HB3607

LRB10010263SMS20449b

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB3607

by Rep. Marcus C. Evans, Jr.

SYNOPSIS AS INTRODUCED:

See Index

Amends the Illinois Insurance Code. Provides procedures for conducting pharmacy audits under the Third Party Prescription Programs Article. Prohibits an audit entity from using extrapolation to calculate penalties or amounts to be charged back, unless otherwise required by federal requirements. Defines terms. Contains provisions concerning notice of an audit, confidentiality, records, audit reporting, compensation, interest accrual, and appeal of a final audit report. Makes other changes. Provides that all entities providing prescription drug coverage shall permit and apply a prorated daily cost-sharing rate to prescriptions that are dispensed by a pharmacy for less than a 30-day supply if the prescriber or pharmacist indicates the fill or refill could be in the best interest of the patient or is for the purpose of synchronizing the patient's chronic medications. Provides that no entity providing prescription drug coverage shall deny coverage for the dispensing of any drug prescribed for the treatment of a chronic illness that is made in accordance with a plan among the insured, the prescriber, and a pharmacist to synchronize the refilling of multiple prescriptions for the insured. Provides that no entity providing prescription drug coverage shall use payment structures incorporating prorated dispensing fees determined by calculation of the days' supply of medication dispensed. Provides that dispensing fees shall be determined exclusively on the total number of prescriptions dispensed. Provides that the Department of Insurance and the Director shall have the authority to enforce the provisions of the Act and impose financial penalties. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning regulation.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Insurance Code is amended by changing Section 512-3 and by adding Sections 512-11, 512-12, and 512-13 as follows:

(215 ILCS 5/512-3) (from Ch. 73, par. 1065.59-3)

Sec. 512-3. Definitions. For the purposes of this Article, unless the context otherwise requires, the terms defined in this Article have the meanings ascribed to them herein:

"Audit" means an audit that is conducted by an auditing entity either (i) at a location other than the location of the pharmacist or pharmacy, including an audit that is performed at the offices of the auditing entity during which the pharmacist or pharmacy provides requested documents for review by physical copy or by microfiche, disk, or other electronic media; or (ii) at the physical business address of the pharmacy where the claim was adjudicated.

"Auditing entity" means a person or company that performs a pharmacy audit, including a plan sponsor, covered entity, pharmacy benefits manager, managed care organization, or third party administrator.

"Business day" means any day of the week, excluding

Saturday, Sunday, and any legal holiday.

"Concurrent review" means a review of a prescription claim that occurs at the time of, or subsequent to the adjudication of, the claim that provides information to the pharmacy that is relevant to the claim, including, but not limited to, mandatory or optional edits to the claim.

"Covered entity" means a member, participant, enrollee, contract holder, or policy holder providing pharmacy benefits to a covered individual under a health coverage plan insurance policy pursuant to a contract administered by a pharmacy benefits manager.

"Covered individual" means a member, participant, enrollee, contract holder or policy holder, or beneficiary of a covered entity who is provided health coverage by the covered entity. The term includes a dependent or other person provided health coverage through the policy or contract of a covered individual.

"Department" means the Department of Insurance.

"Extrapolation" means the practice of inferring a frequency of dollar amount of overpayments, underpayments, invalid claims, or other errors on any portion of claims submitted, based on the frequency of dollar amount of overpayments, underpayments, invalid claims, or other errors actually measured in a sample of claims.

"Network" means a pharmacy or group of pharmacies that agree to provide prescription services to covered individuals

on behalf of a covered entity or group of covered entities in exchange for payment for its services by a pharmacy benefits manager or pharmacy services administration organization. "Network" includes a pharmacy that generally dispenses outpatient prescriptions to covered individuals or dispenses particular types of prescriptions, provides pharmacy services to particular types of covered individuals, or dispenses prescriptions in particular health care settings, including networks of specialty, institutional, or long-term care facilities.

"Pharmacist" has the meaning ascribed to that term in the Pharmacy Practice Act.

"Pharmacy" has the meaning ascribed to that term in the Pharmacy Practice Act.

"Pharmacy audit" means an audit, conducted on-site by or on behalf of an auditing entity, of any records of a pharmacy for prescription or nonproprietary drugs dispensed by a pharmacy to a covered individual.

