By: Isett H.B. No. 1696

A BILL TO BE ENTITLED

AN ACT

relating to the regulation of pharmacy benefit managers and to payment of claims to pharmacies and pharmacists.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subtitle D, Title 13, Insurance Code, is amended by adding Chapter 4154 to read as follows:

CHAPTER 4154. PHARMACY BENEFIT MANAGERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4154.001. DEFINITIONS. In this chapter:

(1) "Covered entity" means a nonprofit hospital or medical services corporation, a health insurer, a health benefit plan, a health maintenance organization, a health program administered by a state agency in the capacity of provider of health coverage, or an employer, labor union, or other group of persons organized in this state that provides health coverage. The term does not include:

(A) a self-funded health coverage plan that is exempt from state regulation under the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(B) a plan issued for health coverage for federal employees; or

(C) a health benefit plan that provides coverage only for accidental injury or a specified disease, a hospital indemnity plan, a Medicare supplement plan, a disability income

plan, a long-term care plan, or any other limited benefit health insurance policy or contract.

(2) "Covered individual" means a member, participant, enrollee, contract holder, policyholder, or beneficiary of a covered entity who is provided health coverage by the covered entity. The term includes a dependent or other individual who receives health coverage through a policy, contract, or plan for a covered individual.

(3) "Pharmacy benefit management" means administration or management of prescription drug benefits provided by a covered entity under the terms and conditions of a contract between a pharmacy benefit manager and the covered entity.

(4) "Pharmacy benefit manager" has the meaning assigned by Section 4151.151. The term includes a person acting on behalf of a pharmacy benefit manager in a contractual or employment relationship in the performance of pharmacy benefit management services for a covered entity. The term does not include:

(A) a health insurer that holds a certificate of authority to engage in the business of insurance in this state if the health insurer or any subsidiary provides pharmacy benefit management services exclusively to its own insureds; or

(B) a public self-funded pool or a private single employer self-funded plan that provides pharmacy benefits or pharmacy benefit management services directly to its beneficiaries.

Sec. 4154.002. RULES. The commissioner may adopt rules and standards as necessary to implement this chapter.

[Sections 4154.003-4154.050 reserved for expansion]

SUBCHAPTER B. REGULATION OF PHARMACY BENEFIT MANAGERS

Sec. 4154.051. APPLICABILITY. This chapter applies to each pharmacy benefit manager that provides claims processing services, other prescription drug or device services, or both claims processing services and other prescription drug or device services to covered individuals who are residents of this state.

Sec. 4154.052. CERTIFICATE OF AUTHORITY AS ADMINISTRATOR REQUIRED. (a) A person may not act as or represent that the person is a pharmacy benefit manager in this state unless the person is covered by and is engaging in business under a certificate of authority as a third-party administrator issued under Chapter 4151.

(b) Chapter 4151 applies to a pharmacy benefit manager.

Sec. 4154.053. PERFORMANCE OF DUTIES; GOOD FAITH; CONFLICT OF INTEREST. (a) In operating as a pharmacy benefit manager, a pharmacy benefit manager shall exercise good faith and fair dealing in the performance of contractual obligations toward a covered entity.

(b) A pharmacy benefit manager shall notify a covered entity in writing of any activity, policy, practice, ownership interest, or affiliation of the pharmacy benefit manager that may present a conflict of interest.

Sec. 4154.054. REQUIREMENTS REGARDING CONTACTING COVERED INDIVIDUALS. Except as otherwise provided by the terms of the contract with a covered entity, a pharmacy benefit manager may not contact a covered individual without the express written permission of the covered entity.

Sec. 4154.055. DISPENSING OF SUBSTITUTE PRESCRIPTION DRUG FOR PRESCRIBED DRUG. (a) A pharmacy benefit manager may request the substitution of a lower priced generic and therapeutically equivalent drug for a higher priced prescribed drug only as provided by this section. The pharmacy benefit manager must obtain the approval of the prescribing practitioner before requesting any substitution under this section.

(b) If the net cost to the covered individual or covered entity of the substituted drug exceeds the cost of the prescribed drug, the substitution may be made only for medical reasons that benefit the covered individual.

(c) A pharmacy benefit manager may not substitute an equivalent prescribed drug contrary to a prescription drug order that prohibits a substitution.

Sec. 4154.056. DUTIES TO PHARMACY NETWORK PROVIDER. (a) A pharmacy benefit manager may not require a pharmacy network provider to comply with recordkeeping provisions more stringent than those required by other state law or rule or by federal law or regulation.

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

(c) Not later than the third business day after the date of a price increase notification by a manufacturer or supplier, a

pharmacy benefit manager shall adjust its payment to the pharmacy network provider in a manner consistent with the price increase.

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

(9-a) "Extrapolation" means a mathematical process or technique used by a health maintenance organization or pharmacy benefit manager that administers pharmacy claims for a health maintenance organization 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 health maintenance organization or pharmacy benefit manager.

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

Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except 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 transfer not later than the 14th day after the date on which the claim was affirmatively adjudicated.

(b) 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 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 5. Section 843.340, Insurance Code, is amended by adding Subsections (f) and (g) to read as follows:

(f) A health maintenance organization or a pharmacy benefit manager that administers pharmacy claims for the health maintenance

organization may not use extrapolation to complete the audit of a provider who is a pharmacist or pharmacy. A health maintenance organization or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization may not require extrapolation audits as a condition of participation in the health maintenance organization's contract, network, or program for a provider who is a pharmacist or pharmacy.

