Rep. Franco Coladipietro

Filed: 4/13/2011

AMENDMENT TO HOUSE BILL 2017

AMENDMENT NO. _____. Amend House Bill 2017 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Insurance Code is amended by changing Sections 512-3 and 512-7 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:

(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" or "entity" means any pharmacy benefits manager or person, business, or other entity that performs pharmacy benefits management. The terms include a person or auditing entity acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a managed care company or nonprofit hospital or the services of a pharmacy benefits administrator, medical service organization, insurance company, third-party payor, 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.

(c) "Fraud" means an intentional act of deception or misrepresentation to obtain an authorized benefit.

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

(215 ILCS 5/512-7) (from Ch. 73, par. 1065.59-7)

Sec. 512-7. Contractual provisions.

(a) Any agreement or contract entered into in this State between the administrator of a program and a pharmacy shall include a statement of the method and amount of reimbursement to the pharmacy for services rendered to persons enrolled in the program, the frequency of payment by the program administrator to the pharmacy for those services, and a method for the adjudication of complaints and the settlement of disputes between the contracting parties.

(b)(1) A program shall provide an annual period of at least 30 days during which any pharmacy licensed under the Pharmacy Practice Act may elect to participate in the program under the program terms for at least one year.

(2) If compliance with the requirements of this subsection (b) would impair any provision of a contract between a program and any other person, and if the contract provision was in existence before January 1, 1990, then immediately after the expiration of those contract provisions the program shall comply with the requirements of this subsection (b).

(3) This subsection (b) does not apply if:

(A) the program administrator is a licensed health maintenance organization that owns or controls a pharmacy and that enters into an agreement or contract with that pharmacy in accordance with subsection (a); or

(B) the program administrator is a licensed health

maintenance organization that is owned or controlled by another entity that also owns or controls a pharmacy, and the administrator enters into an agreement or contract with that pharmacy in accordance with subsection (a).

(4) This subsection (b) shall be inoperative after October 31, 1992.

(c) The program administrator shall cause to be issued an identification card to each person enrolled in the program. The identification card shall include:

(1) the name of the individual enrolled in the program; and

(2) an expiration date if required under the contractual arrangement or agreement between a provider of pharmaceutical services and prescription drug products and the third party prescription program administrator.

(d) Notwithstanding any other law, either State or federal, when an on-site audit of the records of a pharmacy is conducted by any entity, the audit shall be conducted in accordance with the following criteria:

(1) the entity conducting the on-site audit must give the pharmacy written notice prior to conducting the initial on-site audit and must specify the records and documents to be examined;

(2) any audit that involves clinical or professional judgment must be conducted by or in consultation with a

pharmacist that that is duly licensed;

(3) any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error, regarding a required document or record does not constitute fraud; however, such claims may be subject to recoupment;

(4) a finding of an overpayment or underpayment must be based on the actual overpayment or underpayment and may not be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs unless mutually agreed to in writing by both parties;

(5) each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by the entity; and

(6) the period covered by an audit may not exceed 2 years from the date the claim was submitted to or adjudicated by an entity.

(e) The auditing entity, administrator, or its representative described in subsection (d) of this Section must provide the pharmacy with a written report of the audit and comply with the following requirements:

(1) the preliminary audit report must be delivered to the pharmacy within 90 days after conclusion of the audit along with a written copy of the appeals process to the pharmacy that is being audited;

(2) a pharmacy shall be allowed at least 30 business

days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during the audit;

(3) a final audit report shall be delivered to the pharmacy within 180 days after receipt of the preliminary audit report or final appeal, as provided for in Section 6 of this Code, whichever is later;

(4) an acknowledgement of the audit, as conducted, must be signed and shall include the signature of any pharmacist participating in the audit;

(5) recoupments of any disputed funds, or repayment of funds to the entity by the pharmacy if permitted pursuant to contractual agreement, shall occur, to the extent demonstrated and/or documented pursuant to the pharmacy audit findings, after final internal disposition of the audit; should the identified discrepancy for an individual audit exceed $25,000, then future payments to the pharmacy may be withheld pending finalization of the audit;

(6) interest shall not accrue during the audit period; and

(7) each entity conducting an audit shall provide a copy of the final audit report, after completion of any review process, to the audited pharmacy.

(f) Notwithstanding any other provision in this Code, the administrator conducting the audit pursuant to subsections (d) and (e) of this Section shall not use the accounting practice

of extrapolation in calculating recoupments or penalties for audits.

As used in this Section, "accounting practice of extrapolation" means an audit of a sample of prescription drug benefit claims submitted by a pharmacy to the administrator conducting the audit that is then used to estimate audit results for a larger batch or group of claims not reviewed by the auditor.

(g) The audit criteria set forth in this Section shall apply only to audits of claims for services provided and claims submitted for payment after the effective date of this amendatory Act of the 97th General Assembly.

(h) This Section shall not apply to any investigative audit that involves potential fraud, willful misrepresentation, or abuse, including, without limitation, investigative audits or any other statutory provision that authorizes investigations relating to insurance fraud.

(Source: P.A. 95-689, eff. 10-29-07.)".