BILL ANALYSIS

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S.B. 1106
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Currently, the Texas Insurance Code requires health maintenance organizations (HMOs) and preferred provider organizations (PPOs) to pay health care providers promptly and within specified timeframes for paper and electronic claims. Current law also requires HMOs and PPOs to adhere to certain procedures when auditing health care providers.

The Insurance Code needs to be updated to reflect that the vast majority of pharmacy claims are filed electronically, with the pharmacy receiving feedback almost instantly from the plan or pharmacy benefit manager whether the claim is accepted or rejected.

As proposed, S.B. 1106 requires an HMO or a pharmacy benefit manager that administers pharmacy claims for the HMO, or an insurer, or pharmacy benefit manager who processes claims for an insurer, to pay all prescription claims not later than the 21st day after the date the entity affirmatively adjudicates a claim from a pharmacist or pharmacy provider in a non-electronic format or the 14th day after the date the entity affirmatively adjudicates a pharmacist or pharmacy claim that is electronically submitted.

S.B. 1106 requires an HMO, insurer, or a pharmacy benefit manager to accommodate a provider's schedule to the greatest extent possible and to provide the pharmacy with written notice of an onsite audit by certified mail no later than the 15th day before the date the audit is scheduled to occur.

Additionally, S.B. 1106 prohibits the use of extrapolation when auditing pharmacy claims and establishes a complaint filing and resolution process for allegations of noncompliance with the Texas Insurance Code, including an appeals process through the State Office of Administrative Hearings.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 843.002, Insurance Code, by adding Subdivision (9-a), to define "extrapolation."

SECTION 2. Amends Section 843.338, Insurance Code, to create an exception as provided under Section 843.339 and make a nonsubstantive change.

SECTION 3. Amends Section 843.339, Insurance Code, as follows:

> Sec. 843.339. New heading: DEADLINE FOR ACTION ON PRESCRIPTION CLAIMS; PAYMENT. (a) Creates this subsection from existing text. Requires a health maintenance organization (HMO), or a pharmacy benefit manager that administers pharmacy claims for the HMO (pharmacy benefit manager), that affirmatively adjudicates a pharmacy claim that is electronically submitted, to pay the total amount of the claim through electronic funds transfer not later than the 14th day, rather than 21st

day, after the date on which the claim was affirmatively adjudicated. Makes nonsubstantive changes.

(b) Requires an HMO or a pharmacy benefit manager that affirmatively adjudicates a pharmacy claim that is not electronically submitted, to 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. Amends Section 843.340, Insurance Code, by adding Subsections (f) and (g), as follows:

(f) Prohibits an HMO or a pharmacy benefit manager from using extrapolation to complete the audit of a provider who is a pharmacist or pharmacy or from requiring extrapolation audits as a condition of participation in the HMO's contract, network, or program for a provider who is a pharmacist or pharmacy.

(g) Requires an HMO or a pharmacy benefit manager that performs an on-site audit under this chapter of a provider who is a pharmacist or pharmacy to provide the provider reasonable notice of the audit and accommodate the provider's schedule to the greatest extent possible. Requires that the notice required under this subsection be in writing and 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. Amends Section 843.344, Insurance Code, to provide that this subchapter applies to a person, including a pharmacy benefit manager, with whom an HMO contracts for certain services.

SECTION 6. Amends Subchapter J, Chapter 843, Insurance Code, by adding Sections 843.354-843.356, as follows:

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

(b) Authorizes a provider who is a pharmacist or pharmacy to submit a complaint to the Texas Department of Insurance (TDI) alleging noncompliance with the requirements of this subchapter by an HMO, a pharmacy benefit manager, or another entity that contracts with the HMO as provided by Section 843.344. Requires that a complaint be submitted in writing or by submitting a completed complaint form to TDI by mail or through another delivery method. Requires TDI to maintain a complaint form on TDI's Internet website and at TDI's offices for use by a complainant.

(c) Requires the commissioner of insurance (commissioner), after investigation of the complaint by TDI, to determine the validity of the complaint and enter a written order. Requires the commissioner, in the order, to provide the HMO and the complainant with certain information.

(d) Provides that an order issued under Subsection (c) is final in the absence of a request by the complainant or HMO for a hearing under Section 843.355.

(e) Requires the commissioner, if the TDI investigation substantiates the allegations of noncompliance made under Subsection (b) and after notice and an opportunity for a hearing as described by Subsection (c), to require the HMO to pay penalties as provided by Section 843.342 (Violation of Certain Claims Payment Provisions; Penalties).

Sec. 843.355. HEARING BY STATE OFFICE OF ADMINISTRATIVE HEARINGS; FINAL ORDER. (a) Requires the State Office of Administrative Hearings (SOAH) to conduct a hearing regarding a written order of the commissioner under Section 843.354

on the request of TDI. Provides that a hearing under this section must be conducted as a contested case hearing and is subject to Chapter 2001 (Administrative Procedure), Government Code.

