HB3761

LRB10330051BMS56474b

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB3761

Introduced 2/17/2023, by Rep. Will Guzzardi

SYNOPSIS AS INTRODUCED:

215 ILCS 5/155.37
215 ILCS 5/513b1
215 ILCS 5/513b1.1 new
215 ILCS 5/513b1.3 new
215 ILCS 5/513b1.5 new
215 ILCS 124/35 new

Amends the Pharmacy Benefit Managers Article of the Illinois Insurance Code. Provides that a pharmacy benefit manager may not prohibit a pharmacy or pharmacist from selling a more affordable alternative to the covered person if a more affordable alternative is available. Provides that a pharmacy benefit manager shall not reimburse a pharmacy or pharmacist in this State an amount less than the amount that the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate for providing the same pharmaceutical product. Provides that a pharmacy benefit manager is prohibited from conducting spread pricing in the State. Sets forth provisions concerning pharmacy network participation, fiduciary responsibility, and pharmacy benefit manager transparency. Provides that a pharmacy benefit manager shall report to the Director on a quarterly basis and that the report is confidential and not subject to disclosure under the Freedom of Information Act. Provides that the provisions apply to contracts entered into or renewed on or after July 1, 2023 (rather than July 1, 2022). Defines terms. Amends the Network Adequacy and Transparency Act. Sets forth provisions concerning pharmacy benefit manager network adequacy. Makes other changes.

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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 Illinois Insurance Code is amended by changing Sections 155.37 and 513b1 and by adding Sections 513b1.1, 513b1.3, and 513b1.5 as follows:

(215 ILCS 5/155.37)

Sec. 155.37. Drug formulary; notice.

(a) As used in this Section:

"Brand name drug" means a prescription drug marketed under a proprietary name or registered trademark name.

"Formulary" means a list of prescription drugs that is developed by clinical and pharmacy experts and represents the carrier's medically appropriate and cost-effective prescription drugs approved for use.

"Generic drug" means a prescription drug, whether identified by its chemical, proprietary, or nonproprietary name, that is not a brand name drug and is therapeutically equivalent to a brand name drug in dosage, safety, strength, method of consumption, quality, performance, and intended use.

(b) Insurance companies that transact the kinds of insurance authorized under Class 1(b) or Class 2(a) of Section 4 of this Code and provide coverage for prescription drugs

through the use of a drug formulary must notify insureds of any change in the formulary. A company may comply with this Section by posting changes in the formulary on its website.

(c) If a generic equivalent for a brand name drug is approved by the U.S. Food and Drug Administration, then insurance companies with plans that provide coverage for prescription drugs through the use of a drug formulary that are amended, delivered, issued, or renewed in this State on or after January 1, 2024 shall:

(1) immediately make the generic equivalent available on the formulary to the brand name drug; or

(2) move the brand name drug to a formulary tier that reduces an enrollee's cost.

(d) Nothing in this Section shall interfere with a pharmacist complying with the Pharmacy Practice Act.

(e) The Department may adopt rules to implement this Section.

(Source: P.A. 92-440, eff. 8-17-01; 92-651, eff. 7-11-02.)

(215 ILCS 5/513b1)

Sec. 513b1. Pharmacy benefit manager contracts.

(a) As used in this Section:

"340B drug discount program" means the program established under Section 340B of the federal Public Health Service Act, 42 U.S.C. 256b.

"340B entity" means a covered entity as defined in 42

U.S.C. 256b(a)(4) authorized to participate in the 340B drug discount program.

"340B pharmacy" means any pharmacy used to dispense 340B drugs for a covered entity, whether entity-owned or external.

"Biological product" has the meaning ascribed to that term in Section 19.5 of the Pharmacy Practice Act.

"Covered person" means a member, policyholder, subscriber, enrollee, beneficiary, dependent, or other individual participating in a health benefit plan.

"Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of physical, mental, or behavioral health care services.

"Maximum allowable cost" means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a drug.