"Pharmacy benefits manager" or "PBM" means a person, business, or other entity that performs pharmacy benefits management for covered entities.

"Pharmacy record" means any record stored electronically or as a physical copy by a pharmacy that relates to the provision of prescription or nonproprietary drugs or pharmacy services or other component of pharmacist care that is included in the practice of pharmacy.

"Pharmacy services administration organization" means any entity that contracts with a pharmacy to assist with third party payer interactions and that may provide a variety of other administrative services, including contracting with PBMs on behalf of pharmacies and managing pharmacies' claims payments from third party payers.

~~(a)~~ "Third party prescription program" or "program" means any system of providing for the reimbursement of pharmaceutical services and prescription drug products offered or operated in this State under a contractual arrangement or agreement between a provider of such services and another party who is not the consumer of those services and products. Such programs may include, but need not be limited to, employee benefit plans whereby a consumer receives prescription drugs or other pharmaceutical services and those services are paid for by an agent of the employer or others.

~~(b)~~ "Third party program administrator" or "administrator" means any person, partnership or corporation who issues or causes to be issued any payment or reimbursement to a provider for services rendered pursuant to a third party prescription program, but does not include the Director of Healthcare and Family Services or any agent authorized by the Director to reimburse a provider of services rendered pursuant to a program of which the Department of Healthcare and Family Services is the third party.

(Source: P.A. 95-331, eff. 8-21-07.)

(215 ILCS 5/512-11 new)

Sec. 512-11. Medication synchronization. All entities providing prescription drug coverage shall permit and apply a prorated daily cost-sharing rate to prescriptions that are dispensed by a pharmacy for less than a 30-day supply if the prescriber or pharmacist indicates the fill or refill could be in the best interest of the patient or is for the purpose of synchronizing the patient's chronic medications.

No entity providing prescription drug coverage shall deny coverage for the dispensing of any drug prescribed for the treatment of a chronic illness that is made in accordance with a plan among the insured, the prescriber, and a pharmacist to synchronize the refilling of multiple prescriptions for the insured.

No entity providing prescription drug coverage shall use payment structures incorporating prorated dispensing fees determined by calculation of the days' supply of medication dispensed. Dispensing fees shall be determined exclusively on the total number of prescriptions dispensed.

The provisions of this Section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified-disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, or short-term major medical policy of 6 months or less in duration or any other

supplemental policy.

(215 ILCS 5/512-12 new)

Sec. 512-12. Audit of pharmacy records.

(a) An entity conducting a pharmacy audit under this Article shall conform to the following requirements:

(1) Except as otherwise provided by federal or State law, an auditing entity conducting a pharmacy audit may have access to a pharmacy's previous audit report only if the report was prepared by that auditing entity.

(2) Information collected during a pharmacy audit shall be confidential by law, except that the auditing entity conducting the pharmacy audit may share the information with the pharmacy benefits manager and the covered entity for which the pharmacy audit is being conducted.

(3) The auditing entity conducting a pharmacy audit may not compensate an employee or contractor with which an auditing entity contracts to conduct a pharmacy audit solely based on the amount claimed or the actual amount recouped by the pharmacy being audited.

(4) The auditing entity shall provide the pharmacy being audited with at least 14 calendar days' prior written notice before conducting a pharmacy audit. If a delay is requested by the pharmacy, the pharmacy shall provide notice to the PBM within 72 hours after receiving notice of

the audit.

(5) The auditing entity may not initiate or schedule a pharmacy audit during the first 5 business days of any month without the express consent of the pharmacy.

(6) The auditing entity shall accept paper or electronic signature logs that document the delivery of prescription or nonproprietary drugs and pharmacist services to a health plan beneficiary or the beneficiary's caregiver or guardian.

(7) The auditing entity shall provide to the representative of the pharmacy, prior to leaving the pharmacy at the conclusion of the on-site portion of the pharmacy audit, a complete list of pharmacy records reviewed.

(8) A pharmacy audit that involves clinical judgment shall be conducted by or in consultation with an Illinois-licensed pharmacist.

(9) A pharmacy audit may not cover:

(i) a period of more than 24 months after the date a claim was submitted by the pharmacy to the pharmacy benefits manager or covered entity, unless a longer period is required by law; or

(ii) more than 250 prescriptions; however, a refill does not constitute a separate prescription for the purposes of this subparagraph.

