Sen. David Koehler

Filed: 3/21/2023

1 AMENDMENT TO SENATE BILL 757

2 AMENDMENT NO. ______. Amend Senate Bill 757 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The Illinois Insurance Code is amended by
5 changing Section 424 and by adding Section 513b7 as follows:

6 (215 ILCS 5/424) (from Ch. 73, par. 1031)
7 Sec. 424. Unfair methods of competition and unfair or
8 deceptive acts or practices defined. The following are hereby
9 defined as unfair methods of competition and unfair and
10 deceptive acts or practices in the business of insurance:
11 (1) The commission by any person of any one or more of
12 the acts defined or prohibited by Sections 134, 143.24c,
13 147, 148, 149, 151, 155.22, 155.22a, 155.42, 236, 237,
14 364, 469, ~~and~~ 513b1<u>, and 513b7</u> of this Code.
15 (2) Entering into any agreement to commit, or by any
16 concerted action committing, any act of boycott, coercion

1 or intimidation resulting in or tending to result in
2 unreasonable restraint of, or monopoly in, the business of
3 insurance.

4 (3) Making or permitting, in the case of insurance of
5 the types enumerated in Classes 1, 2, and 3 of Section 4,
6 any unfair discrimination between individuals or risks of
7 the same class or of essentially the same hazard and
8 expense element because of the race, color, religion, or
9 national origin of such insurance risks or applicants. The
10 application of this Article to the types of insurance
11 enumerated in Class 1 of Section 4 shall in no way limit,
12 reduce, or impair the protections and remedies already
13 provided for by Sections 236 and 364 of this Code or any
14 other provision of this Code.

15 (4) Engaging in any of the acts or practices defined
16 in or prohibited by Sections 154.5 through 154.8 of this
17 Code.

18 (5) Making or charging any rate for insurance against
19 losses arising from the use or ownership of a motor
20 vehicle which requires a higher premium of any person by
21 reason of his physical disability, race, color, religion,
22 or national origin.

23 (6) Failing to meet any requirement of the Unclaimed
24 Life Insurance Benefits Act with such frequency as to
25 constitute a general business practice.

26 (Source: P.A. 102-778, eff. 7-1-22.)

1 (215 ILCS 5/513b7 new)
2 Sec. 513b7. Pharmacy audits.
3 (a) As used in this Section:
4 "Audit" means any physical on-site, remote electronic, or
5 concurrent review of a pharmacist service submitted to the
6 pharmacy benefit manager or pharmacy benefit manager affiliate
7 by a pharmacist or pharmacy for payment.
8 "Auditing entity" means a person or company that performs
9 a pharmacy audit.
10 "Extrapolation" means the practice of inferring a
11 frequency of dollar amount of overpayments, underpayments,
12 nonvalid claims, or other errors on any portion of claims
13 submitted, based on the frequency of dollar amount of
14 overpayments, underpayments, nonvalid claims, or other errors
15 actually measured in a sample of claims.
16 "Misfill" means a prescription that was not dispensed; a
17 prescription that was dispensed but was an incorrect dose,
18 amount, or type of medication; a prescription that was
19 dispensed to the wrong person; a prescription in which the
20 prescriber denied the authorization request; or a prescription
21 in which an additional dispensing fee was charged.
22 "Pharmacy audit" means an audit conducted of any records
23 of a pharmacy for prescriptions dispensed or nonproprietary
24 drugs or pharmacist services provided by a pharmacy or
25 pharmacist to a covered person.

1 "Pharmacy record" means any record stored electronically
2 or as a hard copy by a pharmacy that relates to the provision
3 of a prescription or pharmacy services or other component of
4 pharmacist care that is included in the practice of pharmacy.
5 (b) Notwithstanding any other law, when conducting a
6 pharmacy audit, an auditing entity shall:
7 (1) not conduct an on-site audit of a pharmacy at any
8 time during the first 3 business days of a month or the
9 first 2 weeks and final 2 weeks of the calendar year or
10 during a declared State or federal public health
11 emergency;
12 (2) notify the pharmacy or its contracting agent no
13 later than 30 days before the date of initial on-site
14 audit; the notification to the pharmacy or its contracting
15 agent shall be in writing and delivered either:
16 (A) by mail or common carrier, return receipt
17 requested; or
18 (B) electronically with electronic receipt
19 confirmation, addressed to the supervising pharmacist
20 of record and pharmacy corporate office, if
21 applicable, at least 30 days before the date of an
22 initial on-site audit;
23 (3) limit the audit period to 24 months after the date
24 a claim is submitted to or adjudicated by the pharmacy
25 benefit manager;
26 (4) include in the written advance notice of an

