

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

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:

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

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

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

1 [Sections 4154.003-4154.050 reserved for expansion]

2 SUBCHAPTER B. REGULATION OF PHARMACY BENEFIT MANAGERS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (9-a) "Extrapolation" means a mathematical process or
6 technique used by a health maintenance organization or pharmacy
7 benefit manager that administers pharmacy claims for a health
8 maintenance organization in the audit of a pharmacy or pharmacist
9 to estimate audit results or findings for a larger batch or group of
10 claims not reviewed by the health maintenance organization or
11 pharmacy benefit manager.

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

14 Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Except
15 as provided by Sections [~~Section~~] 843.3385 and 843.339, not later
16 than the 45th day after the date on which a health maintenance
17 organization receives a clean claim from a participating physician
18 or provider in a nonelectronic format or the 30th day after the date
19 the health maintenance organization receives a clean claim from a
20 participating physician or provider that is electronically
21 submitted, the health maintenance organization shall make a
22 determination of whether the claim is payable and:

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

27 (2) if the health maintenance organization determines

1 a portion of the claim is payable, pay the portion of the claim that
2 is not in dispute and notify the physician or provider in writing
3 why the remaining portion of the claim will not be paid; or

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

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

9 Sec. 843.339. DEADLINE FOR ACTION ON [~~CERTAIN~~] PRESCRIPTION
10 CLAIMS; PAYMENT. (a) A [Not later than the 21st day after the date
11 a] health maintenance organization, or a pharmacy benefit manager
12 that administers pharmacy claims for the health maintenance
13 organization, that affirmatively adjudicates a pharmacy claim that
14 is electronically submitted, [the health maintenance organization]
15 shall pay the total amount of the claim through electronic funds
16 transfer not later than the 14th day after the date on which the
17 claim was affirmatively adjudicated.

18 (b) A health maintenance organization, or a pharmacy
19 benefit manager that administers pharmacy claims for the health
20 maintenance organization, that affirmatively adjudicates a
21 pharmacy claim that is not electronically submitted, shall pay the
22 total amount of the claim not later than the 21st day after the date
23 on which the claim was affirmatively adjudicated.

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

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

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

8 (g) A health maintenance organization or a pharmacy benefit
9 manager that administers pharmacy claims for the health maintenance
10 organization that performs an on-site audit under this chapter of a
11 provider who is a pharmacist or pharmacy shall provide the provider
12 reasonable notice of the audit and accommodate the provider's
13 schedule to the greatest extent possible. The notice required
14 under this subsection must be in writing and must be sent by
15 certified mail to the provider not later than the 15th day before
16 the date on which the on-site audit is scheduled to occur.

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

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

- 23 (1) process or pay claims;
24 (2) obtain the services of physicians and providers to
25 provide health care services to enrollees; or
26 (3) issue verifications or preauthorizations.

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

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

3 Sec. 843.354. DEPARTMENT ENFORCEMENT OF PHARMACY CLAIMS.

4 (a) Notwithstanding any other provision of this subchapter, a
5 dispute regarding payment of a claim to a provider who is a
6 pharmacist or pharmacy shall be resolved as provided by this
7 section.

8 (b) A provider who is a pharmacist or pharmacy may submit a
9 complaint to the department alleging noncompliance with the
10 requirements of this subchapter by a health maintenance
11 organization, a pharmacy benefit manager that administers pharmacy
12 claims for the health maintenance organization, or another entity
13 that contracts with the health maintenance organization as provided
14 by Section 843.344. A complaint must be submitted in writing or by
15 submitting a completed complaint form to the department by mail or
16 through another delivery method. The department shall maintain a
17 complaint form on the department's Internet website and at the
18 department's offices for use by a complainant.

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

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

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

1 (A) of the legal authority, jurisdiction, and
2 alleged conduct under which an enforcement action is imposed or
3 denied, with a reference to the statutes and rules involved; and

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

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

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

15 (e) If the department investigation substantiates the
16 allegations of noncompliance made under Subsection (b), the
17 commissioner, after notice and an opportunity for a hearing as
18 described by Subsection (c), shall require the health maintenance
19 organization to pay penalties as provided by Section 843.342.

20 Sec. 843.355. HEARING BY STATE OFFICE OF ADMINISTRATIVE
21 HEARINGS; FINAL ORDER. (a) The State Office of Administrative
22 Hearings shall conduct a hearing regarding a written order of the
23 commissioner under Section 843.354 on the request of the
24 department. A hearing under this section is subject to Chapter
25 2001, Government Code, and shall be conducted as a contested case
26 hearing.

