HB4761

LRB104 19429 BAB 32877 b

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB4761

by Rep. Natalie A. Manley

SYNOPSIS AS INTRODUCED:

215 ILCS 5/513b1

Amends the Illinois Insurance Code. In provisions concerning pharmacy benefit manager contracts, provides that a pharmacy benefit manager must not reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the national average drug acquisition cost for the prescription drug or pharmacy service at the time the drug is administered or dispensed, plus a professional dispensing fee of $10.49. Provides that, if the national average drug acquisition cost is not available at the time a drug is administered or dispensed, a pharmacy benefit manager may not reimburse in an amount that is less than the wholesale acquisition cost of the drug, plus a professional dispensing fee of $10.49.

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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 Section 513b1 as follows:

(215 ILCS 5/513b1)

Sec. 513b1. Pharmacy benefit manager contracts.

(a) As used in this Article:

"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.

"Affiliate" means a person or entity that directly or indirectly through one or more intermediaries controls or is controlled by, or is under common control with, the person or entity specified. The location of a person or entity's domicile, whether in Illinois or a foreign or alien jurisdiction, does not affect the person or entity's status as an affiliate.

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

"Brand name drug" means a drug that has been approved under 42 U.S.C. 262 or 21 U.S.C. 355(c), as applicable, and is marketed, sold, or distributed under a proprietary, trademark-protected name.

"Complex or chronic medical condition" means a physical, behavioral, or developmental condition that has no known cure, is progressive, or can be debilitating or fatal if unmanaged or untreated.

"Covered individual" means a member, participant, enrollee, contract holder, policyholder, or beneficiary of a health benefit plan who is provided a drug benefit by the health benefit plan.

"Critical access pharmacy" means a critical access care pharmacy as defined in Section 5-5.12b of the Illinois Public Aid Code.

"Drugs" has the meaning ascribed to that term in Section 3 of the Pharmacy Practice Act and includes biological products.

"Employee welfare benefit plan" has the meaning given to that term in 29 U.S.C. 1002(1), without regard for whether the employee welfare benefit plan is covered under 29 U.S.C. 1003.

"Federal governmental plan" has the meaning given to that term in 42 U.S.C. 300gg-91(d)(8)(B).

"Generic drug" means a drug that has been approved under 42 U.S.C. 262 or 21 U.S.C. 355(c), as applicable, and is

marketed, sold, or distributed directly or indirectly to the retail class of trade with labeling, packaging (other than repackaging as the listed drug in blister packs, unit doses, or similar packaging for use in institutions), product code, labeler code, trade name, or trademark that differs from that of the brand name drug.

"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. Notwithstanding Sections 122-1 through 122-4 of this Code, "health benefit plan" includes self-funded employee welfare benefit plans except for self-funded multiemployer plans that are not nonfederal government plans. "Health benefit plan" does not include:

(1) workers compensation insurance, a federal governmental plan, Medicare Advantage, Medicare Part D, a Medicare demonstration program, or Tricare; or

(2) any program for dually eligible Medicare-Medicaid beneficiaries enrolled in a program under which Medicare pays for most or all of the covered drugs.

"Health benefit plan sponsor" or "plan sponsor" means:

(1) a plan sponsor, as defined in 29 U.S.C. 1002(16)(B), without regard for whether the employee welfare benefit plan is covered under 29 U.S.C. 1003. Except as provided by subsection (m), "plan sponsor"

includes the plan sponsor of a nonfederal governmental plan, including a joint insurance pool described in Section 6 of the Intergovernmental Cooperation Act; and

(2) any other governmental unit or public agency to which any State law grants the rights of a plan sponsor when incorporating this Article by reference.

"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.

"Multiemployer plan" has the meaning given to that term in 29 U.S.C. 1002(37).

"Nonfederal governmental plan" has the meaning given to that term in 42 U.S.C. 300gg-91(d)(8)(C).