"Maximum allowable cost list" means a list of drugs for which a maximum allowable cost has been established by a pharmacy benefit manager.

"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.

"Retail price" means the price an individual without

prescription drug coverage would pay at a retail pharmacy, not including a pharmacist dispensing fee.

"Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits manager charges a health benefit plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

"Third-party payer" means any entity that pays for prescription drugs on behalf of a patient other than a health care provider or sponsor of a plan subject to regulation under Medicare Part D, 42 U.S.C. 1395w-101~~,~~ et seq.

(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.

(3) Provide access to its maximum allowable cost list to each pharmacy or pharmacy services administrative organization subject to the maximum allowable cost list.

Access may include a real-time pharmacy website portal to be able to view the maximum allowable cost list. As used in this Section, "pharmacy services administrative organization" means an entity operating within the State that contracts with independent pharmacies to conduct business on their behalf with third-party payers. A pharmacy services administrative organization may provide administrative services to pharmacies and negotiate and enter into contracts with third-party payers or pharmacy benefit managers on behalf of pharmacies.

(4) Provide a process by which a contracted pharmacy can appeal the provider's reimbursement for a drug subject to maximum allowable cost pricing. The appeals process must, at a minimum, include the following:

(A) A requirement that a contracted pharmacy has 14 calendar days after the applicable fill date to appeal a maximum allowable cost if the reimbursement for the drug is less than the net amount that the network provider paid to the supplier of the drug.

(B) A requirement that a pharmacy benefit manager must respond to a challenge within 14 calendar days of the contracted pharmacy making the claim for which the appeal has been submitted.

(C) A telephone number and e-mail address or website to network providers, at which the provider can contact the pharmacy benefit manager to process

and submit an appeal.

(D) A requirement that, if an appeal is denied, the pharmacy benefit manager must provide the reason for the denial and the name and the national drug code number from national or regional wholesalers.

(E) A requirement that, if an appeal is sustained, the pharmacy benefit manager must make an adjustment in the drug price effective the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the managed care organization or pharmacy benefit manager.

(5) Allow a plan sponsor contracting with a pharmacy benefit manager an annual right to audit compliance with the terms of the contract by the pharmacy benefit manager, including, but not limited to, full disclosure of any and all rebate amounts secured, whether product specific or generalized rebates, that were provided to the pharmacy benefit manager by a pharmaceutical manufacturer.

(6) Allow a plan sponsor contracting with a pharmacy benefit manager to request that the pharmacy benefit manager disclose the actual amounts paid by the pharmacy benefit manager to the pharmacy.

(7) Provide notice to the party contracting with the pharmacy benefit manager of any consideration that the pharmacy benefit manager receives from the manufacturer

for dispense as written prescriptions once a generic or biologically similar product becomes available.

(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) if the drug is a generically equivalent drug, it is listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the United States Food and Drug Administration's most recent version of the "Orange Book" or have an NR or NA rating by Medi-Span, Gold Standard, or a similar rating by a nationally recognized reference;

(2) the drug is available for purchase by each pharmacy in the State from national or regional wholesalers operating in Illinois; and

(3) the drug is not obsolete.

(d) A pharmacy benefit manager is prohibited from limiting a pharmacist's ability to disclose to a covered person:

(1) whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, if one is available in accordance with Section 42 of the Pharmacy Practice Act; or ~~.~~

(2) any health care information that the pharmacy or pharmacist deems appropriate regarding:

(i) the nature of treatment, risks, or

alternatives thereto, if such disclosure is consistent with the permissible practice of pharmacy under the Pharmacy Practice Act;

(ii) the availability of alternative therapies, consultations, or tests if such disclosure is consistent with the permissible practice of pharmacy under the Pharmacy Practice Act;

(iii) the decision of utilization reviewers or similar persons to authorize or deny services;

(iv) the process that is used to authorize or deny health care services or benefits; or

(v) information on financial incentives and structures used by the insurer.