(b) Requires the commissioner to issue a final order after receipt of a proposal for decision issued by SOAH after a hearing conducted under Subsection (a).

(c) Authorizes TDI, the complainant, or the HMO, if it appears to TDI, the complainant, or the HMO that a person or entity is engaging in or is about to engage in a violation of a final order issued under Subsection (b), to bring an action for judicial review in the district court in Travis County to enjoin or restrain the continuation or commencement of the violation or to compel compliance with the final order. Authorizes the complainant or the HMO to also bring an action for judicial review of the final order.

Sec. 843.356. LEGISLATIVE DECLARATION. Provides that 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 HMOs and pharmacy benefit managers unless otherwise prohibited by federal law.

SECTION 7. Amends Section 1301.001, Insurance Code, by amending Subdivision (1) and adding Subdivision (1-a), to define "extrapolation" and to redefine "health care provider."

SECTION 8. Amends Section 1301.103, Insurance Code, to create an exception under Section 1301.104 and make a nonsubstantive change.

SECTION 9. Amends Section 1301.104, Insurance Code, as follows:

Sec. 1301.104. New heading: DEADLINE FOR ACTION ON CERTAIN PHARMACY CLAIMS; PAYMENT. (a) Creates this subsection from existing text. Requires an insurer, or a pharmacy benefit manager that administers pharmacy claims for the insurer (pharmacy benefit manager for an insurer), that affirmatively adjudicates a pharmacy claim that is electronically submitted, to pay the total amount of the claim through electronic funds transfer not later than the 14th day, rather than 21st day, after the date on which the claim was affirmatively adjudicated. Makes nonsubstantive changes.

(b) Requires an insurer or a pharmacy benefit manager for an insurer that affirmatively adjudicates a pharmacy claim that is not electronically submitted, to 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. Amends Section 1301.105, Insurance Code, by adding Subsections (e) and (f), as follows:

(e) Prohibits an insurer or a pharmacy benefit manager for an insurer from using extrapolation to complete the audit of a preferred provider that is a pharmacist or pharmacy or from requiring 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) Requires an insurer or a pharmacy benefit manager for an insurer that performs an on-site audit of a preferred provider that is a pharmacist or pharmacy to provide the provider reasonable notice of the audit and accommodate the provider's schedule to the greatest extent possible. Requires that the notice required under this subsection be in writing and 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. Amends Section 1301.109, Insurance Code, to provide that this subchapter applies to a person, including a pharmacy benefit manager, with whom an insurer contracts for certain services.

SECTION 12. Amends Subchapter C-1, Chapter 1301, Insurance Code, by adding Sections 1301.139-1301.141, as follows:

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

(b) Authorizes a preferred provider who is a pharmacist or pharmacy to submit a complaint to TDI alleging noncompliance with the requirements of this subchapter by an insurer, a pharmacy benefit manager for an insurer, or another entity that contracts with the insurer as provided by Section 1301.109. Requires that a complaint be submitted in writing or by submitting a completed complaint form to TDI by mail or through another delivery method. Requires TDI to maintain a complaint form on TDI's Internet website and at TDI's offices for use by a complainant.

(c) Requires the commissioner, after investigation of the complaint by TDI, to determine the validity of the complaint and enter a written order. Requires the commissioner, in the order, to provide the insurer and the complainant with certain information.

(d) Provides that 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) Requires the commissioner, if the TDI investigation substantiates the allegations of noncompliance made under Subsection (b) and after notice and an opportunity for a hearing as described by Subsection (c), to require the insurer to pay penalties as provided by Section 1301.137 (Violation of Claims Payment Requirements; Penalty).

Sec. 1301.140. HEARING BY STATE OFFICE OF ADMINISTRATIVE HEARINGS; FINAL ORDER. (a) Requires SOAH to conduct a hearing regarding a written order of the commissioner under Section 1301.139 on the request of TDI. Provides that a hearing under this section must be conducted as a contested case hearing and is subject to Chapter 2001, Government Code.

(b) Requires the commissioner to issue a final order after receipt of a proposal for decision issued by SOAH after a hearing conducted under Subsection (a).

(c) Authorizes TDI, the complainant, or the insurer, if it appears to TDI, 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), to bring an action for judicial review in the district court in Travis County to enjoin or restrain the continuation or commencement of the violation or to compel compliance with the final order. Authorizes the complainant or the insurer to also bring an action for judicial review of the final order.

Sec. 1301.141. LEGISLATIVE DECLARATION. Provides that 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. Makes application of this Act to a claim prospective.

SECTION 14. Makes application of this Act to a contract prospective to January 1, 2010.

SECTION 15. Effective date: September 1, 2009.