By: Van de Putte S.B. No. 1106

(In the Senate - Filed February 24, 2009; March 13, 2009, read first time and referred to Committee on State Affairs; April 17, 2009, reported favorably by the following vote: Yeas 7, Nays 0; April 17, 2009, sent to printer.)

A BILL TO BE ENTITLED
AN ACT

relating to payment of claims to pharmacies and pharmacists.

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

SECTION 1. 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 2. 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 3. 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 4. 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 5. 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 6. 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 7. 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 8. 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 9. 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 10. 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 11. 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 12. 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 13. 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 14. 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 15. This Act takes effect September 1, 2009.

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