(e) A health insurer or pharmacy benefit manager shall not require 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) Unless required by law, a contract between a pharmacy benefit manager or third-party payer and a 340B entity or 340B pharmacy shall not contain any provision that:

(1) distinguishes between drugs purchased through the 340B drug discount program and other drugs when determining reimbursement or reimbursement methodologies, or contains otherwise less favorable payment terms or

reimbursement methodologies for 340B entities or 340B pharmacies when compared to similarly situated non-340B entities;

(2) imposes any fee, chargeback, or rate adjustment that is not similarly imposed on similarly situated pharmacies that are not 340B entities or 340B pharmacies;

(3) imposes any fee, chargeback, or rate adjustment that exceeds the fee, chargeback, or rate adjustment that is not similarly imposed on similarly situated pharmacies that are not 340B entities or 340B pharmacies;

(4) prevents or interferes with an individual's choice to receive a covered prescription drug from a 340B entity or 340B pharmacy through any legally permissible means, except that nothing in this paragraph shall prohibit the establishment of differing copayments or other cost-sharing amounts within the benefit plan for covered persons who acquire covered prescription drugs from a nonpreferred or nonparticipating provider;

(5) excludes a 340B entity or 340B pharmacy from a pharmacy network on any basis that includes consideration of whether the 340B entity or 340B pharmacy participates in the 340B drug discount program;

(6) prevents a 340B entity or 340B pharmacy from using a drug purchased under the 340B drug discount program; or

(7) any other provision that discriminates against a 340B entity or 340B pharmacy by treating the 340B entity

or 340B pharmacy differently than non-340B entities or non-340B pharmacies for any reason relating to the entity's participation in the 340B drug discount program.

As used in this subsection, "pharmacy benefit manager" and "third-party payer" do not include pharmacy benefit managers and third-party payers acting on behalf of a Medicaid program.

(g) A violation of this Section by a pharmacy benefit manager constitutes an unfair or deceptive act or practice in the business of insurance under Section 424.

(h) A provision that violates subsection (f) in a contract between a pharmacy benefit manager or a third-party payer and a 340B entity that is entered into, amended, or renewed after July 1, 2022 shall be void and unenforceable.

(i) A pharmacy benefit manager may not prohibit a pharmacy or pharmacist from selling a more affordable alternative to the covered person if a more affordable alternative is available.

(j) A pharmacy benefit manager shall not reimburse a pharmacy or pharmacist in this State an amount less than the amount that the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate for providing the same pharmaceutical product.

(k) A pharmacy benefit manager shall not:

(1) condition payment, reimbursement, or network participation on any type of accreditation, certification, or credentialing standard beyond those required by the

State Board of Pharmacy or applicable State or federal law;

(2) prohibit or otherwise restrict a pharmacist or pharmacy from offering prescription delivery services to any covered person; or

(3) require any additional requirement for a prescription claim that is more restrictive than the standards established under the Illinois Food, Drug and Cosmetic Act; the Pharmacy Practice Act; or the Illinois Controlled Substances Act.

(l) A pharmacy benefit manager is prohibited from conducting spread pricing in this State.

(m) ~~(i)~~ This Section applies to contracts entered into or renewed on or after July 1, 2023 ~~2022~~.

(n) ~~(j)~~ 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.

(Source: P.A. 101-452, eff. 1-1-20; 102-778, eff. 7-1-22; revised 8-19-22.)

(215 ILCS 5/513b1.1 new)

Sec. 513b1.1. Pharmacy network participation.

(a) As used in this Section:

"Claims processing services" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:

(1) receiving payments for pharmacist services; or

(2) making payments to a pharmacist or pharmacy for pharmacist services.

"Pharmacy benefit manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefit manager. "Pharmacy benefit manager affiliate" includes any mail-order pharmacy that is directly or indirectly owned or controlled by a pharmacy benefit manager.

