SB1618

LRB10329540BMS55935b

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

SB1618

Introduced 2/8/2023, by Sen. Julie A. Morrison

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.61 new
215 ILCS 5/513b7 new

Amends the Illinois Insurance Code. Provides that no later than July 1, 2024, each health plan and pharmacy benefit manager operating in this State shall, upon request of a covered individual, his or her health care provider, or an authorized third party on his or her behalf, furnish specified cost, benefit, and coverage data to the covered individual, his or her health care provider, or the third party of his or her choosing and shall ensure that the data is: (1) current no later than one business day after any change is made; (2) provided in real time; and (3) in a format that is easily accessible to the covered individual or, in the case of his or her health care provider, through an electronic health records system. Provides that the format of the request shall use specified industry content and transport standards. Provides that a facsimile is not an acceptable electronic format. Provides that upon request, specified data shall be provided for any drug covered under the covered individual's health plan. Makes other changes. Defines terms.

LRB103 29540 BMS 55935 b

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 adding Sections 356z.61 and 513b7 as follows:

(215 ILCS 5/356z.61 new)

Sec. 356z.61. Patient prescription pricing transparency.

(a) As used in this Section:

"Authorized third party" includes a third party legally authorized under State or federal law subject to a Health Insurance Portability and Accountability Act of 1996 business associate agreement.

"Cost-sharing information" means the amount a covered individual is required to pay to receive a drug that is covered under the covered individual's health plan.

"Coverage" means those health care services to which a covered individual is entitled under the terms of the health plan.

"Electronic health record" means a digital version of a patient's paper chart and medical history that makes information available instantly and securely to authorized users.

"Electronic prescribing system" means a system that

enables prescribers to enter prescription information into a computer prescription device and securely transmit the prescription to pharmacies using a special software program and connectivity to a transmission network.

"Prescriber" means a health care provider licensed to prescribe medication or medical devices in this State.

"Real-time benefit tool" means an electronic prescription decision support tool that (i) is capable of integrating with prescribers' electronic prescribing and, if feasible, electronic health record systems; and (ii) complies with the technical standards adopted by an American National Standards Institute accredited standards development organization.

(b) No later than July 1, 2024, each health plan operating in this State shall, upon request of a covered individual, his or her health care provider, or an authorized third party on his or her behalf, furnish the cost, benefit, and coverage data required under this Section to the covered individual, his or her health care provider, or the third party of his or her choosing and shall ensure that the data is:

(1) current no later than one business day after any change is made;

(2) provided in real time; and

(3) in a format that is easily accessible to the covered individual or, in the case of his or her health care provider, through an electronic health records system.

(c) The format of the request shall use established industry content and transport standards published by:

(1) a standards developing organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, Accredited Standards Committee X12, and Health Level 7;

(2) a relevant federal or state governing body, including the Centers for Medicare & Medicaid Services or the Office of the National Coordinator for Health Information Technology; or

(3) another format deemed acceptable to the Department that provides the data described in subsection (a) and with the same timeliness as required by this Section.

(d) A facsimile is not an acceptable electronic format under this Section.

(e) Upon request, the following data shall be provided for any drug covered under the covered individual's health plan:

(1) patient-specific eligibility information;

(2) patient-specific prescription cost and benefit data, such as applicable formulary, benefit, coverage and cost-sharing data for the prescribed drug, and clinically appropriate alternatives, when appropriate;

(3) patient-specific cost-sharing information that describes variance in cost sharing based on the pharmacy dispensing the prescribed drug or its alternatives, and in relation to the patient's benefit, such as spending

related to the out-of-pocket maximum;

(4) information regarding lower cost clinically appropriate treatment alternatives; and

(5) applicable utilization management requirements.

(f) Any health plan shall furnish the data as required whether the request is made using the drug's unique billing code, such as a National Drug Code or Healthcare Common Procedure Coding System code, or descriptive term. A health plan shall not deny or unreasonably delay a request as a method of blocking the required data from being shared based on how the drug was requested.

