



99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

HB4079

by Rep. Kelly M. Cassidy

SYNOPSIS AS INTRODUCED:

See Index

Amends the Illinois Insurance Code. Provides a process to register with the Department of Insurance as a pharmacy benefits manager and what information must be included. Provides that the Director of Insurance can revoke, suspend, deny, or restrict a certificate of registration for violation of the Code or on other grounds as determined necessary or appropriate by the Director. Provides that the Department shall regulate the drug pricing process used by pharmacy benefits managers, and specifies the appeals process for such pricing. Provides that pharmacy benefits managers shall not mandate that a covered individual use a specific pharmacy or provide incentives to encourage the use of a specific pharmacy under specified circumstances. Provides criteria for entities to use in performing on-site audits of pharmacy records. Provides that health plans must permit their enrollees to receive benefits, which may include a 90-day supply of covered prescription drugs, at any of its network community pharmacies. Contains provisions concerning medication synchronization. Provides that dispensing fees shall be determined exclusively on the total number of prescriptions dispensed. Regulates how pharmacy benefits managers may utilize personally identifiable data. Provides that the Department can regulate other specified activities of pharmacy benefits managers. Makes other changes. Effective January 1, 2016.

LRB099 10333 MLM 30560 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning insurance.

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 Sections 512-3, 512-4, 512-5, 512-6, 512-7, 512-8,
6 512-9, and 512-10 and by adding Sections 512-11, 512-12,
7 512-13, 512-14, 512-15, 512-16, 512-17, and 512-18 as follows:

8 (215 ILCS 5/512-3) (from Ch. 73, par. 1065.59-3)

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

12 "Compounding" has the meaning ascribed to it in the
13 Pharmacy Practice Act.

14 "Department" means the Department of Insurance.

15 "Director" means the Director of Insurance.

16 "Entity" means a managed care company, insurance company,
17 third-party payor, a PBM, third-party prescription program, or
18 any other organization that represents these companies,
19 groups, or organizations.

20 "Generic exclusivity period" means the period established
21 in Section 355(j)(5)(B)(iv) of Title 21 of the United States
22 Code.

23 "Health plan" has the meaning ascribed to it in 45 CFR

1 160.103.

2 "Maximum allowable cost" or "MAC" means a maximum
3 reimbursement amount for a group of therapeutically and
4 pharmaceutically equivalent multiple source drugs that are
5 listed in the federal Food and Drug Administration's "Approved
6 Drug Products with Therapeutic Equivalence Evaluations" and
7 for which there are no fewer than 3 nationally available
8 equivalent drug products.

9 "Medical device" has the meaning ascribed to it in the
10 Pharmacy Practice Act.

11 "Medication synchronization" means the coordination of
12 medication refills for a patient taking 2 or more medications
13 for a chronic condition such that the patient's medications are
14 refilled on the same schedule for a given time period.

15 "Medication therapy management services" has the meaning
16 ascribed to it in the Pharmacy Practice Act.

17 "Multiple source drug" means a drug for which there are 3
18 or more drug products that are:

19 (1) rated by the federal Food and Drug Administration
20 as therapeutically equivalent under the federal Food and
21 Drug Administration's most recent publication of Approved
22 Drug Products with Therapeutic Equivalence Evaluations;

23 (2) determined by the federal Food and Drug
24 Administration to be pharmaceutically equivalent or
25 bioequivalent; and

26 (3) separately sold or marketed in the United States

1 during the same calendar quarter.

2 "Nationally available" means that such products are
3 available for purchase by pharmacies or chain-operated
4 warehouses in sufficient supply from national pharmaceutical
5 wholesalers and are not obsolete or temporarily unavailable.
6 Products must be available for purchase from a wholesale drug
7 distributor as defined and licensed according to the Wholesale
8 Drug Distribution Licensing Act.

9 "Obsolete" means that such products may be listed in the
10 national pricing compendia but are no longer actively marketed
11 by the manufacturer or labeler.

12 "Patient counseling" has the meaning ascribed to it in the
13 Pharmacy Practice Act.

14 "Pharmacist" has the meaning ascribed to it in the Pharmacy
15 Practice Act.

16 "Pharmacist care" has the meaning ascribed to it in the
17 Pharmacy Practice Act and is considered to be a component of
18 pharmacist-provided care.

19 "Pharmacy" has the meaning ascribed to it in the Pharmacy
20 Practice Act.