(b) A pharmacy benefit manager shall not:

(1) prohibit or limit a participant or beneficiary of pharmacy services under a health benefit plan from selecting a pharmacy or pharmacist of his or her choice if the pharmacy or pharmacist is willing and agrees to accept the same terms and conditions that the pharmacy benefit manager has established for at least one of the networks of pharmacies that the pharmacy benefit manager has established to serve patients within this State;

(2) prohibit a pharmacy from participating in any given network of pharmacies within the State if the pharmacy is licensed by the Department of Financial and

Professional Regulation and agrees to the same terms and conditions, including the terms of reimbursement, that the pharmacy benefit manager has established for other pharmacies participating within the network that the pharmacy wishes to join;

(3) charge a participant or beneficiary of a pharmacy benefits plan or program that the pharmacy benefit manager serves a different copayment obligation or additional fee for using any pharmacy within a given network of pharmacies established by the pharmacy benefit manager to serve patients within this State;

(4) impose a monetary advantage, incentive, or penalty under a health benefit plan that would affect or influence a beneficiary's choice among those pharmacies or pharmacists who have agreed to participate in the plan according to the terms offered by the insurer;

(5) require a participant or beneficiary to use or otherwise obtain services exclusively from a mail-order pharmacy or one or more pharmacy benefit manager affiliates;

(6) impose upon a beneficiary any copayment obligation or other limitation, restriction, or condition, including the number of days of a drug supply for which coverage will be allowed, that is more costly or more restrictive than that which would be imposed upon the beneficiary if such services were purchased from a pharmacy benefit manager

affiliate or any other pharmacy within a given network of pharmacies established by the pharmacy benefit manager to serve patients within this State;

(7) require participation in additional networks for a pharmacy to enroll in an individual network;

(8) include in any manner on any material, including, but not limited to, mail and identifications cards, the name of any pharmacy, hospital, or other providers unless it specifically lists all pharmacies, hospitals, and providers participating in the given network of pharmacies established by the pharmacy benefit manager to serve patients within this State; or

(9) share, transfer, or otherwise utilize patient information or pharmacy service data collected pursuant to the provision of claims processing services for the purpose of referring a participant or beneficiary to a pharmacy benefit manager affiliate.

(c) A pharmacy licensed in or holding a nonresident pharmacy permit in Illinois shall be prohibited from:

(1) transferring or sharing records relative to prescription information containing patient identifiable and prescriber identifiable data to or from an affiliate for any commercial purpose; however, nothing shall be construed to prohibit the exchange of prescription information between a pharmacy and its affiliate for the limited purposes of pharmacy reimbursement, formulary

compliance, pharmacy care, public health activities otherwise authorized by law, or utilization review by a health care provider; or

(2) presenting a claim for payment to any individual, third-party payer, affiliate, or other entity for a service furnished pursuant to a referral from an affiliate or other person licensed under this Article.

(d) If a pharmacy licensed or holding a nonresident pharmacy permit in this State has an affiliate, it shall annually file with the Department a disclosure statement identifying all such affiliates.

(e) This Section shall not be construed to prohibit a pharmacy from entering into an agreement with an affiliate to provide pharmacy care to patients if the pharmacy does not receive referrals in violation of subsection (c) and the pharmacy provides the disclosure statement required in subsection (d).

(f) In addition to any other remedy provided by law, a violation of this Section by a pharmacy shall be grounds for disciplinary action by the Department.

(g) A pharmacist who fills a prescription that violates subsection (c) shall not be liable under this Section.

(h) This Section does not apply to:

(1) any hospital or related institution; or

(2) any referrals by an affiliate for pharmacy services and prescriptions to patients in skilled nursing

facilities, intermediate care facilities, continuing care retirement communities, home health agencies, or hospices.

