Sen. Andy Manar

Filed: 3/12/2019

AMENDMENT TO SENATE BILL 652

AMENDMENT NO. _____. Amend Senate Bill 652 by replacing everything after the enacting clause with the following:

"Section 1. The Freedom of Information Act is amended by changing Section 7.5 as follows:

(5 ILCS 140/7.5)

Sec. 7.5. Statutory exemptions. To the extent provided for by the statutes referenced below, the following shall be exempt from inspection and copying:

(a) All information determined to be confidential under Section 4002 of the Technology Advancement and Development Act.

(b) Library circulation and order records identifying library users with specific materials under the Library Records Confidentiality Act.

(c) Applications, related documents, and medical

records received by the Experimental Organ Transplantation Procedures Board and any and all documents or other records prepared by the Experimental Organ Transplantation Procedures Board or its staff relating to applications it has received.

(d) Information and records held by the Department of Public Health and its authorized representatives relating to known or suspected cases of sexually transmissible disease or any information the disclosure of which is restricted under the Illinois Sexually Transmissible Disease Control Act.

(e) Information the disclosure of which is exempted under Section 30 of the Radon Industry Licensing Act.

(f) Firm performance evaluations under Section 55 of the Architectural, Engineering, and Land Surveying Qualifications Based Selection Act.

(g) Information the disclosure of which is restricted and exempted under Section 50 of the Illinois Prepaid Tuition Act.

(h) Information the disclosure of which is exempted under the State Officials and Employees Ethics Act, and records of any lawfully created State or local inspector general's office that would be exempt if created or obtained by an Executive Inspector General's office under that Act.

(i) Information contained in a local emergency energy

plan submitted to a municipality in accordance with a local emergency energy plan ordinance that is adopted under Section 11-21.5-5 of the Illinois Municipal Code.

(j) Information and data concerning the distribution of surcharge moneys collected and remitted by carriers under the Emergency Telephone System Act.

(k) Law enforcement officer identification information or driver identification information compiled by a law enforcement agency or the Department of Transportation under Section 11-212 of the Illinois Vehicle Code.

(l) Records and information provided to a residential health care facility resident sexual assault and death review team or the Executive Council under the Abuse Prevention Review Team Act.

(m) Information provided to the predatory lending database created pursuant to Article 3 of the Residential Real Property Disclosure Act, except to the extent authorized under that Article.

(n) Defense budgets and petitions for certification of compensation and expenses for court appointed trial counsel as provided under Sections 10 and 15 of the Capital Crimes Litigation Act. This subsection (n) shall apply until the conclusion of the trial of the case, even if the prosecution chooses not to pursue the death penalty prior to trial or sentencing.

(o) Information that is prohibited from being

disclosed under Section 4 of the Illinois Health and Hazardous Substances Registry Act.

(p) Security portions of system safety program plans, investigation reports, surveys, schedules, lists, data, or information compiled, collected, or prepared by or for the Regional Transportation Authority under Section 2.11 of the Regional Transportation Authority Act or the St. Clair County Transit District under the Bi-State Transit Safety Act.

(q) Information prohibited from being disclosed by the Personnel Record ~~Records~~ Review Act.

(r) Information prohibited from being disclosed by the Illinois School Student Records Act.

(s) Information the disclosure of which is restricted under Section 5-108 of the Public Utilities Act.

(t) All identified or deidentified health information in the form of health data or medical records contained in, stored in, submitted to, transferred by, or released from the Illinois Health Information Exchange, and identified or deidentified health information in the form of health data and medical records of the Illinois Health Information Exchange in the possession of the Illinois Health Information Exchange Authority due to its administration of the Illinois Health Information Exchange. The terms "identified" and "deidentified" shall be given the same meaning as in the Health Insurance Portability and

Accountability Act of 1996, Public Law 104-191, or any subsequent amendments thereto, and any regulations promulgated thereunder.

(u) Records and information provided to an independent team of experts under the Developmental Disability and Mental Health Safety Act (also known as Brian's Law).

