Sen. John J. Cullerton

Filed: 5/13/2008

AMENDMENT TO HOUSE BILL 5614

AMENDMENT NO. _____. Amend House Bill 5614 by replacing everything after the enacting clause with the following:

"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 512-7.5, 512-7.10, 512-11, and 512-12 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:

"Covered entity" means any entity that has entered into an agreement, directly or indirectly, with a pharmacy benefits manager to provide a pharmacy benefits management program. "Covered entity" includes, but is not limited to, a person or entity that has entered into a contract for prescription health care services with an insurer, Health Maintenance Organization, Limited Health Services Organization, or Voluntary Health Services Plan under which the pharmacy benefits manager is contractually obligated to provide a pharmacy benefits management program.

"Covered individual" means a member, participant, enrollee, contract holder, policy holder, or beneficiary of a covered entity who is provided prescription health coverage by

the covered entity. "Covered individual" 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 individual.

"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.

"Maximum allowable cost" or "MAC" means the maximum allowable cost for a prescribed generic drug dispensed under PBM Program Networks as determined by the program administrator from time to time pursuant to a MAC list to be provided electronically to pharmacy network participants at least quarterly or more frequently upon a pharmacy request. The MAC is based upon the average published wholesale price of at least 2 different manufacturers of the applicable generic drug (for the same strength), or as published in 2 nationally recognized drug databases and identified in the approved pharmacy network contract.

"Pharmacy benefits management program" or "program" means a system providing for the administration of or reimbursement for pharmacy services and prescription drug products offered in this State by a PBM for or on behalf of a covered entity.

"Pharmacy benefits manager" or "PBM" means any person, partnership, or corporation that issues or causes to be issued any payment or reimbursement to a provider for services

rendered pursuant to a pharmacy benefits management program or an entity that procures prescription drugs at a negotiated rate. "Pharmacy benefits manager "or "PBM" does not include the Director of Healthcare and Family Services or any agent authorized by the Director of Healthcare and Family Services to reimburse or procure prescription drugs at a negotiated rate pursuant to a program of which the Department of Healthcare and Family Services is the third party or covered entity, nor does it include a pharmacy or pharmacy network provider.

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

"Pharmacy network provider" means a pharmacist or pharmacy that has a contractual relationship with a health benefit plan or pharmacy benefit manager to provide pharmacist services or medication therapy management services, as defined in the Pharmacy Practice Act.

"Pharmacy reimbursement rate" means the amount a PBM pays to a pharmacy or pharmacy network provider for prescription drugs and services provided by the pharmacy or pharmacy network provider to the PBM.

"Rebates" means any valuable consideration or inducement to directly affect or influence the dispensing of pharmacy drugs, supplies, or services.

~~(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. Licensure; application and fees ~~Registration~~.

(a) No person, partnership, corporation, or other entity may act as a PBM or provide a pharmacy benefits management program in this State without being licensed by the Division.

(b) Each applicant for licensure must file with the Director the following information and documents:

(1) the name of the company and the state or country

under the laws of which the company is organized or authorized;

(2) the title of the Act under or by which the company was incorporated or organized, the date of its incorporation or organization, and, if a corporation, the period of its duration;

(3) an organizational chart;

(4) a list of the names, addresses, titles, and biographical affidavits of the officers of the PBM;

(5) a sample copy of contracts utilized by the PBM between the PBM and covered entities and between the PBM and its pharmacy network providers; and

(6) such other information as the Director may reasonably request.

(c) A licensee shall keep current the information required under items (1) through (5) of subsection (b) of this Section by reporting all material changes or additions to the Director within 30 calendar days after the end of the month of each change or addition. A material change or addition includes any modification of the information that has a significant effect on the operation of the PBM or pharmacy benefit management program.

(d) Beginning on January 1, 2009, each PBM doing business in this State must pay to the Director an initial licensure fee of $1,000. Thereafter, annually on or before January 1 of each year, a PBM doing business in this State that seeks to renew a

PBM license must pay to the Director a renewal fee of $250. All fees collected under this Section shall be deposited into the Insurance Producer Administration Fund.

