THE SENATE
TWENTY-SIXTH LEGISLATURE, 2011
STATE OF HAWAII

S.B. NO. 1414 S.D. 1

A BILL FOR AN ACT

RELATING TO REPACKAGED DRUGS AND COMPOUND MEDICATIONS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that regulating markups of repackaged prescription drugs and compound medications will help to contain unreasonable increases of prescription drug costs in Hawaii's workers' compensation insurance system as repackagers expand into states, including Hawaii, where costs of repackaged drugs and compound medications are not currently regulated.

The legislature further finds that Hawaii's current reimbursement rate for pharmaceuticals is the highest in the nation for both brand and generic products.

The purpose of this Act is to close a loophole in Hawaii's workers' compensation insurance law to reasonably restrict markups of repackaged prescription drugs and physician-dispensed premixed or prepackaged compounded medications to an amount equal to that currently authorized for retail pharmacies under state law.

SECTION 2. Section 386-21, Hawaii Revised Statutes, is amended to read as follows:

"§386-21 **Medical care, services, drugs, and supplies.** (a) Immediately after a work injury is sustained by an employee and so long as reasonably needed, the employer shall furnish to the employee all medical care, services, drugs, and supplies [~~as~~] that the nature of the injury requires. [~~The liability~~] Liability pursuant to this section for [~~the~~] medical care, services, drugs, and supplies shall be subject to [~~the~~] a deductible [~~under~~] pursuant to section 386-100.

(b) Whenever medical care is needed, the injured employee may select any physician or surgeon who [~~is practicing~~] practices on the island where the injury was incurred to render medical care. If the services of a specialist are indicated, the employee may select any physician or surgeon practicing [~~in~~] the relevant specialty within the State. The director may authorize the selection of a specialist practicing outside of the State [~~where~~] when no comparable medical attendance within the State is available. Upon procuring the services of a physician or surgeon, the injured employee shall give proper notice of the employee's selection to the employer within a reasonable time after [~~the~~] beginning [~~of the~~] treatment. If for any reason during the period when medical care is needed, the employee wishes to change to another physician or surgeon,

the employee may do so in accordance with rules prescribed by the director. If the employee is unable to select a physician or surgeon and the emergency nature of the injury requires immediate medical attendance, or if the employee does not desire to select a physician or surgeon and so advises the employer, the employer shall select the physician or surgeon[~~. The selection, however,~~]; provided that selection of a physician or surgeon by an employer shall not deprive the employee of the employee's right [~~of~~] to subsequently [~~selecting~~] select a physician or surgeon for continuance of needed medical care.

(c) The liability of the employer for medical care, services, drugs, and supplies shall be limited to the charges computed [~~as set forth in~~] pursuant to this section. The director shall make determinations of [~~the~~] allowable charges and shall adopt fee schedules based upon those determinations. Effective January 1, 1997, and for each succeeding calendar year thereafter, [~~the~~] allowable charges shall not exceed one hundred ten per cent of fees prescribed in the Medicare Resource Based Relative Value Scale applicable to Hawaii as prepared by the United States Department of Health and Human Services, except as provided in this subsection. The rates or fees provided for in this section shall be adequate to ensure at all times the

standard of services and care intended by this chapter [~~to~~] for injured employees.

If the director determines that an allowance under the medicare program is not reasonable or if a medical treatment, accommodation, product, or service existing as of June 29, 1995, is not covered under the medicare program, the director, at any time, may establish an additional fee schedule or schedules not exceeding the prevalent charge for fees for services actually received by providers of health care services, to cover allowable charges for that treatment, accommodation, product, or service. If no prevalent charge for a fee for service has been established for a given service or procedure, the director shall adopt a reasonable rate which shall be the same for all providers of health care services to be paid for that service or procedure.

The director shall update the schedules required by this section every three years or annually, as required[~~. The updates shall be~~], based upon:

(1) Future charges or additions prescribed in the Medicare Resource Based Relative Value Scale applicable to Hawaii as prepared by the United States Department of Health and Human Services; or

(2) A statistically valid survey by the director of prevalent charges for fees for services actually received by providers of health care services or based upon the information provided to the director by the appropriate state agency [~~having~~] with access to prevalent charges for medical fee information.

When a dispute exists between an insurer or self-insured employer and a medical services provider regarding the amount of a fee for medical services, the director may resolve the dispute in a summary manner as the director may prescribe; provided that a provider shall not charge more than the provider's private patient charge for the service rendered.

