HB5614

LRB095 19960 RAS 46386 b

95TH GENERAL ASSEMBLY

State of Illinois

2007 and 2008

HB5614

by Rep. Dan Reitz

SYNOPSIS AS INTRODUCED:

See Index

Amends the Third Party Prescription Programs Article of the Insurance Code to change the name of the Article to the Pharmacy Benefits Management Programs Law. Provides for the registration of all pharmacy benefits management programs and pharmacy benefits managers (PBMs) doing business in the State with the Director of the Division of Insurance of the Department of Financial and Professional Regulation. Creates the Advisory Council on Pharmacy Benefits Managers. Makes changes concerning fiduciary and bonding, notice, and contractual requirements, cancellation procedures, denial of payment, and failure to register. Sets forth provisions concerning drug substitution, pricing, claims, maximum allowable cost (MAC) adjustments, audit standards, contact of covered persons, record keeping, information sharing with out-of-network pharmacies, prohibitions, the collection and payment of taxes and fees, and failure to comply. Grants rulemaking authority to the Director of the Division of Insurance. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

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 the heading of Article XXXI 1/2 and Sections 512-1, 512-2, 512-3, 512-4, 512-5, 512-6, 512-7, 512-8, 512-9, and 512-10 and by adding Sections 512-4.5, 512-11, 512-12, 512-13, 512-14, 512-15, 512-16, and 512-17 as follows:

(215 ILCS 5/Art. XXXI.5 heading)

ARTICLE XXXI 1/2.

PHARMACY BENEFITS MANAGEMENT ~~THIRD PARTY PRESCRIPTION~~ PROGRAMS

(215 ILCS 5/512-1) (from Ch. 73, par. 1065.59-1)

Sec. 512-1. Short Title. This Article shall be known and may be cited as the "Pharmacy Benefits Management Programs Law ~~Third Party Prescription Program Act~~".

(Source: P.A. 82-1005.)

(215 ILCS 5/512-2) (from Ch. 73, par. 1065.59-2)

Sec. 512-2. Purpose. It is hereby determined and declared that the purpose of this Article is to regulate pharmacy benefits management programs ~~certain practices engaged in by third-party prescription program administrators~~.

(Source: P.A. 82-1005.)

(215 ILCS 5/512-3) (from Ch. 73, par. 1065.59-3)

Sec. 512-3. Definitions. For the purposes of this Article, unless the context otherwise requires, the terms defined in this Article have the meanings ascribed to them herein:

"Council" means the Advisory Council on Pharmacy Benefit Managers.

"Covered entity" means a nonprofit hospital or medical service organization, insurer, health coverage plan or health maintenance organization, or a health program administered by the Department or the State in the capacity of provider of health coverage; or an employer, labor union, or other group of persons organized in this State that provides health coverage to covered persons who are employed or reside in this State. "Covered entity" does not include a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, or long-term care or other limited benefit health insurance policies and contracts.

"Covered person" means a member, participant, enrollee, contract holder, or policy beneficiary of a covered entity who is provided health coverage by the covered entity. "Covered person" includes, but is not limited to, a dependent or other person who is provided health coverage though a policy, contract, or plan for a covered person.

"Director" means the Director of the Division of Insurance of the Department of Financial and Professional Regulation.

"Division" means the Division of Insurance of the Department of Financial and Professional Regulation.

"Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the cost of health care services, including prescription drug benefits.

"Pharmacist" means any individual properly licensed as a pharmacist under the Pharmacy Practice Act.

"Pharmacist services" means and includes drug therapy and other patient care services provided by a licensed pharmacist intended to achieve outcomes related to the cure or prevention of a disease, elimination or reduction of a patient's symptoms, or arresting or slowing of a disease process, as defined in the Pharmacy Practice Act.

"Pharmacy" has the meaning given to the term in the Pharmacy Practice Act.

"Pharmacy benefits management" means the administration or management of prescription drug benefits provided by a covered entity for the benefit of covered persons.