(10) The auditing entity may not use extrapolation to

calculate penalties or amounts to be charged back or recouped unless otherwise required by federal requirements or federal plans.

(11) The auditing entity may not include dispensing fees in the calculation of overpayments unless a prescription is considered a misfill. As used in this paragraph, "misfill" means a prescription that was not dispensed, a prescription error, a prescription where the prescriber denied the authorization request, or a prescription where an extra dispensing fee was charged.

(12) A pharmacy may do any of the following when a pharmacy audit is performed:

(i) Use verifiable statements or records, including, but not limited to, medication administration records of a nursing home, assisted living facility, hospital, or health care practitioner with prescriptive authority, to validate the pharmacy record and delivery.

(ii) Use any valid prescription, including, but not limited to, medication administration records, facsimiles, electronic prescriptions, electronically stored images of prescriptions, electronically created annotations, or documented telephone calls from the prescribing health care practitioner or practitioner's agent, to validate claims in connection with prescriptions, changes in prescriptions, or refills of

prescription or nonproprietary drugs. Documentation of an oral prescription order that has been verified by the prescribing health care practitioner shall meet the provisions of this subparagraph for the initial audit review.

(b) An auditing entity shall provide the pharmacy with a written report of the pharmacy audit and shall comply with the following requirements:

(1) A preliminary pharmacy audit report must be delivered to the pharmacy or its corporate parent within 30 calendar days after the completion of the pharmacy audit. The preliminary report shall include contact information for the auditing entity that conducted the pharmacy audit and an appropriate and accessible point of contact, including the contact's telephone number, facsimile number, e-mail, and auditing firm, so that audit results, discrepancies, and procedures can be reviewed. The preliminary pharmacy audit report shall include, but not be limited to, claim-level information for any discrepancy found and total dollar amount of claims subject to recovery.

(2) A pharmacy shall be allowed 30 calendar days following receipt of the preliminary audit report to respond to the findings of the preliminary report.

(3) A final audit report shall be delivered to the pharmacy or its corporate parent not later than 30 calendar

days after any responses from the pharmacy or corporate parent are received by the auditing entity. The final audit report may be delivered electronically. The auditing entity shall issue a final pharmacy audit report that includes replying to any responses provided to the auditing entity by the pharmacy or corporate parent.

(c) A pharmacy may not be subject to a charge-back or recoupment for a concurrent review or, in the case of an audit, a clerical or recordkeeping error in a required document or record, including a typographical error, scrivener's error, or computer error, unless the error resulted in overpayment to the pharmacy.

(d) An auditing entity conducting a pharmacy audit or person acting on behalf of the entity may not withhold payment or charge-back, recoup, or collect penalties from a pharmacy until the time period to file an appeal of a final pharmacy audit report has passed or the appeals process has been exhausted, whichever is later.

(e) No interest shall accrue for any party during the audit period, beginning with the notice of the pharmacy audit and ending with the conclusion of the appeals process.

(f) A PBM may not recover payment of claims from the pharmacy that are identified through the audit process to be the responsibility of another payer. The PBM must reconcile directly with the other payer for any monies owed without requiring the pharmacy to reverse and rebill the original claim

in the retail setting.

(g) A pharmacy may appeal a final audit report in accordance with the procedures established by the entity conducting the pharmacy audit.

(h) The provisions of this Section do not apply to an investigative audit of pharmacy records if:

(1) fraud, waste, abuse, or other intentional misconduct is evidenced by physical review or review of claims data or statements; or

(2) other investigative methods provide evidence that a pharmacy is or has been engaged in criminal wrongdoing, fraud, or other intentional or willful misrepresentation.

(i) This Section does not supersede any audit requirements established by federal law.

(215 ILCS 5/512-13 new)

Sec. 512-13. Enforcement.

(a) Enforcement of this Article shall be the responsibility of the Department and the Director.

(b) The Director shall have the authority to adopt any rules necessary for the implementation and administration of this Article.

(c) The Director shall take action or impose penalties to bring non-complying entities into full compliance with this Article. Any violation of this Article may subject a non-complying entity to financial penalties not less than

$1,000 per violation.

Section 99. Effective date. This Act takes effect upon becoming law.

INDEX

Statutes amended in order of appearance