SB3136

LRB09919984KTG44383b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

SB3136

Introduced 2/19/2016, by Sen. Wm. Sam McCann

SYNOPSIS AS INTRODUCED:

5 ILCS 375/6	from Ch. 127, par. 526
305 ILCS 5/5-5.12	from Ch. 23, par. 5-5.12

Amends the State Employees Group Insurance Act of 1971. Makes a technical change in a Section concerning the program of health benefits provided under the Act. Amends the Medical Assistance Article of the Illinois Public Aid Code. Makes a technical change in a Section concerning pharmacy payments.

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A BILL FOR

AN ACT concerning health benefits.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Section 6 as follows:

(5 ILCS 375/6) (from Ch. 127, par. 526)

Sec. 6. Program of health benefits.

(a) The program of health benefits shall provide for protection against the ~~the~~ financial costs of health care expenses incurred in and out of hospital including basic hospital-surgical-medical coverages. The program may include, but shall not be limited to, such supplemental coverages as out-patient diagnostic X-ray and laboratory expenses, prescription drugs, dental services, hearing evaluations, hearing aids, the dispensing and fitting of hearing aids, and similar group benefits as are now or may become available. However, nothing in this Act shall be construed to permit, on or after July 1, 1980, the non-contributory portion of any such program to include the expenses of obtaining an abortion, induced miscarriage or induced premature birth unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live

1 viable child and such procedure is necessary for the health of
2 the mother or the unborn child. The program may also include
3 coverage for those who rely on treatment by prayer or spiritual
4 means alone for healing in accordance with the tenets and
5 practice of a recognized religious denomination.

6 The program of health benefits shall be designed by the
7 Director (1) to provide a reasonable relationship between the
8 benefits to be included and the expected distribution of
9 expenses of each such type to be incurred by the covered
10 members and dependents, (2) to specify, as covered benefits and
11 as optional benefits, the medical services of practitioners in
12 all categories licensed under the Medical Practice Act of 1987,
13 (3) to include reasonable controls, which may include
14 deductible and co-insurance provisions, applicable to some or
15 all of the benefits, or a coordination of benefits provision,
16 to prevent or minimize unnecessary utilization of the various
17 hospital, surgical and medical expenses to be provided and to
18 provide reasonable assurance of stability of the program, and
19 (4) to provide benefits to the extent possible to members
20 throughout the State, wherever located, on an equitable basis.
21 Notwithstanding any other provision of this Section or Act, for
22 all members or dependents who are eligible for benefits under
23 Social Security or the Railroad Retirement system or who had
24 sufficient Medicare-covered government employment, the
25 Department shall reduce benefits which would otherwise be paid
26 by Medicare, by the amount of benefits for which the member or

dependents are eligible under Medicare, except that such reduction in benefits shall apply only to those members or dependents who (1) first become eligible for such medicare coverage on or after the effective date of this amendatory Act of 1992; or (2) are Medicare-eligible members or dependents of a local government unit which began participation in the program on or after July 1, 1992; or (3) remain eligible for but no longer receive Medicare coverage which they had been receiving on or after the effective date of this amendatory Act of 1992.

Notwithstanding any other provisions of this Act, where a covered member or dependents are eligible for benefits under the federal Medicare health insurance program (Title XVIII of the Social Security Act as added by Public Law 89-97, 89th Congress), benefits paid under the State of Illinois program or plan will be reduced by the amount of benefits paid by Medicare. For members or dependents who are eligible for benefits under Social Security or the Railroad Retirement system or who had sufficient Medicare-covered government employment, benefits shall be reduced by the amount for which the member or dependent is eligible under Medicare, except that such reduction in benefits shall apply only to those members or dependents who (1) first become eligible for such Medicare coverage on or after the effective date of this amendatory Act of 1992; or (2) are Medicare-eligible members or dependents of a local government unit which began participation in the

program on or after July 1, 1992; or (3) remain eligible for, but no longer receive Medicare coverage which they had been receiving on or after the effective date of this amendatory Act of 1992. Premiums may be adjusted, where applicable, to an amount deemed by the Director to be reasonably consistent with any reduction of benefits.

(b) A member, not otherwise covered by this Act, who has retired as a participating member under Article 2 of the Illinois Pension Code but is ineligible for the retirement annuity under Section 2-119 of the Illinois Pension Code, shall pay the premiums for coverage, not exceeding the amount paid by the State for the non-contributory coverage for other members, under the group health benefits program under this Act. The Director shall determine the premiums to be paid by a member under this subsection (b).

(Source: P.A. 93-47, eff. 7-1-03.)

Section 10. The Illinois Public Aid Code is amended by changing Section 5-5.12 as follows:

(305 ILCS 5/5-5.12) (from Ch. 23, par. 5-5.12)

Sec. 5-5.12. Pharmacy payments.