(g) A health maintenance organization or a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization that performs an on-site audit under this chapter of a provider who 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 provider not later than the 15th day before the date on which the on-site audit is scheduled to occur.

SECTION 6. Section 843.344, Insurance Code, is amended to read as follows:

Sec. 843.344. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. This subchapter applies to a person, including a pharmacy benefit manager, with whom a health maintenance organization contracts to:

(1) process or pay claims;

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

(3) issue verifications or preauthorizations.

SECTION 7. Subchapter J, Chapter 843, Insurance Code, is

amended by adding Sections 843.354, 843.355, and 843.356 to read as follows:

Sec. 843.354. DEPARTMENT ENFORCEMENT OF PHARMACY CLAIMS. (a) Notwithstanding any other provision of this subchapter, a dispute regarding payment of a claim to a provider who is a pharmacist or pharmacy shall be resolved as provided by this section.

(b) A provider who is a pharmacist or pharmacy may submit a complaint to the department alleging noncompliance with the requirements of this subchapter by a health maintenance organization, a pharmacy benefit manager that administers pharmacy claims for the health maintenance organization, or another entity that contracts with the health maintenance organization as provided by Section 843.344. A complaint must be submitted in writing or by 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 allegations of noncompliance made under Subsection (b), the commissioner, after notice and an opportunity for a hearing as described by Subsection (c), shall require the health maintenance organization to pay penalties as provided by Section 843.342.

Sec. 843.355. HEARING BY STATE OFFICE OF ADMINISTRATIVE HEARINGS; FINAL ORDER. (a) The State Office of Administrative Hearings shall conduct a hearing regarding a written order of the commissioner under Section 843.354 on the request of the department. A hearing under this section is subject to Chapter 2001, Government Code, and shall be conducted as a contested case hearing.

(b) After receipt of a proposal for decision issued by the

State Office of Administrative Hearings after a hearing conducted under Subsection (a), the commissioner shall issue a final order.

(c) If it appears to the department, the complainant, or the health maintenance organization that a person or entity is engaging in or is about to engage in a violation of a final order issued under Subsection (b), the department, the complainant, or the health maintenance organization may 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 complainant or the health maintenance organization may also bring an action for judicial review of the final order.

Sec. 843.356. LEGISLATIVE DECLARATION. It is the intent of the legislature that the requirements contained in this subchapter 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) "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.

(1-a) "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.

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, is amended by adding Sections 1301.139, 1301.140, and 1301.141 to read as follows:

Sec. 1301.139. DEPARTMENT ENFORCEMENT OF PHARMACY CLAIMS. (a) Notwithstanding any other provision of this subchapter, a dispute regarding payment of a claim to a preferred provider who is a pharmacist or pharmacy shall be resolved as provided by this section.

(b) A preferred provider who is a pharmacist or pharmacy may submit a complaint to the department alleging noncompliance with the requirements of this subchapter by an insurer, a pharmacy benefit manager that administers pharmacy claims for the insurer, or another entity that contracts with the insurer as provided by

Section 1301.109. A complaint must be submitted in writing or by 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 insurer 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 insurer and the complainant are entitled to a hearing conducted by the State Office of Administrative Hearings in the manner prescribed by Section 1301.140 regarding the determinations made in the order; and

(3) a determination of the denial of the allegations or the imposition of penalties against the insurer.

(d) An order issued under Subsection (c) is final in the absence of a request by the complainant or insurer for a hearing under Section 1301.140.

(e) If the department investigation substantiates the

allegations of noncompliance made under Subsection (b), the commissioner, after notice and an opportunity for a hearing as described by Subsection (c), shall require the insurer to pay penalties as provided by Section 1301.137.

Sec. 1301.140. HEARING BY STATE OFFICE OF ADMINISTRATIVE HEARINGS; FINAL ORDER. (a) The State Office of Administrative Hearings shall conduct a hearing regarding a written order of the commissioner under Section 1301.139 on the request of the department. A hearing under this section is subject to Chapter 2001, Government Code, and shall be conducted as a contested case hearing.

(b) After receipt of a proposal for decision issued by the State Office of Administrative Hearings after a hearing conducted under Subsection (a), the commissioner shall issue a final order.

(c) If it appears to the department, the complainant, or the insurer that a person or entity is engaging in or is about to engage in a violation of a final order issued under Subsection (b), the department, the complainant, or the insurer may 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 complainant or the insurer may also bring an action for judicial review of the final order.

Sec. 1301.141. LEGISLATIVE DECLARATION. It is the intent of the legislature that the requirements contained in this subchapter regarding payment of claims to preferred providers who are pharmacists or pharmacies apply to all insurers and pharmacy

benefit managers unless otherwise prohibited by federal law.

SECTION 14. The change in law made by this Act applies only to a claim submitted by a provider to a health maintenance organization or an insurer on or after the effective date of this Act. A claim submitted before the effective date of this Act is governed by the law as it existed immediately before that date, and that law is continued in effect for that purpose.

SECTION 15. The change in law made by this Act applies only to a contract between a pharmacy benefit manager and an insurer or health maintenance organization entered into or renewed on or after January 1, 2010. A contract entered into or renewed before January 1, 2010, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 16. This Act takes effect September 1, 2009.