"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 drug or device services, or both, for health benefit plans.

"Pharmacy" has the meaning given to that term in Section 3 of the Pharmacy Practice Act.

"Pharmacy services" means the provision of any services listed within the definition of "practice of pharmacy" under subsection (d) of Section 3 of the Pharmacy Practice Act.

"Rare medical condition" means a physical, behavioral, or developmental condition that affects fewer than 200,000 individuals in the United States or approximately 1 in 1,500 individuals worldwide.

"Rebate" means a discount or pricing concession based on drug utilization or administration that is paid by the manufacturer to a pharmacy benefit manager or its client.

"Rebate aggregator" means a person or entity, including group purchasing organizations, that negotiate rebates or other fees with drug manufacturers on behalf or for the benefit of a pharmacy benefit manager or its client and may also be involved in contracts that entitle the rebate aggregator or its client to receive rebates or other fees from drug manufacturers based on drug utilization or administration.

"Retail price" means the price an individual without drug coverage would pay at a retail pharmacy, not including a pharmacist dispensing fee.

"Specialty drug" means a drug that:

(1) is prescribed for a person with a complex or chronic medical condition or a rare medical condition;

(2) has limited or exclusive distribution; and

(3) requires both:

(A) specialized product handling by the dispensing pharmacy or administration by the dispensing pharmacy; and

(B) specialized clinical care, including frequent dosing adjustments, intensive clinical monitoring, or expanded services for patients, including intensive patient counseling, education, or ongoing clinical support beyond traditional dispensing activities, such as individualized disease and therapy management to support improved health outcomes.

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

"Steer" includes, but is not limited to:

(1) requiring a covered individual to only use a pharmacy, including a mail-order or specialty pharmacy, in which the pharmacy benefit manager or its affiliate, or an insurer or its affiliate, maintains an ownership interest or control;

(2) offering or implementing a plan design that encourages a covered individual to only use a pharmacy in which the pharmacy benefit manager or an affiliate, or an insurer or its affiliate, maintains an ownership interest or control, if the plan design increases costs for the covered individual. This includes a plan design that requires a covered individual to pay higher costs or an

increased share of costs for a drug or drug-related service if the covered individual uses a pharmacy that is not owned or controlled by the pharmacy benefit manager or its affiliate or an insurer or its affiliate; and

(3) reimbursing a pharmacy or pharmacist for a drug and pharmacist service in an amount less than the amount that the pharmacy benefit manager or an insurer reimburses itself or an affiliate, including affiliated manufacturers or joint ventures for providing the same drug or service.

"Third-party payer" means any entity that pays for 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.

The changes made to this subsection by this amendatory Act of the 104th General Assembly shall be deemed to be operative on and after July 1, 2025.

(a-5) In this Article, references to an "insurer" or "health insurer" shall include commercial private health insurance issuers, managed care organizations, managed care community networks, and any other third-party payer that contracts with pharmacy benefit managers or with the Department of Healthcare and Family Services to provide benefits or services under the Medicaid program or to otherwise engage in the administration or payment of pharmacy benefits. However, the terms do not refer to the plan sponsor of a self-funded, single-employer employee welfare benefit

plan or self-funded multiemployer plan if either plan is covered by 29 U.S.C. 1003. This subsection shall be deemed to be operative on and after July 1, 2025.

(b) A contract between a health insurer or plan sponsor 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 or insurer whose coverage is administered by the 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. The cost of the audit shall be borne exclusively by the pharmacy benefit manager.

(6) Allow a plan sponsor or insurer whose coverage is administered by the 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 plan sponsor or the insurer party contracting with the pharmacy benefit manager of any consideration that the pharmacy benefit manager receives from the manufacturer for dispense as written once a generic or biologically similar product becomes available.

(c) In order to place a particular drug on a maximum allowable cost list, the pharmacy benefit manager described in subsection (b) 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 or an insurer is prohibited from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered drug, and the availability of a more affordable alternative drug, if one is available in accordance with Section 42 of the Pharmacy Practice Act.