"Pharmacy benefits manager" or "PBM" means a person, business, or other entity that performs pharmacy benefits management. "Pharmacy benefits management" or "PBM" includes, but is not limited to, a person or entity acting for a PBM in a

contractual or employment relationship in the performance of pharmacy benefits management for a covered entity.

"Pharmacy network provider" means a pharmacist or pharmacy that has a contractual relationship with a health benefit plan or pharmacy benefit manger to provide pharmacist services.

"Practice of pharmacy" has the meaning given to the term in the Pharmacy Practice Act.

~~(a) "Third party prescription program" or "program" means any system of providing for the reimbursement of pharmaceutical services and prescription drug products offered or operated in this State under a contractual arrangement or agreement between a provider of such services and another party who is not the consumer of those services and products. Such programs may include, but need not be limited to, employee benefit plans whereby a consumer receives prescription drugs or other pharmaceutical services and those services are paid for by an agent of the employer or others.~~

~~(b) "Third party program administrator" or "administrator" means any person, partnership or corporation who issues or causes to be issued any payment or reimbursement to a provider for services rendered pursuant to a third party prescription program, but does not include the Director of Healthcare and Family Services or any agent authorized by the Director to reimburse a provider of services rendered pursuant to a program of which the Department of Healthcare and Family Services is the third party.~~

(Source: P.A. 95-331, eff. 8-21-07.)

(215 ILCS 5/512-4) (from Ch. 73, par. 1065.59-4)

Sec. 512-4. Registration. All pharmacy benefits management ~~third party prescription~~ programs and PBMs ~~administrators~~ doing business in the State shall register with the Director ~~of Insurance~~. The Director may ~~shall~~ promulgate regulations establishing criteria for registration in accordance with the terms of this Article. The Director may by rule establish an annual registration fee for each pharmacy benefits management program and may conduct audits of pharmacy benefits management programs registered under this Act, in a manner established by the Director by rule. ~~third party administrator~~.

(Source: P.A. 82-1005.)

(215 ILCS 5/512-4.5 new)

Sec. 512-4.5. Advisory Council on Pharmacy Benefits Managers. There is created within the Division the Advisory Council on Pharmacy Benefits Management to provide for procedural and compliance oversight of all PBMs registered under this Article. The Council shall be comprised of 2 pharmacists nominated by the Illinois Pharmacists Association, 2 pharmacists nominated by the Retail Merchants Association, 2 representatives of the Division, and one representative of the State Employees Group Insurance Program. The Council may assist the Director in issues involving complaint resolution and

healthcare program benefits development.

(215 ILCS 5/512-5) (from Ch. 73, par. 1065.59-5)

Sec. 512-5. Fiduciary and Bonding Requirements.

(a) A fiduciary responsibility shall exist between a PBM registered under this Article and each covered entity. This responsibility may be discharged only in accordance with the provisions of applicable State and federal law.

(b) A PBM ~~third party prescription program administrator~~ shall (1) establish and maintain a fiduciary account, separate and apart from any and all other accounts, for the receipt and disbursement of funds for reimbursement of providers of services under the program, or (2) post, or cause to be posted, a bond of indemnity in an amount equal to not less than 10% of the total estimated annual reimbursements under the program.

(c) The establishment of such fiduciary accounts and bonds shall be consistent with applicable State law. If a bond of indemnity is posted, it shall be held by the Director ~~of Insurance~~ for the benefit and indemnification of the pharmacy network providers of covered pharmacist services under the pharmacy benefits management ~~third party prescription~~ program.

(d) Any PBM ~~An administrator~~ who operates more than one pharmacy benefits management ~~third party prescription~~ program may establish and maintain a separate fiduciary account or bond of indemnity for each such program, or may operate and maintain a consolidated fiduciary account or bond of indemnity for all

such programs.