(v) Names and information of people who have applied for or received Firearm Owner's Identification Cards under the Firearm Owners Identification Card Act or applied for or received a concealed carry license under the Firearm Concealed Carry Act, unless otherwise authorized by the Firearm Concealed Carry Act; and databases under the Firearm Concealed Carry Act, records of the Concealed Carry Licensing Review Board under the Firearm Concealed Carry Act, and law enforcement agency objections under the Firearm Concealed Carry Act.

(w) Personally identifiable information which is exempted from disclosure under subsection (g) of Section 19.1 of the Toll Highway Act.

(x) Information which is exempted from disclosure under Section 5-1014.3 of the Counties Code or Section 8-11-21 of the Illinois Municipal Code.

(y) Confidential information under the Adult Protective Services Act and its predecessor enabling statute, the Elder Abuse and Neglect Act, including information about the identity and administrative finding

against any caregiver of a verified and substantiated decision of abuse, neglect, or financial exploitation of an eligible adult maintained in the Registry established under Section 7.5 of the Adult Protective Services Act.

(z) Records and information provided to a fatality review team or the Illinois Fatality Review Team Advisory Council under Section 15 of the Adult Protective Services Act.

(aa) Information which is exempted from disclosure under Section 2.37 of the Wildlife Code.

(bb) Information which is or was prohibited from disclosure by the Juvenile Court Act of 1987.

(cc) Recordings made under the Law Enforcement Officer-Worn Body Camera Act, except to the extent authorized under that Act.

(dd) Information that is prohibited from being disclosed under Section 45 of the Condominium and Common Interest Community Ombudsperson Act.

(ee) Information that is exempted from disclosure under Section 30.1 of the Pharmacy Practice Act.

(ff) Information that is exempted from disclosure under the Revised Uniform Unclaimed Property Act.

(gg) Information that is prohibited from being disclosed under Section 7-603.5 of the Illinois Vehicle Code.

(hh) Records that are exempt from disclosure under

Section 1A-16.7 of the Election Code.

(ii) Information which is exempted from disclosure under Section 2505-800 of the Department of Revenue Law of the Civil Administrative Code of Illinois.

(jj) Information and reports that are required to be submitted to the Department of Labor by registering day and temporary labor service agencies but are exempt from disclosure under subsection (a-1) of Section 45 of the Day and Temporary Labor Services Act.

(kk) Information prohibited from disclosure under the Seizure and Forfeiture Reporting Act.

(ll) Information the disclosure of which is restricted and exempted under Section 5-30.8 of the Illinois Public Aid Code.

(mm) ~~(ll)~~ Records that are exempt from disclosure under Section 4.2 of the Crime Victims Compensation Act.

(nn) ~~(ll)~~ Information that is exempt from disclosure under Section 70 of the Higher Education Student Assistance Act.

(oo) Information that is exempt from disclosure under subsection (j) of Section 5-36 of the Illinois Public Aid Code.

(Source: P.A. 99-78, eff. 7-20-15; 99-298, eff. 8-6-15; 99-352, eff. 1-1-16; 99-642, eff. 7-28-16; 99-776, eff. 8-12-16; 99-863, eff. 8-19-16; 100-20, eff. 7-1-17; 100-22, eff. 1-1-18; 100-201, eff. 8-18-17; 100-373, eff. 1-1-18; 100-464, eff.

8-28-17; 100-465, eff. 8-31-17; 100-512, eff. 7-1-18; 100-517, eff. 6-1-18; 100-646, eff. 7-27-18; 100-690, eff. 1-1-19; 100-863, eff. 8-14-18; 100-887, eff. 8-14-18; revised 10-12-18.)

Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Section 6.11 as follows:

(5 ILCS 375/6.11)

(Text of Section before amendment by P.A. 100-1170)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22, 356z.25, ~~and~~ 356z.26, ~~and~~ 356z.29, and 356z.32 of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1, and Article XXXIIB of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance

with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; revised 1-8-19.)

(Text of Section after amendment by P.A. 100-1170)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22, 356z.25, 356z.26, 356z.29, and 356z.32 of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1<u>, and Article XXXIIB</u> of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section with respect to Sections 370c and 370c.1 of the Illinois Insurance Code; all other requirements of this Section shall be enforced by the

Department of Central Management Services.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; 100-1170, eff. 6-1-19.)