(e) This Section does not apply to licensed insurance companies, Health Maintenance Organizations, Limited Health Services Organizations, and Voluntary Health Services Plans. ~~All third party prescription programs and administrators doing business in the State shall register with the Director of Insurance. The Director 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 third party administrator.~~

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

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

Sec. 512-5. License denial, non-renewal, or revocation ~~Fiduciary and Bonding Requirements~~.

(a) The Director may place on probation, suspend, revoke, or refuse to issue or renew a PBM license or may levy a civil penalty in accordance with this Section or take any combination of actions for any one or more of the following causes:

(1) Intentionally providing incorrect, misleading, or materially untrue information in the license application.

(2) Intentionally violating any provision of this Law or the insurance laws of this or another state or violating any rule, subpoena, or order of the Director or another

appropriate state regulator.

(3) Obtaining or attempting to obtain a license through misrepresentation or fraud.

(4) Improperly withholding, misappropriating, or converting any moneys or properties received in the course of doing business.

(5) Intentionally misrepresenting the terms of any contract or agreement between a PBM and a covered entity.

(6) Having admitted to or been found to have committed any unfair trade practice or fraud.

(7) Using fraudulent, coercive, or dishonest practices or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this State or elsewhere.

(8) Having a professional license or registration that is comparable to a license issued under this Law denied, suspended, or revoked in any other state, province, district, or territory.

(9) Forging a name to an application.

(10) Failing to pay any tax or fee, as required by law.

(b) If the action by the Director is to deny renewal, suspend, or revoke a license or to deny an application for licensure, the Director shall notify the licensee or applicant and advise, in writing, the licensee or applicant of the reason for the suspension, revocation, or denial. The applicant or licensee may make written demand upon the Director within 30

calendar days after the date of mailing of notice for a hearing before the Director to determine the reasonableness of the Director's action. The hearing must be held within not fewer than 20 calendar days nor more than 30 calendar days after the mailing of the notice of hearing and shall be held pursuant to the Illinois Administrative Code.

(c) In addition to or instead of any applicable denial, suspension, or revocation of a license, an applicant or licensee may, after hearing, be subject to a civil penalty.

(d) The Director has the authority to enforce and, by order, require compliance with the provisions of this Article against any person or PBM who is under investigation for or charged with a violation of this Law or Code even if the license has been surrendered or has lapsed by operation of law.

(e) Upon the suspension, denial, or revocation of a license, the licensee having possession or custody of the license shall promptly deliver it to the Director in person or by mail. The Director shall publish all suspensions, denials, or revocations after the suspension, denial, or revocation becomes final.

(f) A licensee whose license is revoked or applicant whose application is denied pursuant to this Section is ineligible to apply for any pharmacy benefits management program or PBM license under this Law for 3 years after the revocation or denial. A PBM whose license as a pharmacy benefits management program has been revoked, suspended, or denied may not be

employed, contracted, or engaged in any related capacity during the time the revocation, suspension, or denial is in effect.

(g) A PBM must inform the Director in a manner acceptable to the Director of a change of address within 30 calendar days after the change. ~~A 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.~~

~~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 providers of services under the third party prescription program.~~

(h) 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.

The requirements of this subsection (h) ~~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. 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 as soon as possible ~~at least 30 days~~ prior to the time it becomes effective.
(Source: P.A. 82-1005.)

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

Sec. 512-7. Required program and contractual ~~Contractual~~ provisions.

(a) Any agreement or contract entered into ~~in this State~~ between a PBM ~~the administrator of a program~~ and a pharmacy under a pharmacy benefits management program shall include a statement of the method of calculating ~~and amount of~~ reimbursement to be paid to to the pharmacy for services rendered to persons enrolled in the program, the frequency of payment by the PBM ~~program administrator~~ to the pharmacy for those services, and a method for the adjudication of complaints

and the settlement of disputes between the contracting parties.

(b) Every pharmacy benefit management program shall do each of the following:

(1) Provide ~~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. Beginning January 1, 2009, all agreements between a pharmacy benefits management program and any other person shall comply with the requirements of this Law. To the extent that any such agreement renewed or extended after December 31, 2008 fails to comply with the requirements of this Law, such requirements shall be deemed to be incorporated into those agreements by operation of law as of the date of the renewal of execution.