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

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

3 (c) If it appears to the department, the complainant, or the
4 health maintenance organization that a person or entity is engaging
5 in or is about to engage in a violation of a final order issued under
6 Subsection (b), the department, the complainant, or the health
7 maintenance organization may bring an action for judicial review in
8 district court in Travis County to enjoin or restrain the
9 continuation or commencement of the violation or to compel
10 compliance with the final order. The complainant or the health
11 maintenance organization may also bring an action for judicial
12 review of the final order.

13 Sec. 843.356. LEGISLATIVE DECLARATION. It is the intent of
14 the legislature that the requirements contained in this subchapter
15 regarding payment of claims to providers who are pharmacists or
16 pharmacies apply to all health maintenance organizations and
17 pharmacy benefit managers unless otherwise prohibited by federal
18 law.

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

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

27 (1-a) "Extrapolation" means a mathematical process or

1 technique used by an insurer or pharmacy benefit manager that
2 administers pharmacy claims for an insurer in the audit of a
3 pharmacy or pharmacist to estimate audit results or findings for a
4 larger batch or group of claims not reviewed by the insurer or
5 pharmacy benefit manager.

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

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

15 (1) if the insurer determines the entire claim is
16 payable, pay the total amount of the claim in accordance with the
17 contract between the preferred provider and the insurer;

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

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

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

27 Sec. 1301.104. DEADLINE FOR ACTION ON CERTAIN PHARMACY

1 CLAIMS; PAYMENT. (a) An ~~[Not later than the 21st day after the date~~
2 ~~an]~~ insurer, or a pharmacy benefit manager that administers
3 pharmacy claims for the insurer under a preferred provider benefit
4 plan, that affirmatively adjudicates a pharmacy claim that is
5 electronically submitted, [the insurer] shall pay the total amount
6 of the claim through electronic funds transfer not later than the
7 14th day after the date on which the claim was affirmatively
8 adjudicated.

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

15 SECTION 11. Section 1301.105, Insurance Code, is amended by
16 adding Subsections (e) and (f) to read as follows:

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

24 (f) An insurer or a pharmacy benefit manager that
25 administers pharmacy claims for the insurer that performs an
26 on-site audit of a preferred provider that is a pharmacist or
27 pharmacy shall provide the provider reasonable notice of the audit

1 and accommodate the provider's schedule to the greatest extent
2 possible. The notice required under this subsection must be in
3 writing and must be sent by certified mail to the preferred provider
4 not later than the 15th day before the date on which the on-site
5 audit is scheduled to occur.

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

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

- 11 (1) process or pay claims;
12 (2) obtain the services of physicians and health care
13 providers to provide health care services to insureds; or
14 (3) issue verifications or preauthorizations.

15 SECTION 13. Subchapter C-1, Chapter 1301, Insurance Code,
16 is amended by adding Sections 1301.139, 1301.140, and 1301.141 to
17 read as follows:

18 Sec. 1301.139. DEPARTMENT ENFORCEMENT OF PHARMACY CLAIMS.

19 (a) Notwithstanding any other provision of this subchapter, a
20 dispute regarding payment of a claim to a preferred provider who is
21 a pharmacist or pharmacy shall be resolved as provided by this
22 section.

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

1 Section 1301.109. A complaint must be submitted in writing or by
2 submitting a completed complaint form to the department by mail or
3 through another delivery method. The department shall maintain a
4 complaint form on the department's Internet website and at the
5 department's offices for use by a complainant.

6 (c) After investigation of the complaint by the department,
7 the commissioner shall determine the validity of the complaint and
8 shall enter a written order. In the order, the commissioner shall
9 provide the insurer and the complainant with:

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

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

14 (A) of the legal authority, jurisdiction, and
15 alleged conduct under which an enforcement action is imposed or
16 denied, with a reference to the statutes and rules involved; and

17 (B) that, on request to the department, the
18 insurer and the complainant are entitled to a hearing conducted by
19 the State Office of Administrative Hearings in the manner
20 prescribed by Section 1301.140 regarding the determinations made in
21 the order; and

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

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

27 (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 insurer to pay
4 penalties as provided by Section 1301.137.

5 Sec. 1301.140. 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 1301.139 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 insurer that a person or entity is engaging in or is about to engage
17 in a violation of a final order issued under Subsection (b), the
18 department, the complainant, or the insurer may bring an action for
19 judicial review in district court in Travis County to enjoin or
20 restrain the continuation or commencement of the violation or to
21 compel compliance with the final order. The complainant or the
22 insurer may also bring an action for judicial review of the final
23 order.

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

1 benefit managers unless otherwise prohibited by federal law.

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

8 SECTION 15. The change in law made by this Act applies only
9 to a contract between a pharmacy benefit manager and an insurer or
10 health maintenance organization entered into or renewed on or after
11 January 1, 2010. A contract entered into or renewed before January
12 1, 2010, is governed by the law as it existed immediately before the
13 effective date of this Act, and that law is continued in effect for
14 that purpose.

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