1 on-site audit the list of specific prescription numbers to
2 be included in the audit that may or may not include the
3 final 2 digits of the prescription numbers;
4 (5) use the written and verifiable records of a
5 hospital, physician, or other authorized practitioner that
6 are transmitted by any means of communication to validate
7 the pharmacy records in accordance with State and federal
8 law;
9 (6) limit the number of prescriptions audited to no
10 more than 100 randomly selected in a 12-month period and
11 no more than one on-site audit per quarter of the calendar
12 year, except in cases of fraud;
13 (7) provide the pharmacy or its contracting agent with
14 a copy of the preliminary audit report within 45 days
15 after the conclusion of the audit;
16 (8) be allowed to conduct a follow-up audit on site if
17 a remote or desk audit reveals the necessity for a review
18 of additional claims;
19 (9) accept invoice audits as validation invoices from
20 any wholesaler registered with the Department of Financial
21 and Professional Regulation from which the pharmacy has
22 purchased prescription drugs or, in the case of durable
23 medical equipment or sickroom supplies, invoices from an
24 authorized distributor other than a wholesaler;
25 (10) provide the pharmacy or its contracting agent
26 with the ability to provide documentation to address a

1 discrepancy or audit finding if the documentation is
2 received by the pharmacy benefit manager no later than the
3 45th day after the preliminary audit report was provided
4 to the pharmacy or its contracting agent; the pharmacy
5 benefit manager shall consider a reasonable request from
6 the pharmacy for an extension of time to submit
7 documentation to address or correct any findings in the
8 report;
9 (11) be required to provide the pharmacy or its
10 contracting agent with the final audit report no later
11 than 60 days after the initial audit report was provided
12 to the pharmacy or its contracting agent;
13 (12) conduct the audit in consultation with a
14 pharmacist if the audit involves clinical or professional
15 judgment;
16 (13) not chargeback, recoup, or collect penalties from
17 a pharmacy until the time period to file an appeal of the
18 final pharmacy audit report has passed or the appeals
19 process has been exhausted, whichever is later, unless the
20 identified discrepancy is expected to exceed $25,000, in
21 which case the auditing entity may withhold future
22 payments in excess of that amount until the final
23 resolution of the audit;
24 (14) not compensate the employee or contractor
25 conducting the audit based on a percentage of the amount
26 claimed or recouped pursuant to the audit;

(15) not use extrapolation to calculate penalties or amounts to be charged back or recouped unless otherwise required by federal law or regulation; any amount to be charged back or recouped due to overpayment may not exceed the amount the pharmacy was overpaid;

(16) not include dispensing fees in the calculation of overpayments unless a prescription is considered a misfill; and

(17) conduct a pharmacy audit under the same standards and parameters as conducted for other similarly situated pharmacies audited by the auditing entity.

(c) Except as otherwise provided by State or federal 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.

(d) 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 health benefit plan for which a pharmacy audit is being conducted and with any regulatory agencies and law enforcement agencies as required by law.

(e) A pharmacy may not be subject to a chargeback or recoupment for a clerical or recordkeeping error in a required document or record, including a typographical error or computer error, unless the pharmacy benefit manager can provide proof of intent to commit fraud or such error results

1 in actual financial harm to the pharmacy benefit manager, a
2 health plan managed by the pharmacy benefit manager, or a
3 consumer.
4 (f) A pharmacy shall have the right to file a written
5 appeal of a preliminary and final pharmacy audit report in
6 accordance with the procedures established by the entity
7 conducting the pharmacy audit.
8 (g) No interest shall accrue for any party during the
9 audit period, beginning with the notice of the pharmacy audit
10 and ending with the conclusion of the appeals process.
11 (h) A contract between a pharmacy or pharmacist and a
12 pharmacy benefit manager must contain a provision allowing,
13 during the course of a pharmacy audit conducted by or on behalf
14 of a pharmacy benefit manager, a pharmacy or pharmacist to
15 withdraw and resubmit a claim within 30 days after:
16 (1) the preliminary written audit report is delivered
17 if the pharmacy or pharmacist does not request an internal
18 appeal; or
19 (2) the conclusion of the internal audit appeals
20 process if the pharmacy or pharmacist requests an internal
21 audit appeal.
22 (i) This Section shall not apply to:
23 (1) audits in which suspected fraudulent activity or
24 other intentional or willful misrepresentation is
25 evidenced by a physical review, review of claims data or
26 statements, or other investigative methods;

(2) audits of claims paid for by federally funded programs; or

(3) concurrent reviews or desk audits that occur within 3 business days after transmission of a claim and in which no chargeback or recoupment is demanded.

(j) A violation of this Section is an unfair and deceptive act or practice under Section 424.".