HB3204

LRB09903976MLM23993b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

HB3204

by Rep. Michael J. Zalewski

SYNOPSIS AS INTRODUCED:

215 ILCS 134/45.1
215 ILCS 134/45.2

Amends the Managed Care Reform and Patients Rights Act. Provides that if a health carrier or insurer denies a request for coverage of a prescription drug, then the health carrier or insurer must give a covered person's pharmacist, along with the prescribing provider, the reason for denial of coverage of the prescription drug, along with an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial. Effective immediately.

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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 Managed Care Reform and Patient Rights Act is amended by changing Sections 45.1 and 45.2 as follows:

(215 ILCS 134/45.1)

Sec. 45.1. Medical exceptions procedures required.

(a) Every health carrier that offers a qualified health plan, as defined in the federal Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under those Acts (collectively, "the Federal Act"), directly to consumers in this State shall establish and maintain a medical exceptions process that allows covered persons or their authorized representatives to request any clinically appropriate prescription drug when (1) the drug is not covered based on the health benefit plan's formulary; (2) the health benefit plan is discontinuing coverage of the drug on the plan's formulary for reasons other than safety or other than because the prescription drug has been withdrawn from the market by the drug's manufacturer; (3) the prescription drug alternatives required to be used in

accordance with a step therapy requirement (A) has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and the known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance or (B) has caused or, based on sound medical evidence, is likely to cause an adverse reaction or harm to the enrollee; or (4) the number of doses available under a dose restriction for the prescription drug (A) has been ineffective in the treatment of the enrollee's disease or medical condition or (B) based on both sound clinical evidence and medical and scientific evidence, the known relevant physical and mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effective or patient compliance.

(b) The health carrier's established medical exceptions procedures must require, at a minimum, the following:

(1) Any request for approval of coverage made verbally or in writing (regardless of whether made using a paper or electronic form or some other writing) at any time shall be reviewed by appropriate health care professionals.

(2) The health carrier must, within 72 hours after receipt of a request made under subsection (a) of this Section, either approve or deny the request. In the case of

a denial, the health carrier shall provide the covered person or the covered person's authorized representative and the covered person's prescribing provider and pharmacist with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

(3) In the case of an expedited coverage determination, the health carrier must either approve or deny the request within 24 hours after receipt of the request. In the case of a denial, the health carrier shall provide the covered person or the covered person's authorized representative and the covered person's prescribing provider with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

(c) Notwithstanding any other provision of this Section, nothing in this Section shall be interpreted or implemented in a manner not consistent with the Federal Act.

(Source: P.A. 98-1035, eff. 8-25-14.)

(215 ILCS 134/45.2)

Sec. 45.2. Prior authorization form; prescription benefits.

(a) Notwithstanding any other provision of law, on and after January 1, 2015, a health insurer that provides

prescription drug benefits must, within 72 hours after receipt of a paper or electronic prior authorization form from a prescribing provider or pharmacist, either approve or deny the prior authorization. In the case of a denial, the insurer shall provide the prescriber and pharmacist with the reason for the denial, an alternative covered medication, if applicable, and information regarding the denial.

In the case of an expedited coverage determination, the health insurer must either approve or deny the prior authorization within 24 hours after receipt of the paper or electronic prior authorization form. In the case of a denial, the health insurer shall provide the prescriber with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial.

(b) This Section does not apply to plans for beneficiaries of Medicare or Medicaid.

(c) For the purposes of this Section:

"Pharmacist" has the same meaning as set forth in the Pharmacy Practice Act.

"Prescribing provider" includes a provider authorized to write a prescription, as described in subsection (e) of Section 3 of the Pharmacy Practice Act, to treat a medical condition of an insured.

(Source: P.A. 98-1035, eff. 8-25-14.)

Section 99. Effective date. This Act takes effect upon

becoming law.