(e) The requirements of this Section do not apply to any pharmacy benefits management ~~third party prescription~~ program administered by or on behalf of any insurance company, Health Maintenance Organization, Limited Health Service Organization, or Voluntary Health Services Plan ~~Care Service Plan Corporation or Pharmaceutical Service Plan Corporation~~ authorized to do business in the State of Illinois.

(Source: P.A. 82-1005.)

(215 ILCS 5/512-6) (from Ch. 73, par. 1065.59-6)

Sec. 512-6. Notice; drug substitution.

(a) Notice of any change in the terms of a pharmacy benefits management ~~third party prescription~~ program, including but not limited to drugs covered, reimbursement rates, co-payments, and dosage quantity, shall be given to each ~~enrolled~~ pharmacy network provider at least 30 days prior to the time it becomes effective.

(b) Written notice of any activity, policy, practice, ownership, interest, or affiliation of a PBM that may be construed as a conflict of interest must be provided by the PBM to the pharmacy network provider with which the conflict exists within an amount of time determined by the Division.

(c) A PBM may request the substitution of a lower-priced, generic, therapeutically-equivalent drug if the cost of the substitute drug to the covered person or the covered entity is

higher. A PBM may request the substitution of a lower, generic, therapeutically-equivalent drug for a higher-priced drug if the cost of the substitute drug to the covered person or the covered entity exceeds the cost of the prescribed medication, in which case the dispensing pharmacy shall be paid in accordance with contract terms relevant to the original prescription. Drug substitution may be requested only for medical reasons that benefit the covered person and may take place only after the PBM has obtained the approval of the prescriber. A PBM may not substitute any drug with a prescription order that prohibits substitution. Any time that a substitution is attempted for formulary reasons, the original prescription, as directed by the prescriber, must be honored by the dispensing pharmacy network provider and the PBM must contact the prescriber within 30 days after the substitution is attempted and obtain authorization for the substitution in writing. If a PBM fails to obtain the required written authorization for the drug substitution, the pharmacy network provider and covered person shall be paid or charged based on the orignal prescription terms. The co-payment of a covered person may not be impacted by any drug substitution carried out under this Section, and pharmacy network provider reimbursement shall be based on the network contract relating to the original prescription.

(Source: P.A. 82-1005.)

(215 ILCS 5/512-7) (from Ch. 73, par. 1065.59-7)

Sec. 512-7. Contractual provisions.

(a) Any agreement or contract entered into ~~in this State~~ between a PBM ~~the administrator of a program~~ and a pharmacy network provider under a pharmacy benefits management program shall include a statement of the method and amount of reimbursement to the pharmacy network provider for services rendered to covered persons enrolled in the program, the frequency of payment by the PBM ~~program administrator~~ to the pharmacy network provider for those services, and a method for the adjudication of complaints and the settlement of disputes between the contracting parties.

(b)(1) A program shall provide an annual period of at least 30 days during which any pharmacy licensed under the Pharmacy Practice Act may elect to participate in the program under the program terms for at least one year.

(2) If compliance with the requirements of this subsection (b) would impair any provision of a contract between a program and any other person, and if the contract provision was in existence before January 1, 2009 ~~1990~~, then immediately after the expiration of those contract provisions the program shall comply with the requirements of this subsection (b).

(3) This subsection (b) does not apply if:

(A) the PBM ~~program administrator~~ is a licensed health maintenance organization, limited health

service organization, or voluntary health services plan that owns or controls a pharmacy and that enters into an agreement or contract with that pharmacy in accordance with subsection (a); or

(B) (blank). ~~the program administrator is a licensed health maintenance organization that is owned or controlled by another entity that also owns or controls a pharmacy, and the administrator enters into an agreement or contract with that pharmacy in accordance with subsection (a).~~

(4) (Blank). ~~This subsection (b) shall be inoperative after October 31, 1992.~~

(c) The PBM ~~program administrator~~ shall cause to be issued an identification card to each person enrolled in the program. The identification card shall comply with the Uniform Prescription Drug Information Card Act. ~~include:~~