Section 10. The Illinois Insurance Code is amended by adding Article XXXIIB as follows:

(215 ILCS 5/Art. XXXIIB heading new)

ARTICLE XXXIIB. PHARMACY BENEFIT MANAGERS

(215 ILCS 5/513b1 new)

Sec. 513b1. Pharmacy benefit manager contracts.

(a) As used in this Section:

"Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

"Pharmacy benefit manager" means a person, business, or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, for health benefit plans.

(b) A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager:

(1) Update maximum allowable cost pricing information at least every 7 calendar days.

(2) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(c) In order to place a particular prescription drug on a maximum allowable cost list, the pharmacy benefit manager must, at a minimum, ensure that:

(1) The drug must have at least 3 or more nationally available, therapeutically equivalent, multiple source generic drugs with a significant cost difference.

(2) The products must be listed as therapeutically and pharmaceutically equivalent or "A" or "AB" rated in the Food and Drug Administration's most recent version of the "Orange Book."

(3) The product must be available for purchase without limitations by all pharmacies in the State from national or

regional wholesalers and not obsolete or temporarily unavailable.

(d) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, in accordance with Section 42 of the Pharmacy Practice Act.

(e) A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(1) the applicable cost-sharing amount; or

(2) the retail price of the drug in the absence of prescription drug coverage.

(f) This Section applies to contracts entered into or renewed on or after July 1, 2020.

(g) This Section applies to any group or individual policy of accident and health insurance or managed care plan that provides coverage for prescription drugs and that is amended, delivered, issued, or renewed on or after July 1, 2020.

(215 ILCS 5/513b2 new)

Sec. 513b2. Licensure requirements.

(a) Beginning on July 1, 2020, to conduct business in this

State, a pharmacy benefit manager must register with the Director. To initially register or renew a registration, a pharmacy benefit manager shall submit:

(1) A nonrefundable fee not to exceed $500.

(2) A copy of the registrant's corporate charter, articles of incorporation, or other charter document.

(3) A completed registration form adopted by the Director containing:

(A) The name and address of the registrant.

(B) The name, address, and official position of each officer and director of the registrant.

(b) The registrant shall report any change in information required under this Section to the Director in writing within 60 days after the change occurs.

(c) Upon receipt of a completed registration form, the required documents, and the registration fee, the Director shall issue a registration certificate. The certificate may be in paper or electronic form, and shall clearly indicate the expiration date of the registration. Registration certificates are nontransferable.

(d) A registration certificate is valid for 2 years after its date of issue. The Director shall adopt by rule an initial registration fee not to exceed $500 and a registration renewal fee not to exceed $500, both of which shall be nonrefundable. Total fees may not exceed the cost of administering this Section.

(e) The Department shall adopt any rules necessary to implement this Section.

(215 ILCS 5/513b3 new)

Sec. 513b3. Examination.

(a) The Director, or his or her designee, may examine a registered pharmacy benefit manager.

(b) Any pharmacy benefit manager being examined shall provide to the Director, or his or her designee, convenient and free access to all books, records, documents, and other papers relating to such pharmacy benefit manager's business affairs at all reasonable hours at its offices.

(c) The Director, or his or her designee, may administer oaths and thereafter examine any individual about the business of the pharmacy benefit manager.

(d) The examiners designated by the Director under this Section may make reports to the Director. Any report alleging substantive violations of this Article, any applicable provisions of this Code, or any applicable Part of Title 50 of the Illinois Administrative Code shall be in writing and be based upon facts obtained by the examiners. The report shall be verified by the examiners.

