BILL ANALYSIS

Senate Research Center
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H.B. 2292
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State Affairs
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Observers note that a health maintenance organization (HMO), preferred provider benefit plan, or an entity such as a pharmacy benefit manager that contracts with such an organization to administer pharmacy claims must pay health care providers promptly within a specified time frame for claims submitted electronically or on paper. Those observers explain that existing technology and the fact that the majority of pharmacy claims are filed electronically allow a pharmacy to receive feedback almost instantly regarding a claim's acceptance or rejection, and it is further noted that an HMO, preferred provider benefit plan, or pharmacy benefit manager also must adhere to certain procedures when auditing health care provider claims.

Interested parties contend that legislation is required to address the increasing use of electronic transactions, current auditing practices, and the need to provide a pharmacy a reasonable amount of time to make necessary staffing changes to maintain patient care while simultaneously accommodating an on-site audit, among other issues.

H.B. 2292 amends current law relating to payment of claims to pharmacies and pharmacists.

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 amending Subdivision (9-a) and adding Subdivision (9-b), to define "extrapolation" and to make a nonsubstantive change.

SECTION 2. Amends Section 843.338, Insurance Code, as follows:

> Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Requires a health maintenance organization (HMO), except as provided by Sections 843.3385 (Additional Information) and 843.339 (Additional Information), not later than the 45th day after the date on which the HMO receives a clean claim from a participating physician or provider in a nonelectronic format or the 30th day after the date the HMO receives a clean claim from a participating physician or provider that is electronically submitted, to make a determination of whether the claim is payable and:
>
> > (1) if the HMO 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 HMO;
> >
> > (2) if the HMO 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 HMO determines that the claim is not payable, notify the physician or provider in writing why the claim will not be paid.

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 section from existing text. Requires an HMO, or a pharmacy benefit manager that administers pharmacy claims for the HMO, 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 18th day after the date on which the claim was affirmatively adjudicated. Deletes existing text requiring that the claim be paid not later than the 21st day after the date the HMO affirmatively adjudicates a pharmacy claim that is electronically submitted.

(b) Requires an HMO, or a pharmacy benefit manager that administers pharmacy claims for the HMO, 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 Subchapter J, Chapter 843, Insurance Code, by adding Section 843.3401, as follows:

Sec. 843.3401. AUDIT OF PHARMACIST OR PHARMACY. (a) Prohibits an HMO or a pharmacy benefit manager that administers pharmacy claims for the HMO from using extrapolation to complete the audit of a provider who is a pharmacist or pharmacy. Prohibits an HMO 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.

(b) Requires an HMO or a pharmacy benefit manager that administers pharmacy claims for the HMO 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 to 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, as follows:

Sec. 843.344. APPLICABILITY OF SUBCHAPTER TO ENTITIES CONTRACTING WITH HMO. Provides that this subchapter applies to a person, including a pharmacy benefit manager, with whom an HMO 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. Amends Subchapter J, Chapter 843, Insurance Code, by adding Section 843.354, as follows:

Sec. 843.354. 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, to define "extrapolation" and to redefine "health care provider."

SECTION 8. Amends Section 1301.103, Insurance Code, as follows:

Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS. Requires the insurer, except as provided by Sections 1301.104 and 1301.1054 (Requests for Additional Information), 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, to 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. Amends Section 1301.104, Insurance Code, as follows:

Sec. 1301.104. New heading: DEADLINE FOR ACTION ON PHARMACY CLAIMS; PAYMENT. (a) Requires 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 to pay the total amount of the claim through electronic funds transfer not later than the 18th day after the date on which the claim was affirmatively adjudicated, rather than not later than the 21st day after the date on which the claim was affirmatively adjudicated.

(b) Requires 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 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 Subchapter C, Chapter 1301, Insurance Code, by adding Section 1301.1041, as follows:

Sec. 1301.1041. AUDIT OF PHARMACIST OR PHARMACY. (a) Prohibits an insurer or a pharmacy benefit manager that administers pharmacy claims for the insurer from using extrapolation to complete the audit of a preferred provider that is a pharmacist or pharmacy. Prohibits an insurer 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.

(b) Requires an insurer or a pharmacy benefit manager that administers pharmacy claims for the insurer that performs an on-site audit of a preferred 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 to 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, as follows:

Sec. 1301.109. APPLICABILITY TO ENTITIES CONTRACTING WITH INSURER. Provides that 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. Amends Subchapter C-1, Chapter 1301, Insurance Code, by adding Section 1301.139, as follows:

Sec. 1301.139. 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. (a) Provides that with respect to pharmacy benefits provided under a contract, the changes in law made by this Act apply only to a contract entered into or renewed on or after the effective date of this Act and payment for pharmacy benefits provided under the contract. Provides that a contract entered into before the effective date of this Act and not renewed or that was last renewed before the effective date of this Act, and payment for pharmacy benefits provided under the contract, are governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

(b) Provides that with respect to payment for pharmacy benefits not provided under a contract to which Subsection (a) of this section applies, the changes in law made by this Act apply only to payment for benefits provided on or after the effective date of this Act. Provides that payment for benefits not subject to Subsection (a) of this section and provided before the effective date of this Act is governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

(c) Provides that Sections 843.3401 and 1301.1041, Insurance Code, as added by this Act, apply to an audit of a pharmacist or pharmacy performed on or after the effective date of this Act unless the audit is performed under a contract that is entered into before the effective date of this Act and that, at the time of the audit, has not been renewed or was last renewed before the effective date of this Act.

SECTION 14. Effective date: September 1, 2011.