(e) A health insurer or pharmacy benefit manager shall not require a covered individual to make a payment for a drug at the point of sale in an amount that exceeds the lesser of:

(1) the applicable cost-sharing amount;

(2) the retail price of the drug in the absence of drug coverage;

(3) the discounted price presented by the covered individual through a no-cost drug program or drug manufacturer voucher provided by or for the covered individual at the point of sale; or

(4) the discounted price presented by the covered

individual through a discounted health care services plan provided by or for the covered individual at the point of sale.

This subsection applies to any covered individual of a health benefit plan from an insurer, a nonfederal governmental plan sponsor, or any other governmental unit or public agency to which any State law grants the rights of a plan sponsor when incorporating this Article by reference.

(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 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 health benefit plan for covered individuals who acquire covered 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.

(f-5) A pharmacy benefit manager or an affiliate acting on its behalf shall not conduct spread pricing.

(f-10) A pharmacy benefit manager or an affiliate acting on its behalf shall not steer a covered individual. This prohibition also applies to an insurer and its affiliates.

Existing agreements entered into before the effective date of this amendatory Act of the 104th General Assembly shall supersede this subsection until the termination of the current term of such agreement.

(f-15) A pharmacy benefit manager or affiliated rebate aggregator must remit no less than 100% of any amounts paid by a pharmaceutical manufacturer, wholesaler, or other distributor of a drug, including, but not limited to, rebates, group purchasing fees, and other fees, to the health benefit plan sponsor, covered individual, or employer. Records of rebates and fees remitted from the pharmacy benefit manager or rebate aggregator must be disclosed to the Department annually in a format to be specified by the Department. The records received by the Department shall be considered confidential and privileged for all purposes, including for purposes of the Freedom of Information Act, shall not be subject to subpoena from any private party, and shall not be admissible as evidence in a civil action.

(f-20) A pharmacy benefit manager or an affiliate acting on its behalf is prohibited from limiting a covered individual's access to drugs from a pharmacy or pharmacist enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage area by designating the covered drug as a specialty drug contrary to the definition in this Section. This prohibition also applies to an insurer and its affiliates.

(f-25) The contract between the pharmacy benefit manager and the insurer or health benefit plan sponsor must allow and provide for the pharmacy benefit manager's compliance with an audit at least once per calendar year of the rebate and fee records remitted from a pharmacy benefit manager or its affiliated party to a health benefit plan. This audit may be incorporated into the audit under paragraph (5) of subsection (b) of this Section. Contracts with rebate aggregators, pharmacy services administrative organizations, pharmacies, or drug manufacturers must be available for audit by health benefit plan sponsors, insurers, or their designees at least once per plan year. Audits shall be performed by an auditor selected by the health benefit plan sponsor, insurer, or its designee. Health benefit plan sponsors and insurers shall give the pharmacy benefit manager a complete copy of the audit and the pharmacy benefit manager shall provide a complete copy of those findings to the Department within 60 days of initial receipt. Rebate contracts with rebate aggregators, pharmacy services administrative organizations, pharmacies, or drug manufacturers shall be available for audit by health benefit plan sponsor, insurer, or designee. Nothing in this Section shall limit the Department's ability to access the books and records and any and all copies thereof of pharmacy benefit managers, their affiliates, or affiliated rebate aggregators. The records received by the Department shall be considered confidential and privileged for all purposes, including for

purposes of the Freedom of Information Act, shall not be subject to subpoena from any private party, and shall not be admissible as evidence in a civil action.

(f-30) A pharmacy benefit manager must not reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the national average drug acquisition cost for the prescription drug or pharmacy service at the time the drug is administered or dispensed, plus a professional dispensing fee of $10.49.