21 "Pharmacy benefits manager" or "PBM" means an entity that
22 contracts with third-party pharmacies or pharmacists on behalf
23 of a health plan for the third-party pharmacy and pharmacists
24 to provide pharmacy services to such health plans.

25 "Practice of pharmacy" has the meaning ascribed to it in
26 the Pharmacy Practice Act.

1 "Prescription" has the meaning ascribed to it in the
2 Pharmacy Practice Act.

3 "Standing Order" has the meaning ascribed to it in the
4 Pharmacy Practice Act.

5 "Temporarily unavailable" means that such products are
6 experiencing short-term supply interruptions for which only
7 inconsistent or intermittent supply is available in the current
8 marketplace.

9 "Unique Identifier" has the meaning ascribed to it in the
10 Pharmacy Practice Act.

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

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

1 ~~reimburse a provider of services rendered pursuant to a program~~
2 ~~of which the Department of Healthcare and Family Services is~~
3 ~~the third party.~~

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

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

6 Sec. 512-4. Registration.

7 (a) All PBMs that provide services to residents of this
8 State shall apply for, obtain, and maintain a certificate of
9 registration to operate as a PBM from the Department.

10 (b) The PBM certificate of registration shall be renewed
11 annually.

12 (c) The Director shall establish the fees and shall have
13 the authority to assess fees to cover the annual expenses and
14 costs of administering this Article.

15 (d) The application for a certificate of registration to
16 operate in this State as a PBM shall be in a form prescribed by
17 the Director and shall be verified by an officer or authorized
18 representative of the PBM.

19 (e) The application shall include, but is not limited to,
20 the following:

21 (1) All organizational documents, including, but not
22 limited to, articles of incorporation, bylaws, and other
23 similar documents and any amendments.

24 (2) The names, addresses, titles, and qualifications
25 of the members and officers of the board of directors,

1 board of trustees, or other governing body or committee, or
2 the partners or owners in case of a partnership or other
3 entity or association.

4 (3) A detailed description of the claims processing
5 services, pharmacy services, insurance services, other
6 prescription drug or device services, or other
7 administrative services provided.

8 (4) The name and address of the agent for service of
9 process in the State.

10 (5) Financial statements for the current and the
11 preceding year, showing the assets, liabilities, direct or
12 indirect income, and any other sources of financial support
13 as deemed sufficient by the Director to show financial
14 stability and viability to meet its full obligations to
15 participants and participating pharmacies. The Director
16 may allow a recent financial statement prepared by an
17 independent certified public accountant to meet this
18 requirement.

19 (6) Such other information as the Director may require.

20 (f) The Director may revoke, suspend, deny, or restrict a
21 certificate of registration of a PBM for violation of this
22 Article or on other grounds or violations of State or federal
23 laws, rules, or regulations as determined necessary or
24 appropriate by the Director. In the event that a certificate is
25 revoked, suspended, or denied, the Director may permit such
26 further operation of the PBM for a limited time, not to exceed

1 60 days, under conditions and restrictions as determined by the
2 Director as necessary for the beneficial interests of the
3 participants and pharmacy and pharmacist providers.

4 (g) The Director may renew the certificate of any PBM,
5 subject to any restrictions considered necessary or
6 appropriate by the Director.

7 (h) The Director shall provide written notice to the PBM of
8 any revocation, denial, suspension, or restriction, including
9 the specific reasons. The PBM shall have the same rights to
10 notice, hearings, and other provisions as provided to insurers
11 or third party administrators, respectively, under State law.

12 (i) The Director shall, upon request, provide the
13 Department of Financial and Professional Regulation with
14 copies of applications, correspondence, and any other
15 documents provided by the PBM to the Director, and with
16 notices, findings, determinations, and other documents
17 provided by the Director to the PBM.

18 ~~All third party prescription programs and administrators doing~~
19 ~~business in the State shall register with the Director of~~
20 ~~Insurance. The Director shall promulgate regulations~~
21 ~~establishing criteria for registration in accordance with the~~
22 ~~terms of this Article. The Director may by rule establish an~~
23 ~~annual registration fee for each third party administrator.~~

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

1 Sec. 512-5. Fiduciary and Bonding Requirements. An entity
2 ~~A third party prescription program administrator~~ shall (1)
3 establish and maintain a fiduciary account, separate and apart
4 from any and all other accounts, for the receipt and
5 disbursement of funds for reimbursement of providers of
6 services under the entity's program, or (2) post, or cause to
7 be posted, a bond of indemnity in an amount equal to not less
8 than 10% of the total estimated annual reimbursements under the
9 entity's program.