(e) If a report is made, the Director shall either deliver a duplicate report to the pharmacy benefit manager being examined or send such duplicate by certified or registered mail to the pharmacy benefit manager's address specified in the

records of the Department. The Director shall afford the pharmacy benefit manager an opportunity to request a hearing to object to the report. The pharmacy benefit manager may request a hearing within 30 days after receipt of the duplicate report by giving the Director written notice of such request together with written objections to the report. Any hearing shall be conducted in accordance with Sections 402 and 403 of this Code. The right to a hearing is waived if the delivery of the report is refused or the report is otherwise undeliverable or the pharmacy benefit manager does not timely request a hearing. After the hearing or upon expiration of the time period during which a pharmacy benefit manager may request a hearing, if the examination reveals that the pharmacy benefit manager is operating in violation of any applicable provision of this Code, any applicable Part of Title 50 of the Illinois Administrative Code, a provision of this Article, or prior order, the Director, in the written order, may require the pharmacy benefit manager to take any action the Director considers necessary or appropriate in accordance with the report or examination hearing. If the Director issues an order, it shall be issued within 90 days after the report is filed, or if there is a hearing, within 90 days after the conclusion of the hearing. The order is subject to review under the Administrative Review Law.

(215 ILCS 5/513b4 new)

Sec. 513b4. Administrative fine.

(a) If the Director finds that one or more grounds exist for the revocation or suspension of a registration issued under this Article, the Director may, in lieu of or in addition to such suspension or revocation, impose a fine upon the pharmacy benefit manager as provided under subsection (b).

(b) With respect to any knowing and willful violation of a lawful order of the Director, any applicable portion of this Code, Part of Title 50 of the Illinois Administrative Code, or provision of this Article, the Director may impose a fine upon the pharmacy benefit manager in an amount not to exceed $50,000 for each violation.

(215 ILCS 5/513b5 new)

Sec. 513b5. Failure to register. Any pharmacy benefit manager that operates without a registration or fails to register with the Director and pay the fee prescribed by this Article is an unauthorized insurer as defined in Article VII of this Code and shall be subject to all penalties provided for therein.

(215 ILCS 5/513b6 new)

Sec. 513b6. Insurance Producer Administration Fund. All fees and fines paid to and collected by the Director under this Article shall be paid promptly after receipt thereof, together with a detailed statement of such fees, into the Insurance

Producer Administration Fund. The moneys deposited into the Insurance Producer Administration Fund may be transferred to the Professions Indirect Cost Fund, as authorized under Section 2105-300 of the Department of Professional Regulation Law of the Civil Administrative Code of Illinois.

Section 15. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 355.2, 355.3, 355b, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 364, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, ~~and~~ XXVI, and XXXIIB of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health

Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or

other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service

agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the

period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any

refund authorized under this Section.

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-761, eff. 1-1-18; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1026, eff. 8-22-18; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; revised 10-4-18.)

Section 20. The Managed Care Reform and Patient Rights Act is amended by changing Sections 30 and 65 as follows:

(215 ILCS 134/30)

Sec. 30. Prohibitions.

(a) No health care plan or its subcontractors may prohibit or discourage health care providers by contract or policy from discussing any health care services and health care providers, utilization review and quality assurance policies, terms and conditions of plans and plan policy with enrollees, prospective enrollees, providers, or the public.

(b) No health care plan by contract, written policy, or procedure may permit or allow an individual or entity to dispense a different drug in place of the drug or brand of drug

ordered or prescribed without the express permission of the person ordering or prescribing the drug, except as provided under Section 3.14 of the Illinois Food, Drug and Cosmetic Act.

(c) No health care plan or its subcontractors may by contract, written policy, procedure, or otherwise mandate or require an enrollee to substitute his or her participating primary care physician under the plan during inpatient hospitalization, such as with a hospitalist physician licensed to practice medicine in all its branches, without the agreement of that enrollee's participating primary care physician. "Participating primary care physician" for health care plans and subcontractors that do not require coordination of care by a primary care physician means the participating physician treating the patient. All health care plans shall inform enrollees of any policies, recommendations, or guidelines concerning the substitution of the enrollee's primary care physician when hospitalization is necessary in the manner set forth in subsections (d) and (e) of Section 15.

(d) A health care plan shall apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by or on behalf of such insured for prescription drugs toward a covered individual's deductible, copay, or cost-sharing responsibility, or out-of-pocket maximum associated with the individual's health insurance.

(e) ~~(d)~~ Any violation of this Section shall be subject to

the penalties under this Act.