~~(1) the name of the individual enrolled in the program; and~~

~~(2) an expiration date if required under the contractual arrangement or agreement between a provider of pharmaceutical services and prescription drug products and the third party prescription program administrator.~~

(d) PBMs must provide full contract disclosure of terms and conditions for pharmacy network providers and may not relate the terms and conditions of one covered entity contract for pharmacy network providers to the terms and conditions of an

unrelated covered entity contract and its pharmacy network providers. Each pharmacy network provider contract shall be independent of and unrelated to other pharmacy network provider contracts. Enrolled pharmacy network providers may negotiate all terms and conditions of any network contract and may not be restricted from disclosing the terms and conditions of such contract with other pharmacy network providers. All network contracts for any covered entity must be identical in all terms and conditions for all participating pharmacy network providers.

(Source: P.A. 95-689, eff. 10-29-07.)

(215 ILCS 5/512-8) (from Ch. 73, par. 1065.59-8)

Sec. 512-8. Cancellation procedures.

(a) The pharmacy benefits manager ~~administrator of a program~~ shall notify all pharmacy network providers ~~pharmacies~~ enrolled in the program of any cancellation of the coverage of benefits of any group enrolled in the program at least 10 business ~~30~~ days prior to the effective date of such cancellation. However, if the PBM ~~administrator of a program~~ is not notified at least 45 days prior to the effective date of such cancellation, the PBM ~~administrator~~ shall notify all pharmacies enrolled in the program of the cancellation as soon as practicable after having received notice. Any claims adjudicated by the pharmacy network provider and accepted by the PBM must be paid outside of the 10-day notification period.

(b) When a program is terminated, all persons enrolled therein shall be so notified, and the employer shall make every reasonable effort to gain possession of any plan identification cards in such persons' possession.

(c) Any person who intentionally uses a program identification card to obtain services from a pharmacy after having received notice of the cancellation of his benefits shall be guilty of a Class C misdemeanor. Persons shall be liable to the PBM ~~program administrator~~ for all monies paid by the PBM ~~program administrator~~ for any services received pursuant to such misuse ~~any improper use~~ of the identification card.

(Source: P.A. 82-1005.)

(215 ILCS 5/512-9) (from Ch. 73, par. 1065.59-9)

Sec. 512-9. Denial of Payment.

(a) No PBM ~~administrator~~ shall deny payment to any pharmacy for covered pharmaceutical services or prescription drug products rendered as a result of the misuse, fraudulent or illegal use of an identification card unless such identification card had expired, been noticeably altered, or the pharmacy was notified of the cancellation of such card. In lieu of notifying pharmacies which have a common ownership, the PBM ~~administrator~~ may notify a party designated by the pharmacy to receive such notice, in which case, notification shall not become effective until 5 calendar days after the designee

receives notification.

(b) No PBM ~~program administrator~~ may withhold any payment to any pharmacy for covered pharmaceutical services or prescription drug products beyond the time period specified in the payment schedule provisions of the agreement, except for individual claims for payment which have been returned to the pharmacy as incomplete or illegible. Such returned claims shall be paid if resubmitted by the pharmacy to the PBM ~~program administrator~~ with the appropriate corrections made.

(Source: P.A. 82-1005.)

(215 ILCS 5/512-10) (from Ch. 73, par. 1065.59-10)

Sec. 512-10. Failure to Register. Any pharmacy benefits management ~~third party prescription~~ program or PBM that ~~administrator which~~ operates without a certificate of registration or fails to register with the Director and pay the fee prescribed by this Article shall be construed to be an unauthorized insurer as defined in Article VII of this Code and shall be subject to all penalties contained therein.

The provisions of this ~~the~~ Article shall apply to all new programs established on or after January 1, 2009 ~~1983~~. Programs existing on the effective date of this amendatory Act of the 95th General Assembly ~~Existing programs~~ shall comply with the provisions of this Article as they existed before the effective date of this amendatory Act of the 95th General Assembly until ~~on~~ the anniversary date of the programs that occurs on or after

January 1, 2009, at which time the programs shall comply with the provisions of this Article as they exist beginning on the effective date of this amendatory Act of the 95th General Assembly ~~1983~~.