If the national average drug acquisition cost is not available at the time a drug is administered or dispensed, a pharmacy benefit manager may not reimburse in an amount that is less than the wholesale acquisition cost of the drug, as defined in 42 U.S.C. 1395w-3a(c)(6)(B), plus a professional dispensing fee of $10.49.

(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. This subsection and subsection (f) do not apply to a contract directly between a 340B entity and the plan sponsor of a self-funded, single-employer or multiemployer employee welfare benefit plan subject to 29 U.S.C. 1003.

(i)(1) A pharmacy benefit manager may not retaliate against a pharmacist or pharmacy for disclosing information in a court, in an administrative hearing, before a legislative commission or committee, or in any other proceeding, if the pharmacist or pharmacy has reasonable cause to believe that the disclosed information is evidence of a violation of a State or federal law, rule, or regulation.

(2) A pharmacy benefit manager may not retaliate against a pharmacist or pharmacy for disclosing information to a government or law enforcement agency, if the pharmacist or pharmacy has reasonable cause to believe that the disclosed information is evidence of a violation of a State or federal law, rule, or regulation.

(3) A pharmacist or pharmacy shall make commercially reasonable efforts to limit the disclosure of confidential and proprietary information.

(4) Retaliatory actions against a pharmacy or pharmacist include cancellation of, restriction of, or refusal to renew or offer a contract to a pharmacy solely because the pharmacy or pharmacist has:

(A) made disclosures of information that the pharmacist or pharmacy has reasonable cause to believe is evidence of a violation of a State or federal law, rule, or regulation;

(B) filed complaints with the plan or pharmacy benefit manager; or

(C) filed complaints against the plan or pharmacy benefit manager with the Department.

(j) This Section applies to contracts entered into or renewed on or after July 1, 2022. Unless provided otherwise in this Section or in the Illinois Public Aid Code, this Section applies to pharmacy benefit managers that are contracted with a Medicaid managed care entity on or after January 1, 2026. To the extent not otherwise provided, this Section applies to contracts entered into, renewed, or amended on or after January 1, 2026.

(k) This Section applies to any health benefit plan that provides coverage for drugs and that is amended, delivered, issued, or renewed on or after July 1, 2020. The changes made to this Section by Public Act 104-27 shall apply with respect to any health benefit plan that provides coverage for drugs that is amended, delivered, issued, or renewed on or after January 1, 2026.

(l) A pharmacy benefit manager is responsible for compliance with all State requirements applicable to pharmacy benefit managers even if an action or responsibility of a pharmacy benefit manager is delegated to or completed by an affiliate.

(m) This Article applies in relation to plan sponsors of self-funded nonfederal governmental plans only when a State law organizing the governmental unit incorporates this Article by reference. Nothing shall be construed to exclude a joint

self-insurance pool created under Section 6 of the Intergovernmental Cooperation Act from references to a plan sponsor if any pool member's organizing State law incorporates this Article by reference, but a pharmacy benefit manager is not subject to the requirements of this Article in relation to any pool member whose organizing State law does not incorporate this Article. This subsection shall be deemed to be operative on and after July 1, 2025.

(n) Regardless of whether a health benefit plan is insurance, the applicability of this Article to a health benefit plan shall be determined in the same manner as the determination of whether a person is transacting insurance in this State under Sections 121-2.03, 121-2.04, and 121-2.05 and subsections (a), (c), and (e) of Section 121-3. For any health benefit plan subject to this Article, unless specifically provided otherwise, this Article applies to all covered individuals under the health benefit plan, regardless of the individual's residence. The exemption for group accident and health insurance described in subsection (c) of Section 352, as implemented by Department regulation, extends in the same manner to all other health benefit plans with respect to the requirements of this Article. This subsection shall be deemed to be operative on and after July 1, 2025.

(Source: P.A. 103-154, eff. 6-30-23; 103-453, eff. 8-4-23; 104-27, eff. 1-1-26; 104-439, eff. 12-2-25.)