(a) Every request submitted by a pharmacy for ~~for~~ reimbursement under this Article for prescription drugs provided to a recipient of aid under this Article shall include the name of the prescriber or an acceptable identification

1 number as established by the Department.
2 (b) Pharmacies providing prescription drugs under this
3 Article shall be reimbursed at a rate which shall include a
4 professional dispensing fee as determined by the Illinois
5 Department, plus the current acquisition cost of the
6 prescription drug dispensed. The Illinois Department shall
7 update its information on the acquisition costs of all
8 prescription drugs no less frequently than every 30 days.
9 However, the Illinois Department may set the rate of
10 reimbursement for the acquisition cost, by rule, at a
11 percentage of the current average wholesale acquisition cost.
12 (c) (Blank).
13 (d) The Department shall review utilization of narcotic
14 medications in the medical assistance program and impose
15 utilization controls that protect against abuse.
16 (e) When making determinations as to which drugs shall be
17 on a prior approval list, the Department shall include as part
18 of the analysis for this determination, the degree to which a
19 drug may affect individuals in different ways based on factors
20 including the gender of the person taking the medication.
21 (f) The Department shall cooperate with the Department of
22 Public Health and the Department of Human Services Division of
23 Mental Health in identifying psychotropic medications that,
24 when given in a particular form, manner, duration, or frequency
25 (including "as needed") in a dosage, or in conjunction with
26 other psychotropic medications to a nursing home resident or to

1 a resident of a facility licensed under the ID/DD Community
2 Care Act or the MC/DD Act, may constitute a chemical restraint
3 or an "unnecessary drug" as defined by the Nursing Home Care
4 Act or Titles XVIII and XIX of the Social Security Act and the
5 implementing rules and regulations. The Department shall
6 require prior approval for any such medication prescribed for a
7 nursing home resident or to a resident of a facility licensed
8 under the ID/DD Community Care Act or the MC/DD Act, that
9 appears to be a chemical restraint or an unnecessary drug. The
10 Department shall consult with the Department of Human Services
11 Division of Mental Health in developing a protocol and criteria
12 for deciding whether to grant such prior approval.
13 (g) The Department may by rule provide for reimbursement of
14 the dispensing of a 90-day supply of a generic or brand name,
15 non-narcotic maintenance medication in circumstances where it
16 is cost effective.
17 (g-5) On and after July 1, 2012, the Department may require
18 the dispensing of drugs to nursing home residents be in a 7-day
19 supply or other amount less than a 31-day supply. The
20 Department shall pay only one dispensing fee per 31-day supply.
21 (h) Effective July 1, 2011, the Department shall
22 discontinue coverage of select over-the-counter drugs,
23 including analgesics and cough and cold and allergy
24 medications.
25 (h-5) On and after July 1, 2012, the Department shall
26 impose utilization controls, including, but not limited to,

1 prior approval on specialty drugs, oncolytic drugs, drugs for
2 the treatment of HIV or AIDS, immunosuppressant drugs, and
3 biological products in order to maximize savings on these
4 drugs. The Department may adjust payment methodologies for
5 non-pharmacy billed drugs in order to incentivize the selection
6 of lower-cost drugs. For drugs for the treatment of AIDS, the
7 Department shall take into consideration the potential for
8 non-adherence by certain populations, and shall develop
9 protocols with organizations or providers primarily serving
10 those with HIV/AIDS, as long as such measures intend to
11 maintain cost neutrality with other utilization management
12 controls such as prior approval. For hemophilia, the Department
13 shall develop a program of utilization review and control which
14 may include, in the discretion of the Department, prior
15 approvals. The Department may impose special standards on
16 providers that dispense blood factors which shall include, in
17 the discretion of the Department, staff training and education;
18 patient outreach and education; case management; in-home
19 patient assessments; assay management; maintenance of stock;
20 emergency dispensing timeframes; data collection and
21 reporting; dispensing of supplies related to blood factor
22 infusions; cold chain management and packaging practices; care
23 coordination; product recalls; and emergency clinical
24 consultation. The Department may require patients to receive a
25 comprehensive examination annually at an appropriate provider
26 in order to be eligible to continue to receive blood factor.

1 (i) On and after July 1, 2012, the Department shall reduce
2 any rate of reimbursement for services or other payments or
3 alter any methodologies authorized by this Code to reduce any
4 rate of reimbursement for services or other payments in
5 accordance with Section 5-5e.

6 (j) On and after July 1, 2012, the Department shall impose
7 limitations on prescription drugs such that the Department
8 shall not provide reimbursement for more than 4 prescriptions,
9 including 3 brand name prescriptions, for distinct drugs in a
10 30-day period, unless prior approval is received for all
11 prescriptions in excess of the 4-prescription limit. Drugs in
12 the following therapeutic classes shall not be subject to prior
13 approval as a result of the 4-prescription limit:
14 immunosuppressant drugs, oncolytic drugs, anti-retroviral
15 drugs, and, on or after July 1, 2014, antipsychotic drugs. On
16 or after July 1, 2014, the Department may exempt children with
17 complex medical needs enrolled in a care coordination entity
18 contracted with the Department to solely coordinate care for
19 such children, if the Department determines that the entity has
20 a comprehensive drug reconciliation program.

21 (k) No medication therapy management program implemented
22 by the Department shall be contrary to the provisions of the
23 Pharmacy Practice Act.

24 (l) Any provider enrolled with the Department that bills
25 the Department for outpatient drugs and is eligible to enroll
26 in the federal Drug Pricing Program under Section 340B of the

1 federal Public Health Services Act shall enroll in that
2 program. No entity participating in the federal Drug Pricing
3 Program under Section 340B of the federal Public Health
4 Services Act may exclude Medicaid from their participation in
5 that program, although the Department may exclude entities
6 defined in Section 1905(l)(2)(B) of the Social Security Act
7 from this requirement.
8 (Source: P.A. 98-463, eff. 8-16-13; 98-651, eff. 6-16-14;
9 99-180, eff. 7-29-15.)