(Source: P.A. 82-1005.)

(215 ILCS 5/512-11 new)

Sec. 512-11. Pricing; claims; MAC adjustments.

(a) Within 2 days after a notice of price increase or decrease by the manufacturer or supplier of a drug, a PBM must adjust its payment to the pharmacy network provider consistent with the price change.

(b) PBMs must provide full transparent pricing. A PBM must disclose to a covered entity the amount that the PBM has paid to a pharmacy network provider and the amount charged to the covered entity for pharmacy network provider reimbursement fees. All rebate dollars or other forms of remuneration received by the manufacturer or supplier must be disclosed to the covered entity on a quarterly basis or more often as requested by the covered entity.

(c) A PBM may not accept any unreported revenue from any third party.

(d) All claims accepted and adjudicated by a PBM for a pharmacy network provider must be paid within 15 calendar days after the date of transaction. Payment to the pharmacy network provider must be transmitted by electronic funds transfer,

unless otherwise agreed to by the enrolled pharmacy network provider.

(e) PBMs may not decrease pharmacy network provider reimbursement by the arbitrary use of maximum allowable cost (MAC) adjustments unless MAC policy formulae are disclosed, MAC pricing sources are disclosed to provide for pharmacy purchase, or recommended prices are deemed to be readily available in the local market for all pharmacy network providers.

(215 ILCS 5/512-12 new)

Sec. 512-12. Audit standards.

(a) Each of the following requirements must be met in the performance of an audit of records of a pharmacist or pharmacy network provider conducted by a covered entity or PBM or a representative of a covered entity or PBM:

(1) Written notice must be given to the pharmacy network provider or pharmacist at least 2 weeks before the performance of the initial on-site audit for each audit cycle.

(2) Any audit performed that involves clinical or professional judgment must be conducted in consultation with a pharmacist who has knowledge of the provisions of this Article.

(3) Any clerical or record keeping error, including typographical errors, scrivener's errors, or computer errors, regarding a required document or record may not, in

and of itself, constitute fraud; however, such claims may be subject to recoupment. Notwithstanding any other provision of law to the contrary, no such claim shall be subject to criminal penalties without proof of intent to commit fraud.

(4) A pharmacy network provider or pharmacist may use the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medical supplies written or transmitted by any means of communication for purposes of validating pharmacy records with respect to orders or refills of a legend or narcotic drug.

(5) Extrapolation audits may not be conducted for the purpose of pharmacy audits. A finding of overpayment or underpayment may be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs; however, recoupment of claims must be based on the actual overpayment or underpayment unless the projection for overpayment or underpayment is part of a settlement as agreed to by the pharmacy network provider or pharmacist.

(6) Each pharmacy network provider or pharmacist shall be audited under the standards and parameters as other similarly situated pharmacies or pharmacists audited by a covered entity, a PBM, or a representative of a covered entity or a PBM.

(7) A pharmacy network provider or pharmacist shall be allowed the length of time described in the pharmacy's or pharmacist's contract or provider manual, whichever is applicable, which length of time shall not be less than 30 days after receipt of the preliminary audit report, in which to produce documentation to address any discrepancy found during an audit. If the pharmacy's or pharmacist's contract or provider manual does not specify the allowed length of time for the pharmacy network provider or pharmacist to address any discrepancy found in the audit following receipt of the preliminary report, the pharmacy network provider or pharmacist shall be allowed at least 30 days after receipt of the preliminary audit report to respond and produce documentation.

(8) The period covered by an audit may not exceed 2 years from the date the claim was submitted to or adjudicated by a covered entity, a PBM, or a representative of a covered entity or PBM, except that this item (8) does not apply where a longer period is required by a federal rule or law.