10 The establishment of such fiduciary accounts and bonds
11 shall be consistent with applicable State law. If a bond of
12 indemnity is posted, it shall be held by the Director of
13 Insurance for the benefit and indemnification of the providers
14 of services under the entity ~~third party prescription program~~.

15 An entity administrator who operates more than one ~~third~~
16 ~~party prescription~~ program may establish and maintain a
17 separate fiduciary account or bond of indemnity for each such
18 program, or may operate and maintain a consolidated fiduciary
19 account or bond of indemnity for all such programs.

20 ~~The requirements of this Section do not apply to any third~~
21 ~~party prescription program administered by or on behalf of any~~
22 ~~insurance company, Health Care Service Plan Corporation or~~
23 ~~Pharmaceutical Service Plan Corporation authorized to do~~
24 ~~business in the State of Illinois.~~

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

1 (215 ILCS 5/512-6) (from Ch. 73, par. 1065.59-6)

2 Sec. 512-6. Notice. Notice of any change in the terms of a
3 PBM ~~third party prescription program~~, including but not limited
4 to drugs covered, pharmacist-provided services, reimbursement
5 rates, co-payments, and dosage quantity, shall be given to each
6 enrolled pharmacy at least 30 days prior to the time it becomes
7 effective.

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

9 (215 ILCS 5/512-7) (from Ch. 73, par. 1065.59-7)

10 Sec. 512-7. Contractual provisions.

11 (a) Any agreement or contract entered into in this State
12 between the PBM ~~administrator of a program~~ and a pharmacy or
13 pharmacist shall include a statement of the method and amount
14 of reimbursement to the pharmacy or pharmacist for services
15 rendered to persons enrolled in the program, the frequency of
16 payment by the PBM ~~program administrator~~ to the pharmacy or
17 pharmacist for those services, and a method for the
18 adjudication of complaints and the settlement of disputes
19 between the contracting parties.

20 (b) (1) A program shall provide an annual period of at least
21 30 days during which any pharmacy licensed under the
22 Pharmacy Practice Act may elect to participate in the
23 program under the program terms for at least one year.

24 (2) If compliance with the requirements of this
25 subsection (b) would impair any provision of a contract

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

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

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

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

18 (4) This subsection (b) shall be inoperative after
19 October 31, 1992.

20 (c) The PBM ~~program administrator~~ shall cause to be issued
21 an identification card to each person enrolled in the program.
22 The identification card shall include:

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

25 (2) an expiration date if required under the
26 contractual arrangement or agreement between a provider of

1 pharmaceutical services and prescription drug products and
2 the PBM ~~third party prescription program administrator~~.

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

4 (215 ILCS 5/512-8) (from Ch. 73, par. 1065.59-8)

5 Sec. 512-8. Cancellation procedures.

6 (a) The PBM ~~administrator of a program~~ shall notify all
7 pharmacies and pharmacists enrolled in the program of any
8 cancellation of the coverage of benefits of any group enrolled
9 in the program at least 30 days prior to the effective date of
10 such cancellation. However, if the PBM ~~administrator of a~~
11 ~~program~~ is not notified at least 45 days prior to the effective
12 date of such cancellation, the PBM ~~administrator~~ shall notify
13 all pharmacies and pharmacists enrolled in the program of the
14 cancellation as soon as practicable after having received
15 notice.

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

20 (c) Any person who intentionally uses a program
21 identification card to obtain services from a pharmacy or
22 pharmacist after having received notice of the cancellation of
23 his benefits shall be guilty of a Class C misdemeanor. Persons
24 shall be liable to the PBM ~~program administrator~~ for all monies
25 paid by the PBM ~~program administrator~~ for any services received

1 pursuant to any improper use of the identification card.

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

3 (215 ILCS 5/512-9) (from Ch. 73, par. 1065.59-9)

4 Sec. 512-9. Denial of Payment.

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

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

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

2 (215 ILCS 5/512-10) (from Ch. 73, par. 1065.59-10)

3 Sec. 512-10. Failure to Register. Any entity ~~third party~~
4 ~~prescription program or administrator~~ which operates without a
5 certificate of registration or fails to register with the
6 Director and pay the fee prescribed by this Article shall be
7 construed to be an unauthorized insurer as defined in Article
8 VII of this Code and shall be subject to all penalties
9 contained therein.