(2) Keep current the information required to be disclosed in its application for licensure by reporting all material changes or additions to the Director within 30 days after each change or addition. ~~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, 1990, then immediately after the expiration of those contract provisions the program shall comply with the requirements of this subsection (b).~~

(3) Cause to be issued an identification card to

covered individuals. The identification card shall comply with the Uniform Prescription Drug Information Card Act. ~~This subsection (b) does not apply if:~~

~~(A) the program administrator is a licensed health maintenance organization that owns or controls a pharmacy and that enters into an agreement or contract with that pharmacy in accordance with subsection (a); or~~

~~(B) 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) Make changes to a formulary or a prescription drug list (PDL) only on the anniversary date of the contract or through mutual consent of the PBM and the covered entity. The PBM shall establish a grievance process and an appeals procedure for covered individuals effected by a formulary or PDL change. ~~This subsection (b) shall be inoperative after October 31, 1992.~~

(c) (Blank). ~~The program administrator shall cause to be issued an identification card to each person enrolled in the program. The identification card shall 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.~~

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

(215 ILCS 5/512-7.5 new)

Sec. 512-7.5. Disclosures.

(a) A PBM shall disclose to the covered entity the aggregate total amount of any rebates received by the PBM from a pharmaceutical product manufacturer or labeler as a result of providing services to the covered entity and its covered individuals. A PBM providing information under this subsection (a) shall designate that information as confidential. Information designated as confidential by a PBM and provided to a covered entity under this subsection (a) may not be disclosed by the covered entity to any person without the consent of the PBM, except that disclosure may be made in a court filing or when authorized by law or ordered by a court of this State for good cause.

(b) A PBM shall disclose to a covered entity the source and amount of any claims processing and pharmacy network fees that are collected from retail pharmacies to the extent that such amounts relate directly to the services provided by the PBM to the covered entity and its covered individuals. Any and all information disclosed under this subsection (b) may be

designated as confidential. Information designated as confidential by a PBM and provided to a covered entity under this subsection (b) may not be disclosed by the covered entity to any person without the consent of the PBM, except as may be required in a court of law with proper jurisdiction or as authorized by law.

(c) Except in the case of non-rebate sharing contracts, a PBM shall disclose to a covered entity the reimbursement rates, including, where applicable, MAC levels, paid to pharmacy network providers for services provided to the covered entity and its covered individuals. Any and all information disclosed under this subsection (c) may be designated as confidential and such information may not be disclosed by a covered entity without the consent of the PBM except as may be required by a court of law with proper jurisdiction or as authorized by law, and further provided that nothing contained herein shall (i) prevent a covered entity from verifying with pharmacy network providers the actual amount of reimbursement that they are receiving from the PBM for services provided to the covered entity and its covered individuals and (ii) prevent a pharmacy network provider from disclosing to the covered entity the amount of reimbursement that it has actually received from the PBM for services provided to the covered entity and its covered individuals. Any provision contained in any contract, agreement or understanding of any type between a PBM and a covered entity or between a PBM and a pharmacy network provider

contrary to this subsection (c) shall be null, void, and unenforceable.

(d) Nothing in this Section shall prohibit a pharmacy network provider from advising a covered individual of (i) generic prescription drugs that might be available to the covered individual at a lower out-of-pocket level and (ii) that the covered individual may contact his or her prescribing provider to determine whether there is an acceptable generic prescription drug that can be used to treat the covered individual's disease or medical condition that is available at a lower out-of-pocket level.

(215 ILCS 5/512-7.10 new)

Sec. 512-7.10. Recoupment; audits.

(a) A PBM shall provide the pharmacy or pharmacy network provider a remittance advice which must include an explanation of a recoupment or offset taken by a PBM, if any. All pharmacy audits and recoupments must be conducted in person or, in the alternative, an official notice of audit must be sent by certified mail to the pharmacy with specific requests for information, and a minimum of 30 days must be granted for a pharmacy response from date of receipt of official request. The recoupment explanation shall, at a minimum, include the name of the patient, the date of dispersing, the prescription drug or drugs dispensed, the recoupment amount, and the reason for the recoupment or offset. In addition, a PBM shall provide with the

remittance advice a telephone number or mailing address to initiate an appeal of the recoupment or offset. The requirements of this Section shall be deemed fulfilled by a PBM if the information required in the recoupment explanation is provided to a pharmacy or pharmacy network provider in a notice prior to the actual recoupment.