(g) A health plan shall not restrict, prohibit, or otherwise hinder the prescriber from communicating or sharing benefit and coverage information that reflects other choices, such as cash price, lower cost clinically appropriate alternatives, whether or not they are covered under the covered individual's plan and support programs, and the cost available at the patient's pharmacy of choice.

(h) A health plan shall not, except as may be required by law, interfere with, prevent, or materially discourage access, exchange, or use of the data as required, which may include charging fees or not responding to a request for such data in a reasonable time frame; nor penalize a health care provider or professional for disclosing such information to a covered individual or legally prescribing, administering, or ordering a clinically appropriate or lower cost alternative.

(i) Nothing in this Section shall be construed to limit access to the most up-to-date patient-specific eligibility or patient-specific prescription cost and benefit data by the health plan.

(j) Nothing in this Section shall interfere with patient choice and a health care professional's ability to convey the full range of prescription drug cost options to a patient. Health plans shall not restrict a health care professional from communicating prescription cost options to the patient.

(k) No real-time benefit tool shall require a patient to use specific plan-preferred drugs or pharmacies.

(215 ILCS 5/513b7 new)

Sec. 513b7. Patient prescription pricing transparency.

(a) No later than July 1, 2024, each pharmacy benefit manager operating in this State shall, upon request of a covered individual, his or her health care provider, or an authorized third party on his or her behalf, furnish the cost, benefit, and coverage data required under this Section to the covered individual, his or her health care provider, or the third party of his or her choosing and shall ensure that the data is:

(1) current no later than one business day after any change is made;

(2) provided in real time; and

(3) in a format that is easily accessible to the

covered individual or, in the case of his or her health care provider, through an electronic health records system.

(b) The format of the request shall use established industry content and transport standards published by:

(1) a standards developing organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, Accredited Standards Committee X12, and Health Level 7;

(2) a relevant federal or state governing body, including the Centers for Medicare & Medicaid Services or the Office of the National Coordinator for Health Information Technology; or

(3) another format deemed acceptable to the Department that provides the data described in subsection (a) and with the same timeliness as required by this Section.

(c) A facsimile is not an acceptable electronic format under this Section.

(d) Upon request, the following data shall be provided for any drug covered under the covered individual's health plan:

(1) patient-specific eligibility information;

(2) patient-specific prescription cost and benefit data, such as applicable formulary, benefit, coverage and cost-sharing data for the prescribed drug, and clinically appropriate alternatives, when appropriate;

(3) patient-specific cost-sharing information that

describes variance in cost sharing based on the pharmacy dispensing the prescribed drug or its alternatives, and in relation to the patient's benefit, such as spending related to the out-of-pocket maximum;

(4) information regarding lower cost clinically appropriate treatment alternatives; and

(5) applicable utilization management requirements.

(e) A pharmacy benefit manager shall furnish the data as required whether the request is made using the drug's unique billing code, such as a National Drug Code or Healthcare Common Procedure Coding System code, or descriptive term. A pharmacy benefit manager shall not deny or unreasonably delay a request as a method of blocking the required data from being shared based on how the drug was requested.

(f) A pharmacy benefit manager shall not restrict, prohibit, or otherwise hinder the prescriber from communicating or sharing benefit and coverage information that reflects other choices, such as cash price, lower cost clinically appropriate alternatives, whether or not they are covered under the covered individual's plan, patient assistance programs, and support programs, and the cost available at the patient's pharmacy of choice.

(g) A pharmacy benefit manager shall not, except as may be required by law, interfere with, prevent, or materially discourage access, exchange, or use of the data as required, which may include charging fees or not responding to a request

for such data in a reasonable time frame; nor penalize a health care provider or professional for disclosing such information to a covered individual or legally prescribing, administering, or ordering a clinically appropriate or lower cost alternative.

(h) Nothing in this Section shall be construed to limit access to the most up-to-date patient-specific eligibility or patient-specific prescription cost and benefit data by the pharmacy benefit manager.

(i) Nothing in this Section shall interfere with patient choice and a health care professional's ability to convey the full range of prescription drug cost options to a patient. A pharmacy benefit manager shall not restrict a health care professional from communicating prescription cost options to the patient.

(j) No real-time benefit tool shall require a patient to use specific plan-preferred drugs or pharmacies.