affirmatively adjudicates a pharmacy claim that is electronically submitted, [~~the insurer~~] shall pay the total amount of the claim through electronic funds transfer not later than the 14th day after the date on which the claim was affirmatively adjudicated.

(b) An insurer, or a pharmacy benefit manager that administers pharmacy claims for the insurer under a preferred provider benefit plan, that affirmatively adjudicates a pharmacy claim that is not electronically submitted, shall pay the total amount of the claim not later than the 21st day after the date on which the claim was affirmatively adjudicated.

SECTION 11. Section 1301.105, Insurance Code, is amended by

adding Subsections (e) and (f) to read as follows:

(e) An insurer or a pharmacy benefit manager that administers pharmacy claims for the insurer may not use extrapolation to complete the audit of a preferred provider that is a pharmacist or pharmacy. An insurer may not require extrapolation audits as a condition of participation in the insurer's contract, network, or program for a preferred provider that is a pharmacist or pharmacy.

(f) An insurer or a pharmacy benefit manager that administers pharmacy claims for the insurer that performs an on-site audit of a preferred provider that is a pharmacist or pharmacy shall provide the provider reasonable notice of the audit and accommodate the provider's schedule to the greatest extent possible. The notice required under this subsection must be in writing and must be sent by certified mail to the preferred provider not later than the 15th day before the date on which the on-site audit is scheduled to occur.

SECTION 12. Section 1301.109, Insurance Code, is amended to read as follows:

Sec. 1301.109. APPLICABILITY TO ENTITIES CONTRACTING WITH INSURER. This subchapter applies to a person, including a pharmacy benefit manager, with whom an insurer contracts to:

(1) process or pay claims;

(2) obtain the services of physicians and health care providers to provide health care services to insureds; or

(3) issue verifications or preauthorizations.

SECTION 13. Subchapter C-1, Chapter 1301, Insurance Code,

1 is amended by adding Sections 1301.139, 1301.140, and 1301.141 to
2 read as follows:
3 Sec. 1301.139. DEPARTMENT ENFORCEMENT OF PHARMACY CLAIMS.
4 (a) Notwithstanding any other provision of this subchapter, a
5 dispute regarding payment of a claim to a preferred provider who is
6 a pharmacist or pharmacy shall be resolved as provided by this
7 section.
8 (b) A preferred provider who is a pharmacist or pharmacy may
9 submit a complaint to the department alleging noncompliance with
10 the requirements of this subchapter by an insurer, a pharmacy
11 benefit manager that administers pharmacy claims for the insurer,
12 or another entity that contracts with the insurer as provided by
13 Section 1301.109. A complaint must be submitted in writing or by
14 submitting a completed complaint form to the department by mail or
15 through another delivery method. The department shall maintain a
16 complaint form on the department's Internet website and at the
17 department's offices for use by a complainant.
18 (c) After investigation of the complaint by the department,
19 the commissioner shall determine the validity of the complaint and
20 shall enter a written order. In the order, the commissioner shall
21 provide the insurer and the complainant with:
22 (1) a summary of the investigation conducted by the
23 department;
24 (2) written notice of the matters asserted, including
25 a statement:
26 (A) of the legal authority, jurisdiction, and
27 alleged conduct under which an enforcement action is imposed or

1 denied, with a reference to the statutes and rules involved; and
2 (B) that, on request to the department, the
3 insurer and the complainant are entitled to a hearing conducted by
4 the State Office of Administrative Hearings in the manner
5 prescribed by Section 1301.140 regarding the determinations made in
6 the order; and
7 (3) a determination of the denial of the allegations
8 or the imposition of penalties against the insurer.
9 (d) An order issued under Subsection (c) is final in the
10 absence of a request by the complainant or insurer for a hearing
11 under Section 1301.140.
12 (e) If the department investigation substantiates the
13 allegations of noncompliance made under Subsection (b), the
14 commissioner, after notice and an opportunity for a hearing as
15 described by Subsection (c), shall require the insurer to pay
16 penalties as provided by Section 1301.137.
17 Sec. 1301.140. HEARING BY STATE OFFICE OF ADMINISTRATIVE
18 HEARINGS; FINAL ORDER. (a) The State Office of Administrative
19 Hearings shall conduct a hearing regarding a written order of the
20 commissioner under Section 1301.139 on the request of the
21 department. A hearing under this section is subject to Chapter
22 2001, Government Code, and shall be conducted as a contested case
23 hearing.
24 (b) After receipt of a proposal for decision issued by the
25 State Office of Administrative Hearings after a hearing conducted
26 under Subsection (a), the commissioner shall issue a final order.
27 (c) If it appears to the department, the complainant, or the

1 insurer that a person or entity is engaging in or is about to engage
2 in a violation of a final order issued under Subsection (b), the
3 department, the complainant, or the insurer may bring an action for
4 judicial review in district court in Travis County to enjoin or
5 restrain the continuation or commencement of the violation or to
6 compel compliance with the final order. The complainant or the
7 insurer may also bring an action for judicial review of the final
8 order.
9 Sec. 1301.141. LEGISLATIVE DECLARATION. It is the intent
10 of the legislature that the requirements contained in this
11 subchapter regarding payment of claims to preferred providers who
12 are pharmacists or pharmacies apply to all insurers and pharmacy
13 benefit managers unless otherwise prohibited by federal law.
14 SECTION 14. The change in law made by this Act applies only
15 to a claim submitted by a provider to a health maintenance
16 organization or an insurer on or after the effective date of this
17 Act. A claim submitted before the effective date of this Act is
18 governed by the law as it existed immediately before that date, and
19 that law is continued in effect for that purpose.
20 SECTION 15. The change in law made by this Act applies only
21 to a contract between a pharmacy benefit manager and an insurer or
22 health maintenance organization entered into or renewed on or after
23 January 1, 2010. A contract entered into or renewed before January
24 1, 2010, is governed by the law as it existed immediately before the
25 effective date of this Act, and that law is continued in effect for
26 that purpose.
27 SECTION 16. This Act takes effect September 1, 2009.