10 The provisions of the Article shall apply to all new
11 programs established on or after January 1, 1983. Existing
12 programs shall comply with the provisions of this Article on
13 the anniversary date of the programs that occurs on or after
14 January 1, 1983.

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

16 (215 ILCS 5/512-11 new)

17 Sec. 512-11. Pricing.

18 (a) A MAC shall be:

19 (1) established for any drug with at least 3 or more
20 A-rated therapeutically equivalent multiple source drugs,
21 as defined by the federal Food and Drug Administration or
22 when only 2 products are available during a generic
23 exclusivity period; and

24 (2) determined using comparable drug prices obtained

1 from multiple nationally recognized comprehensive data
2 sources, including wholesalers, drug file vendors, and
3 pharmaceutical manufacturers for drugs that are nationally
4 available and available for purchase locally by multiple
5 pharmacies in the State. A MAC shall be established for a
6 product using only equivalent drugs as determined by the
7 federal Food and Drug Administration.

8 (b) For those drugs in which a MAC applies, the PBM shall
9 include in contracts with pharmacies information regarding
10 which of the national compendia is used to obtain pricing data
11 used in the calculation of MAC pricing and shall make MAC price
12 adjustments at least twice a month and provide pharmacies with
13 prompt notification of any changes or additions made to the MAC
14 price list and MAC rates at that time, except when a price for
15 a drug changes by more than 100%; in such cases, the MAC price
16 adjustment for that drug shall be made within 3 business days
17 of the change in price.

18 The PBM shall provide a process to allow providers to
19 submit 200 claims per MAC appeal, in an Excel file, containing
20 all National Drug Codes within the Generic Product Identifier,
21 and shall allow pharmacy providers to comment on, contest, or
22 appeal the MAC rates and MAC list. The right to contest shall
23 be limited in duration and provide for retroactive payment in
24 the event it is determined that MAC pricing has been applied
25 incorrectly. All inquiries to the PBM concerning MAC lists, MAC
26 rates, and pricing shall be acted upon and responded to within

1 5 business days.

2 If the challenge is successful, the PBM shall make an
3 adjustment in the drug price to the date of the original
4 challenge and make the adjustment applicable to all similarly
5 situated network pharmacy providers, as determined by the
6 managed care organization or PBM, as appropriate.

7 If the challenge is successful, a network pharmacy retains
8 the right to collect or not collect additional appropriate
9 co-payments from a patient after adjustments in the drug price.

10 The PBM shall make all applicable MAC lists, including all
11 changes in the price of drugs, available to network pharmacies
12 upon request in a readily accessible and usable format that
13 contains a complete list of the drug name, National Drug Code,
14 package size, per unit price, strength of drug, Generic Price
15 Identifier, and Generic Code Number. In the event there are
16 multiple MAC lists under the same contract, the contract shall
17 identify which MAC lists are appropriately applicable.

18 (c) A PBM shall also include in contracts with pharmacies a
19 process for no less than once a week updates to pharmacy
20 product pricing files used to calculate prescription prices
21 that will be used to reimburse pharmacies.

22 (d) A PBM shall provide a contractual commitment to deliver
23 a particular average reimbursement rate for generic drugs. The
24 average reimbursement rate for generic drugs shall be
25 calculated using the actual amount paid to the pharmacy,
26 including patient co-pays and reimbursements from PBMs but

1 excluding the dispensing fee. The average reimbursement rate
2 for generic drugs shall not be calculated solely according to
3 the amount allowed by the plan and shall include all generics
4 dispensed, regardless of whether they are subject to MAC
5 pricing. The PBM shall disclose to the network pharmacy the
6 methodology used in determining the average reimbursement rate
7 for generic drugs.

8 (e) A PBM may not charge a transaction fee for claims
9 submissions provided in an electronic format by a health care
10 provider.

11 (f) The Director may require a pharmacy benefits manager to
12 submit information to the Department related to the pharmacy
13 benefits manager's pricing methodology for MAC prices.

14 (215 ILCS 5/512-12 new)

15 Sec. 512-12. PBM networks.

16 (a) A PBM shall not mandate that a covered individual use a
17 specific community pharmacy, mail order pharmacy, specialty
18 pharmacy, or other pharmacy or entity. Nor can the PBM provide
19 incentives to beneficiaries or plan sponsors to encourage the
20 use of a specific pharmacy if only applicable to a PBM
21 pharmacy.

