SUBJECT: Expediting payment of claims to pharmacies and pharmacists

COMMITTEE: Insurance — favorable, with amendment

VOTE: 5 ayes — Smithee, Eiland, Isett, Taylor, Thompson

0 nays

4 absent — Martinez Fischer, Deshotel, Hancock, Hunter

SENATE VOTE: On final passage, April 23 — 30-0

WITNESSES: For — (*Registered, but did not testify:* Cheri Huddleston, Texas Pharmacy Business Council)

Against — (*Registered, but did not testify:* Jared Wolfe, Texas Association of Health Plans)

On — (*Registered, but did not testify:* Douglas Danzeiser, Texas Department of Insurance)

BACKGROUND: Pharmacy benefit managers (PBMs) play the role of the "middle man" by contracting with a Health Maintenance Organization (HMO), insurers under preferred provider benefit plans (PPO), or other health benefit plan or employer to administer the prescription benefit portion of the plan's health coverage. PBMs contract with pharmacies to create a network, process claims and perform other tasks and services related to pharmacy benefits. Many also own a mail-order pharmacy. A pharmacy does not have negotiating power to obtain more favorable payment and audit provisions in its contract with a PBM.

In 2003, the 78th Legislature enacted SB 418 by Nelson, requiring an insurer to determine if a claim was payable, partially payable, or not payable and to act accordingly within 30 days for electronic submissions, or within 45 days for non-electronic claims. A pharmacy claim submitted electronically would have to be paid, or the pharmacy provider notified, within 21 days of adjudicating the claim.

Under current law, an individual claim can be audited for up to 180 days. The provider would pay the claim and once the audit is concluded can recoup any discrepancy.

DIGEST:

SB 1106, as amended, would amend the Insurance Code, ch. 843, governing Health Maintenance Organizations (HMOs) and ch. 1301, governing Preferred Provider Benefit Plans (PPOs), to decrease the deadline for paying claims to pharmacies and by changing the requirements of a pharmacy audit. SB 1106 would also create a dispute resolution process for the Texas Department of Insurance (TDI) to resolve disputes regarding claim payments by HMOs or insurers under PPO plans, including an opportunity for appeal before the State Office of Administrative Hearings (SOAH).

Payment timelines for prescription claims. A HMO, PPO, or a PBM that administered pharmacy claims for the HMO or PPO would be required to submit payment of the total amount of the claim through electronic funds transfer no later than 18 days after the claim was affirmatively adjudicated. Non-electronic payments would be required to be paid no later than 21 days after the claim was affirmatively adjudicated.

Pharmacy audits. An HMO, PPO, or a PBM that administered pharmacy claims for the HMO or PPO could not use extrapolation to complete an audit or require extrapolation audits as a condition of participation in a contract, network, or program.

Performance of an on-site audit of a pharmacist or pharmacy would require reasonable notice, and the provider's schedule would have to be accommodated to the greatest extent possible. The notice of an on-site audit would have to be in writing and sent by certified mail no later than 15 days before an on-site audit was scheduled to occur.

Dispute resolution regarding payment of a claim. A pharmacist or pharmacy could submit a complaint regarding payment of a claim to TDI alleging noncompliance. A complaint would have to be submitted in writing or by completing a complaint form with TDI. TDI would be required to maintain the complaint form on their website and at their offices.

After investigation of the complaint by TDI, the commissioner would be required to determine the validity of the complaint and enter a written order. In the order, the commissioner would be required to provide:

- a summary of the investigation; and
- written notice of the matters asserted, including a statement of the legal authority, jurisdiction, and alleged conduct under which an enforcement action was imposed or denied, and that the HMO or PPO and the complainant would be entitled to a hearing conducted by the State Office of Administrative Hearings (SOAH).

An order would be final in the absence of a request for a SOAH hearing.

If the TDI investigation substantiated the allegations of noncompliance, the commissioner, after notice and an opportunity for a hearing, would require the HMO to pay penalties.

SOAH hearing. SOAH would be required to conduct a hearing regarding a written order of the commissioner on the request of TDI, to be conducted as a contested case hearing. After SOAH issued a decision, the commissioner would be required to issue a final order.

If it appeared that a person or entity was engaging in or was about to engage in a violation of a final order, action could be brought for judicial review in district court in Travis County. Action also could be brought for judicial review of the final order.

Legislative declaration. The bill would declare the intent of the Legislature that the requirements contained in SB 1106 would apply to all HMOs, PPOs, and PBMs, unless otherwise prohibited by federal law.

Effective date. The bill would take effect September 1, 2009 and would apply only to claims submitted on or after September 1, 2009 and to contracts between a PBM and a HMO or PPO entered into or renewed on or after January 1, 2010.

SUPPORTERS SAY:

SB 1106 would decrease the deadline for payment of prescription claims. All PBM claim filing and adjudication is done electronically and virtually instantaneously. A PBM has all the information it needs at the time of pharmacy service to review and authorize each claim. PBMs get paid promptly from the plan sponsors, so PBMs should pay pharmacies

promptly. There have been problems with delayed payment from PBMs, resulting in pharmacies having to pay their wholesalers for prescriptions without receiving their own payment. In some instances, the pharmacy has filled a prescription twice before receiving any payment. Because prescriptions can be very costly, this has caused a burden on the pharmacies.

Providers currently can do audits only on individual claims. SB 1106 would provide clarity on how general audits could be conducted and would limit the use of extrapolation and provide for clear and standard contract language.

OPPONENTS SAY:

SB 1106 is an unnecessary bill. The law enacted in 2003 was sufficient in addressing the time frame to pay claims. There is no evidence to support that there has been a problem with pharmacies having claims paid promptly. For example, TDI shows 99.9 percent of pharmacy claims are paid timely.

Also, TDI has received any few complaints from pharmacies. For example, in fiscal 2008 there were a total of 9,500 total complaints to TDI, yet in calendar years 2007 and 2008, there were only 16 complaints from pharmacies.

The majority of complaints to TDI never reach the need for written order. Changing the complaint process to require a written order on each complaint would be burdensome and time consuming, especially over something that was not an issue.

NOTES:

The committee recommended an amendment that would increase the amount of time that a claim had to be paid from no later than the 14th day after the date on which the claim was affirmatively adjudicated to no later than the 18th day on which the claim was affirmatively adjudicated.

According to the fiscal note, TDI anticipates that implementing the bill would require an additional three FTEs each fiscal year to administer the complaint and investigation process. For each fiscal year from 2010 to 2014, the three FTEs could cost $163,390 for salaries, $46,680 for benefits, $7,500 for travel expenses, and $6,225 for phone, supplies and other expenses. TDI estimates a one-time expense of $13,824 for equipment costs. Under current law, TDI is required to generate revenues

equivalent to its costs of operation, so all costs incurred could be paid from existing fund balances or insurance maintenance tax revenues.