(Source: P.A. 94-866, eff. 6-16-06.)

(215 ILCS 134/65)

Sec. 65. Emergency services prior to stabilization.

(a) A health care plan that provides or that is required by law to provide coverage for emergency services shall provide coverage such that payment under this coverage is not dependent upon whether the services are performed by a plan or non-plan health care provider and without regard to prior authorization. This coverage shall be at the same benefit level as if the services or treatment had been rendered by the health care plan physician licensed to practice medicine in all its branches or health care provider.

(b) Prior authorization or approval by the plan shall not be required for emergency services.

(c) Coverage and payment shall only be retrospectively denied under the following circumstances:

(1) upon reasonable determination that the emergency services claimed were never performed;

(2) upon timely determination that the emergency evaluation and treatment were rendered to an enrollee who sought emergency services and whose circumstance did not meet the definition of emergency medical condition; <u>any denial under this paragraph (2) shall be based on the prudent layperson standard at the time the enrollee first</u>

sought emergency evaluation and treatment for his or her symptoms; insurers are prohibited from denying claims under this paragraph (2) based on the use of diagnosis or procedure codes;

(3) upon determination that the patient receiving such services was not an enrollee of the health care plan; or

(4) upon material misrepresentation by the enrollee or health care provider; "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation.

(d) When an enrollee presents to a hospital seeking emergency services, the determination as to whether the need for those services exists shall be made for purposes of treatment by a physician licensed to practice medicine in all its branches or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine in all its branches. The physician or other appropriate personnel shall indicate in the patient's chart the results of the emergency medical screening examination.

(e) The appropriate use of the 911 emergency telephone system or its local equivalent shall not be discouraged or penalized by the health care plan when an emergency medical condition exists. This provision shall not imply that the use of 911 or its local equivalent is a factor in determining the existence of an emergency medical condition.

(f) The medical director's or his or her designee's determination of whether the enrollee meets the standard of an emergency medical condition shall be based solely upon the presenting symptoms documented in the medical record at the time care was sought. Only a clinical peer may make an adverse determination.

(g) Nothing in this Section shall prohibit the imposition of deductibles, copayments, and co-insurance. Nothing in this Section alters the prohibition on billing enrollees contained in the Health Maintenance Organization Act.

(Source: P.A. 91-617, eff. 1-1-00.)

Section 25. The Pharmacy Practice Act is amended by adding Section 42 as follows:

(225 ILCS 85/42 new)

Sec. 42. Information disclosure. A pharmacist or her or his authorized employee must inform customers of a less expensive, generically equivalent drug product for her or his prescription and whether the cost-sharing obligation to the customer exceeds the retail price of the prescription in the absence of prescription drug coverage.

Section 30. The Illinois Public Aid Code is amended by adding Section 5-36 as follows:

(305 ILCS 5/5-36 new)

Sec. 5-36. Pharmacy benefits.

(a)(1) The Department may enter into a contract with any third party on a fee-for-service reimbursement model for the purpose of administering pharmacy benefits as provided in this Section; however, these services shall be approved by the Department. The Department shall ensure coordination of care between the third-party administrator and managed care organizations as a consideration in any contracts established in accordance with this Section. Any managed care techniques, principles, or administration of benefits utilized in accordance with this subsection shall comply with State law.

(2) The following shall apply to contracts between entities contracting relating to third-party administrators and pharmacies:

(A) the Department shall approve any contract between a third-party administrator and a pharmacy;

(B) a third-party administrator shall not change the terms of a contract between a third-party administrator and a pharmacy without written approval by the Department; and

(C) a third-party administrator shall not create, modify, implement, or indirectly establish any fee on a pharmacy, pharmacist, or a recipient of medical assistance without written approval by the Department.

