



95TH GENERAL ASSEMBLY

State of Illinois

2007 and 2008

SB2222

Introduced 2/14/2008, by Sen. John J. Cullerton

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.

LRB095 18675 RAS 44769 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning regulation.

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

4 Section 5. The Illinois Insurance Code is amended by
5 changing the heading of Article XXXI 1/2 and Sections 512-1,
6 512-2, 512-3, 512-4, 512-5, 512-6, 512-7, 512-8, 512-9, and
7 512-10 and by adding Sections 512-4.5, 512-11, 512-12, 512-13,
8 512-14, 512-15, 512-16, and 512-17 as follows:

9 (215 ILCS 5/Art. XXXI.5 heading)

10 ARTICLE XXXI 1/2.

11 PHARMACY BENEFITS MANAGEMENT ~~THIRD PARTY PRESCRIPTION~~ PROGRAMS

12 (215 ILCS 5/512-1) (from Ch. 73, par. 1065.59-1)

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

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

17 (215 ILCS 5/512-2) (from Ch. 73, par. 1065.59-2)

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

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

2 (215 ILCS 5/512-3) (from Ch. 73, par. 1065.59-3)

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

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

8 "Covered entity" means a nonprofit hospital or medical
9 service organization, insurer, health coverage plan or health
10 maintenance organization, or a health program administered by
11 the Department or the State in the capacity of provider of
12 health coverage; or an employer, labor union, or other group of
13 persons organized in this State that provides health coverage
14 to covered persons who are employed or reside in this State.

15 "Covered entity" does not include a health plan that provides
16 coverage only for accidental injury, specified disease,
17 hospital indemnity, Medicare supplement, disability income, or
18 long-term care or other limited benefit health insurance
19 policies and contracts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2 (215 ILCS 5/512-4) (from Ch. 73, par. 1065.59-4)

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

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

14 (215 ILCS 5/512-4.5 new)

15 Sec. 512-4.5. Advisory Council on Pharmacy Benefits
16 Managers. There is created within the Division the Advisory
17 Council on Pharmacy Benefits Management to provide for
18 procedural and compliance oversight of all PBMs registered
19 under this Article. The Council shall be comprised of 2
20 pharmacists nominated by the Illinois Pharmacists Association,
21 2 pharmacists nominated by the Retail Merchants Association, 2
22 representatives of the Division, and one representative of the
23 State Employees Group Insurance Program. The Council may assist
24 the Director in issues involving complaint resolution and

1 healthcare program benefits development.

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

3 Sec. 512-5. Fiduciary and Bonding Requirements.

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

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

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

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

1 such programs.

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

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

10 (215 ILCS 5/512-6) (from Ch. 73, par. 1065.59-6)

11 Sec. 512-6. Notice; drug substitution.

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

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

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

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

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

1 (215 ILCS 5/512-7) (from Ch. 73, par. 1065.59-7)

2 Sec. 512-7. Contractual provisions.

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

13 (b) (1) A program shall provide an annual period of at least
14 30 days during which any pharmacy licensed under the
15 Pharmacy Practice Act may elect to participate in the
16 program under the program terms for at least one year.

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

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

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

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

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

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

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

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

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

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

1 unrelated covered entity contract and its pharmacy network
2 providers. Each pharmacy network provider contract shall be
3 independent of and unrelated to other pharmacy network provider
4 contracts. Enrolled pharmacy network providers may negotiate
5 all terms and conditions of any network contract and may not be
6 restricted from disclosing the terms and conditions of such
7 contract with other pharmacy network providers. All network
8 contracts for any covered entity must be identical in all terms
9 and conditions for all participating pharmacy network
10 providers.

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

12 (215 ILCS 5/512-8) (from Ch. 73, par. 1065.59-8)

13 Sec. 512-8. Cancellation procedures.

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

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

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

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

14 (215 ILCS 5/512-9) (from Ch. 73, par. 1065.59-9)

15 Sec. 512-9. Denial of Payment.

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

1 receives notification.

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

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

11 (215 ILCS 5/512-10) (from Ch. 73, par. 1065.59-10)

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

19 The provisions of this ~~the~~ Article shall apply to all new
20 programs established on or after January 1, 2009 ~~1983~~. Programs
21 existing on the effective date of this amendatory Act of the
22 95th General Assembly ~~Existing programs~~ shall comply with the
23 provisions of this Article as they existed before the effective
24 date of this amendatory Act of the 95th General Assembly until
25 ~~on~~ the anniversary date of the programs that occurs on or after

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

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

6 (215 ILCS 5/512-11 new)

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

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

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

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

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

1 unless otherwise agreed to by the enrolled pharmacy network
2 provider.

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

9 (215 ILCS 5/512-12 new)

10 Sec. 512-12. Audit standards.

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

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

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

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

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

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

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

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

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

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

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

26 (10) The preliminary audit report must be delivered to

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

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

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

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

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

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

13 (215 ILCS 5/512-13 new)

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

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

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

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

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

6 (215 ILCS 5/512-14 new)

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

14 (215 ILCS 5/512-15 new)

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

21 (215 ILCS 5/512-16 new)

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

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

7 (215 ILCS 5/512-17 new)

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

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

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