(215 ILCS 5/513b1.3 new)

Sec. 513b1.3. Fiduciary responsibility. A pharmacy benefit manager is a fiduciary to a contracted health insurer and shall:

(1) discharge that duty in accordance with federal and State law;

(2) notify the covered entity in writing of any activity, policy, or practice of the pharmacy benefit manager that directly or indirectly presents any conflict of interest and inability to comply with the duties imposed by this Section, but in no event does this notification exempt the pharmacy benefit manager from compliance with all other Sections of this Code; and

(3) disclose all direct or indirect payments related to the dispensation of prescription drugs or classes or brands of drugs to the covered entity.

(215 ILCS 5/513b1.5 new)

Sec. 513b1.5. Pharmacy benefit manager transparency.

(a) A pharmacy benefit manager shall report to the Director on a quarterly basis for each health care insurer the following information:

(1) the aggregate amount of rebates received by the

pharmacy benefit manager;

(2) the aggregate amount of rebates distributed to the appropriate health care insurer;

(3) the aggregate amount of rebates passed on to the enrollees of each health care insurer at the point of sale that reduced the enrollees' applicable deductible, copayment, coinsurance, or other cost-sharing amount;

(4) the individual and aggregate amount paid by the health care insurer to the pharmacy benefit manager for pharmacist services itemized by pharmacy, by product, and by goods and services; and

(5) the individual and aggregate amount a pharmacy benefit manager paid for pharmacist services itemized by pharmacy, by product, and by goods and services.

(b) The report made to the Department required under this Section is confidential and not subject to disclosure under the Freedom of Information Act.

Section 10. The Network Adequacy and Transparency Act is amended by adding Section 35 as follows:

(215 ILCS 124/35 new)

Sec. 35. Pharmacy benefit manager network adequacy.

(a) As used in this Section:

"Pharmacy benefit manager" has the meaning ascribed to that term in Section 513b1 of the Illinois Insurance Code.

"Pharmacy benefit manager network" means the group or groups of preferred providers of pharmacy services to a network plan.

"Pharmacy benefit manager network plan" means an individual or group policy of accident and health insurance that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use providers of pharmacy services managed, owned, under contract with, or employed by the insurer.

"Pharmacy services" means products, goods, and services or any combination of products, goods, and services, provided as a part of the practice of pharmacy. "Pharmacy services" includes pharmacist care as defined in the Pharmacy Practice Act.

(b) A pharmacy benefit manager shall provide a reasonably adequate and accessible pharmacy benefit manager network for the provision of prescription drugs for a health benefit plan that shall provide for convenient patient access to pharmacies within a reasonable distance from a patient's residence.

(c) Pharmacy benefit managers must file for review by the Director a pharmacy benefit manager network plan describing the pharmacy benefit manager network and the pharmacy benefit manager network's accessibility in this State in the time and manner required by rule issued by the Department.

(1) A mail-order pharmacy shall not be included in the calculations determining pharmacy benefit manager network

adequacy.

(2) A pharmacy benefit manager network plan shall comply with the following retail pharmacy network access standards:

(A) at least 90% of covered individuals residing in an urban service area live within 2 miles of a retail pharmacy participating in the pharmacy benefit manager's retail pharmacy network;

(B) at least 90% of covered individuals residing in an urban service area live within 5 miles of a retail pharmacy designated as a preferred participating pharmacy in the pharmacy benefit manager's retail pharmacy network;

(C) at least 90% of covered individuals residing in a suburban service area live within 5 miles of a retail pharmacy participating in the pharmacy benefit manager's retail pharmacy network;

(D) at least 90% of covered individuals residing in a suburban service area live within 7 miles of a retail pharmacy designated as a preferred participating pharmacy in the pharmacy benefit manager's retail pharmacy network;

(E) at least 70% of covered individuals residing in a rural service area live within 15 miles of a retail pharmacy participating in the pharmacy benefit manager's retail pharmacy network; and

(F) at least 70% of covered individuals residing in a rural service area live within 18 miles of a retail pharmacy designated as a preferred participating pharmacy in the pharmacy benefit manager's retail pharmacy network.

(d) The Director shall establish a process for the review of the adequacy of the standards required under this Section.