When a dispute exists between an employee and [~~the~~] an employer or the employer's insurer regarding the proposed treatment plan or whether medical services should be continued, the employee shall continue to receive essential medical services prescribed by the treating physician necessary to prevent deterioration of the employee's condition or further injury until the director issues a decision on whether the employee's medical treatment should be continued. The director shall make a decision within thirty days of the filing of a dispute. If the director determines that medical services

pursuant to the treatment plan should be or should have been discontinued, the director shall designate the date after which medical services for that treatment plan are denied. The employer or the employer's insurer may recover from the employee's personal health care provider qualified pursuant to section 386-27, or from any other appropriate occupational or non-occupational insurer, all the sums paid for medical services rendered after the date designated by the director. Under no circumstances shall the employee be charged for the disallowed services, unless the services were obtained in violation of section 386-98. The attending physician, employee, employer, or insurance carrier may request in writing that the director review the denial of the treatment plan or [~~the~~] continuation of medical services.

(d) The reimbursement amounts for drugs, supplies, and materials shall be priced in accordance with the medical fee schedules adopted by the director pursuant to subsection (c); provided that the carrier may contract for a lower amount. Payment for prescription drugs shall be made at the lower of the average wholesale price as listed in the Red Book: Pharmacy's Fundamental Reference plus forty per cent of the average wholesale price, or an insurer, self insured, or captive

insurer's pharmacy benefit network price for drugs sold by a physician, hospital, pharmacy, or provider of service other than a physician. Repackaged or relabeled drug prices shall not exceed the amount payable had the drug not been repackaged or relabeled.

(e) Repackaged or relabeled drug price shall be calculated by multiplying the number of units dispensed by the average wholesale price set by the original manufacturer of the underlying drug, plus forty per cent.

(f) Physician-dispensed premixed or prepackaged compounded medications shall be reimbursed based on the sum of the fee due for each medication ingredient having an assigned national drug code that is used in the physician-dispensed premixed or prepackaged compounded medication. If the national drug code for any ingredient is a code for a repackaged drug, then reimbursement for that ingredient shall be as provided in subsection (e).

(g) If information pertaining to the original labeler or manufacturer of the underlying drug product used in repackaged or physician-dispensed premixed or prepackaged compounded medications is not provided or is unknown, then reimbursement

shall be based on the most reasonable and closely related average wholesale price for the underlying drug product.

(h) Upon acceptance of liability by an employer for charges billed for repackaged or premixed compounded medications, payment for the repackaged or physician-dispensed premixed or prepackaged compounded medications shall be made by the insurer, self insured, or captive insurer, or the insured, self insured, or captive insurer's pharmacy benefit network manager within sixty calendar days of receipt of charges except for items where there is a reasonable disagreement. If more than sixty calendar days lapse between the employer's receipt of an undisputed billing and the date of payment, payment of billing shall be increased by one per cent of the outstanding balance per month.

In the event of disagreement, an employer shall pay for all acknowledged charges and shall notify the provider of service and the claimant of the denial of payment and the reason for denial of payment within sixty calendar days of receipt. Notice of an employer's denial of payment shall explicitly state that if the provider of service does not agree, the provider of service may file with the director a "BILL DISPUTE REQUEST" and a copy of the original bill within sixty calendar days after the

postmark of the employer's objection; failure to do so shall constitute acceptance of the employer's denial of payment.

[~~(d)~~] (i) The director, with input from stakeholders in the workers' compensation system, including but not limited to insurers, health care providers, employers, and employees, shall establish standardized forms for health care providers to use when reporting on and billing for injuries compensable under this chapter. The forms may be in triplicate, or in any other configuration so as to minimize, to the extent practicable, the need for a health care provider to fill out multiple forms describing the same workers' compensation case to the department, the injured employee's employer, and the employer's insurer.

[~~(e)~~] (j) If it appears to the director that the injured employee has wilfully refused to accept the services of a competent physician or surgeon selected as provided in this section, or has wilfully obstructed the physician or surgeon, or medical, surgical, or hospital services or supplies, the director may consider [~~such~~] the refusal or obstruction on the part of the injured employee to be a waiver in whole or in part of the right to medical care, services, drugs, and supplies, and may suspend the weekly benefit payments, if any, to which the

employee is entitled so long as the refusal or obstruction continues.

[~~(f)~~] (k) Any funds as are periodically necessary to the department to implement the [~~foregoing~~] provisions of this section may be charged to and paid from the special compensation fund provided by section 386-151.

[~~(g)~~] (l) In cases where the compensability of [~~the~~] a claim is not contested by the employer, the medical services provider shall notify or bill the employer, insurer, or the special compensation fund for services rendered relating to the compensable injury within two years of the date services were rendered. Failure to bill the employer, insurer, or the special compensation fund within the two-year period shall result in the forfeiture of the medical services provider's right to payment. The medical [~~+~~]services[~~+~~] provider shall not directly charge the injured employee for treatments relating to the compensable injury."

SECTION 3. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 4. This Act shall take effect upon its approval.

Report Title:
Workers' Compensation; Repackaged Drugs and Compound Medications

Description:
Restricts markups of repackaged prescription drugs and physician-dispensed premixed or prepackaged compounded medications to what is currently authorized for retail pharmacies under state law. (SD1)

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.