(b) The provisions of this Section shall not apply to outpatient pharmacy services provided by a health care facility

registered as a covered entity pursuant to 42 U.S.C. 256b or any pharmacy owned by or contracted with the covered entity. A Medicaid managed care organization shall, either directly or through a pharmacy benefit manager, administer and reimburse outpatient pharmacy claims submitted by a health care facility registered as a covered entity pursuant to 42 U.S.C. 256b, its owned pharmacies, and contracted pharmacies in accordance with the contractual agreements the Medicaid managed care organization or its pharmacy benefit manager has with such facilities and pharmacies. A Medicaid managed care organization or its pharmacy benefit manager shall not exclude any health care facility registered as a covered entity pursuant to 42 U.S.C. 256b from its pharmacy network. Any pharmacy benefit manager that contracts with a Medicaid managed care organization to administer and reimburse outpatient pharmacy claims as provided in this Section must be registered with the Director of Insurance in accordance with Section 513b2 of the Illinois Insurance Code.

(c) On at least an annual basis, the Director of the Department of Healthcare and Family Services shall submit a report beginning no later than one year after the effective date of this amendatory Act of the 101st General Assembly to the House and Senate Human Services Committees and the House and Senate Financial Institutions Committees that provides an update on any contract, contract issues, formulary, dispensing fees, and maximum allowable cost concerns regarding a

third-party administrator and managed care.

(d) A pharmacy benefit manager shall notify the Department in writing of any activity, policy, or practice of the pharmacy benefit manager that directly or indirectly presents a conflict of interest that interferes with the discharge of the pharmacy benefit manager's duty to a managed care organization to exercise its contractual duties.

(e) A pharmacy benefit manager shall, upon request, disclose to the Department the following information:

(1) whether the pharmacy benefit manager has a contract, agreement, or other arrangement with a pharmaceutical manufacturer to exclusively dispense or provide a drug to a managed care organization's enrollees, and the application of all consideration or economic benefits collected or received pursuant to that arrangement;

(2) the percentage of claims payments made by the pharmacy benefit manager to pharmacies owned, managed, or controlled by the pharmacy benefit manager or any of the pharmacy benefit manager's management companies, parent companies, subsidiary companies, jointly held companies, or companies otherwise affiliated by a common owner, manager, or holding company for the previous year;

(3) the aggregate amount of the fees or assessments imposed on, or collected from, pharmacy providers; and

(4) the average annualized percentage of revenue

collected by the pharmacy benefit manager as a result of each contract it has executed with a managed care organization contracted by the Department to provide medical assistance benefits which is not paid by the pharmacy benefit manager to pharmacy providers and pharmaceutical manufacturers or labelers or in order to perform administrative functions pursuant to its contracts with managed care organizations.

(f) The information disclosed under subsection (e) shall include all retail, mail order, specialty, and compounded prescription products. All information made available to the Department under subsection (e) is confidential and not subject to disclosure under the Freedom of Information Act.

(g) A pharmacy benefit manager shall disclose directly in writing to a pharmacy provider contracting with the pharmacy benefit manager of any material change to a contract provision that affects the terms of the reimbursement, the process for verifying benefits and eligibility, dispute resolution, procedures for verifying drugs included on the formulary, and contract termination at least 30 days prior to the date of the change to the provision.

(h) A pharmacy benefit manager shall not include the following in a contract with a pharmacy provider:

(1) a provision prohibiting the provider from informing a patient of a less costly alternative to a prescribed medication; or

(2) a provision that prohibits the provider from dispensing a particular amount of a prescribed medication, if the pharmacy benefit manager allows that amount to be dispensed through a pharmacy owned or controlled by the pharmacy benefit manager, unless the prescription drug is subject to restricted distribution by the United States Food and Drug Administration or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

(i) Nothing in this Section shall be construed to prohibit a pharmacy benefit manager from requiring the same reimbursement and terms and conditions for a pharmacy provider as for a pharmacy owned, controlled, or otherwise associated with the pharmacy benefit manager.

(j) A pharmacy benefit manager shall establish and implement a process for the resolution of disputes arising out of this Section, which shall be approved by the Department.

(k) The Department shall adopt rules establishing reasonable dispensing fees in accordance with guidance or guidelines from the federal Centers for Medicare and Medicaid Services.

Section 97. Severability. If any provision of this Act or the application of this Act to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this Act which can be given effect without

the invalid provision or application, and to this end, the provisions of this Act are declared severable.".