(9) An audit shall not be initiated or scheduled during the first 7 calendar days of any month due to the high volume of prescriptions filled during that time, unless otherwise consented to by the pharmacy network provider or pharmacist.

(10) The preliminary audit report must be delivered to

the pharmacy network provider or pharmacist within 120 days after conclusion of the audit. A final audit report shall be delivered to the pharmacy network provider or pharmacist within 6 months after receipt of the preliminary audit report or final appeal, whichever is later.

(11) Notwithstanding any other provision of law to the contrary, any audit of a pharmacy network provider or pharmacist may not use the accounting practice of extrapolation in calculating recoupments or penalties for audits.

(b) Recoupments of any disputed funds may occur only after final internal disposition of the audit, including the appeal process, as set forth in this Article.

(c) Each PBM conducting an audit must establish an appeals process under which a pharmacy network provider or pharmacist may appeal an unfavorable preliminary audit report to the PBM on whose behalf the audit was conducted. The PBM conducting an audit shall provide to the pharmacy network provider or pharmacist, before or at the time of delivery of the preliminary audit report, a written explanation of the appeals process, including the name, address, and telephone number of the person to whom an appeal should be addressed. If, following the appeal, it is determined that an unfavorable audit report or any portion thereof is unsubstantiated, the audit report or such portion shall be dismissed without the necessity of further proceedings.

(d) Reimbursement by a PBM under a contract to a pharmacist or pharmacy network provider for prescription drugs and other products and supplies that is calculated according to a formula that uses a nationally recognized reference in the pricing calculation shall use the most current nationally recognized reference price or amount in the actual or constructive possession of the pharmacy benefits manager or its agent.

(e) For purposes of compliance with this Section, PBMs shall be required to update the nationally recognized reference prices or amounts used for calculation of reimbursement for prescription drugs and other products and supplies no more than every 3 business days.

(215 ILCS 5/512-13 new)

Sec. 512-13. Contact of covered persons; record keeping; information sharing with pharmacy network providers.

(a) No PBM may contact any covered person without the expressed written permission of the covered entity, unless authorized to do so under the terms of the existing contract between the PBM and the covered entity.

(b) No PBM may mandate record keeping procedures for any enrolled pharmacy network provider that are more stringent than those required by State or federal law or regulations.

(c) Covered persons must be allowed to use out-of-network pharmacies for 90-day prescriptions and no differential co-payments may be applied. PBMs must share any covered person

information submitted from enrolled pharmacy network providers with out-of-network pharmacies for the purpose of verifying pharmacy records when a request for such information is made by any out-of-network pharmacy that a covered person has chosen to use.

(215 ILCS 5/512-14 new)

Sec. 512-14. Prohibition. A pharmacy network provider may not be terminated or otherwise penalized because it expresses disagreement with a PBM's decision to deny or otherwise limit benefits to a covered person or because the pharmacy network provider assists a covered person in seeking reconsideration of a PBM's decision or discusses alternative medications with a covered person.

(215 ILCS 5/512-15 new)

Sec. 512-15. Collection and payment of taxes and fees. A PBM that is registered under this Article, including any subsidiaries of such PBM, must comply with the collection and payment of all applicable taxes and fees imposed on pharmacies licensed by this State. All taxes and fees are subject to audit penalties if deemed unpaid or delinquent.

(215 ILCS 5/512-16 new)

Sec. 512-16. Failure to comply. In order to enforce the provisions of this Article, the Director may issue a cease and

desist order or require a PBM to pay a civil penalty or both. Subject to the provisions of the Illinois Administrative Procedure Act, the Director may, pursuant to Section 403A of the Illinois Insurance Code, impose upon a pharmacy benefits management program an administrative fine of $5,000 for violations of this Article.

(215 ILCS 5/512-17 new)

Sec. 512-17. Rulemaking. The Director shall have the authority to adopt any rules necessary for the implementation and administration of this Article.

Section 99. Effective date. This Act takes effect upon becoming law.

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Statutes amended in order of appearance