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. 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.

(b) 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.

(c) 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.

(d) 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.

(e) 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.

(f) 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 subsection (f) does not apply where a longer period is required by a federal law.

(g) 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.

(h) 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 its

representative, 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.

(i) Reimbursement by a PBM under a contract to a 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 prices or amount in the actual or constructive possession of the pharmacy benefits manager or its agent.

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

Sec. 512-8. Cancellation procedures.

~~(a) The administrator of a program shall notify all pharmacies enrolled in the program of any cancellation of the coverage of benefits of any group enrolled in the program at least 30 days prior to the effective date of such cancellation. However, if the administrator of a program is not notified at least 45 days prior to the effective date of such cancellation, the administrator shall notify all pharmacies enrolled in the program of the cancellation as soon as practicable after having~~

~~received notice.~~

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

(b) ~~(c)~~ Any covered individual ~~person~~ who intentionally uses a program identification card to obtain services from a pharmacy after having received notice of the cancellation of his or her 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 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 that were in real-time approved to be dispensed pursuant to an on-line adjudication program. ~~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 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.

(c) When a PBM utilizes a method of pharmacy reimbursement that utilizes a MAC calculation, it shall attempt to reimburse the dispensing network pharmacy at an amount not less than the pharmacy acquisition cost plus an acceptable dispensing fee, as set out in the pharmacy network agreement. In the event the MAC rate is less that the network pharmacy acquisition cost, the PBM shall have an appeal procedure in place to respond to pharmacy requests for rate review. This process must provide for a written response explaining the outcome of the review to the requesting pharmacy within 30 days. If the rate is adjusted, the adjustment will be made retroactive to the date of the appeal request. In the event the appeal is not upheld or acknowledged in a timely manner, a third party independent review panel may review the claims as submitted by the pharmacies and submit periodic reports to the Director for

further determination.

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

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

Sec. 512-10. Failure to obtain licensure ~~Register~~. Any PBM that fails to obtain a license from the Director and pay the fee set forth in this Law ~~third party prescription program or 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 the Article shall apply to all pharmacy benefits management programs and PBMs existing and established as of the effective date of this amendatory Act of the 95th General Assembly. ~~new programs established on or after January 1, 1983. Existing programs shall comply with the provisions of this Article on the anniversary date of the programs that occurs on or after January 1, 1983.~~

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

(215 ILCS 5/512-11 new)

Sec. 512-11. Examination of business and affairs.

(a) The Director may, when and as often as the Director deems it reasonably necessary to protect the interests of the public, examine the business and affairs of any licensed PBM.

(b) Licensees shall maintain for a period of 5 years copies of all documents, books, records, accounts, papers, and any or all computer or other recordings relating to the licensee's business and affairs of operating a pharmacy benefit management program.

(c) Every licensee or person from whom information is sought, including all officers, directors, employees and agents of any licensee or person from whom information is sought, shall provide to the examiners timely, convenient, and free access at all reasonable hours at the licensee's or person's offices to all books, records, accounts, papers, documents, assets, and computer or other recordings relating to the property, assets, business, and affairs of the licensee being examined. The officers, directors, employees, and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the Director shall be grounds for suspension, revocation, or denial of issuance or renewal of any license or authority held by the licensee pursuant to this Law.

(d) The Director or his or her designee shall have the power to issue subpoenas, administer oaths, and examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the

Director may petition a court of competent jurisdiction, and, upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence.

(e) When making an examination under this Law, the Director may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners. The costs of retaining the examiners, including their work, travel, and living expenses shall be borne by the licensee that is the subject of the examination.

(215 ILCS 5/512-12 new)

Sec. 512-12. Fines and penalties. In addition to or instead of any applicable denial, suspension, or revocation of a license issued under this Law, a licensee may, after a hearing, be subject to a civil penalty of up to $50,000 for each cause of denial, suspension, or revocation.

Any licensee or other person who willfully or repeatedly fails to observe or who otherwise violates any of the provisions of this Law or this Code or any rule adopted or final order entered thereunder shall, by civil penalty, forfeit to the Division a sum not to exceed $5,000. Each day during which a violation occurs constitutes a separate offense.".