22 (b) A PBM may not require that a pharmacist or pharmacy
23 participate in a network managed by the PBM as a condition for
24 the pharmacy to participate in another network managed by the
25 same PBM.

1 (c) A PBM may not exclude an otherwise qualified pharmacist
2 or pharmacy from participation in a particular network provided
3 that the pharmacist or pharmacy accepts the terms, conditions,
4 and reimbursement rates of the PBM, meets all applicable
5 federal and State licensure and permit requirements, and has
6 not been excluded from participation in any federal or State
7 program.

8 (d) A PBM or entity shall not automatically enroll or
9 disenroll a pharmacy in a contract or modify an existing
10 agreement without written agreement of the pharmacist or
11 pharmacy.

12 (e) If a PBM establishes a discount card network, the PBM
13 shall not require participation in the discount card network by
14 a pharmacy in exchange for participation in the broader retail
15 network. The PBM shall allow a pharmacy to opt out of the
16 discount card network and choose to only participate in the
17 PBM's funded retail network.

18 (f) A PBM must have a contracted pharmacy network
19 consisting of retail pharmacies sufficient to ensure that the
20 following requirements are satisfied:

21 (1) At least 90% of health plan beneficiaries, on
22 average, in urban areas served by the PBM live within 2
23 miles of a network pharmacy that is a community pharmacy.

24 (2) At least 90% of health plan beneficiaries, on
25 average, in suburban areas served by the PBM live within 5
26 miles of a network pharmacy that is a community pharmacy.

1 (3) At least 70% of health plan beneficiaries, on
2 average, in rural areas served by the PBM live within 15
3 miles of a network pharmacy that is a community pharmacy.

4 (215 ILCS 5/512-13 new)

5 Sec. 512-13. Audit of pharmacy records.

6 (a) Notwithstanding any other law, when an on-site audit of
7 the records of a pharmacy is conducted by an entity, the audit
8 shall be conducted in accordance with the following criteria:

9 (1) The entity conducting the initial on-site audit
10 shall give the pharmacy and the pharmacy's corporate office
11 written notice at least 30 days before conducting the
12 initial on-site audit for each audit cycle and shall
13 disclose the specific prescriptions to be included in the
14 audit.

15 (2) Unless otherwise consented to by the pharmacy, an
16 audit shall not be initiated or scheduled during the first
17 5 calendar days of any month or the day before or after a
18 federal holiday due to the high volume of prescriptions
19 filled during that time.

20 (3) The entity conducting the on-site audit shall not
21 interfere with the delivery of pharmacist services to a
22 patient and shall utilize every effort to minimize
23 inconvenience and disruption to pharmacy operations during
24 the audit process. The on-site audit shall not exceed 4
25 hours in duration and shall review no more than 100 unique

1 prescription numbers during an initial audit.

2 (4) No entity shall conduct an on-site audit at a
3 particular pharmacy more than one time annually. However,
4 this paragraph (4) shall not apply when an entity must
5 return to a pharmacy to complete an audit already in
6 progress.

7 (5) The period covered by an audit shall not exceed 2
8 years from the date the initial prescription claim was
9 submitted to or adjudicated by an entity.

10 (6) Each pharmacy shall be audited under the same
11 standards and parameters as other similarly situated
12 pharmacies audited by the entity. Any documentation and
13 records required by an auditor during an audit shall be of
14 the same type as the documentation and records required for
15 other similarly situated pharmacies.

16 (7) Any audit that involves clinical or professional
17 judgment shall be conducted by or in consultation with a
18 pharmacist.

19 (8) Each audit shall be conducted by a field agent who
20 possesses the requisite expertise in pharmacy practice.

21 (9) Any unintentional clerical or record-keeping
22 error, such as a typographical error, scrivener's error, or
23 computer error, regarding a required document or record
24 shall not necessarily constitute fraud. These claims may be
25 subject to recoupment, but shall not subject a pharmacy to
26 criminal penalties without proof of intent to commit fraud.

1 In the case of errors which have no financial harm to the
2 patient or plan, the entity must not assess any
3 chargebacks.

4 (10) All audits shall be conducted in accordance with
5 generally accepted accounting principles, standards, and
6 procedures; and auditing principles, standards, and
7 procedures; and using standards and parameters established
8 by rule that are identical for all audits conducted.

9 (11) Prescriptions are considered valid prescriptions
10 if they are compliant with the Pharmacy Practice Act and
11 Illinois Controlled Substances Act and have been
12 positively adjudicated upon claim submission by the
13 entity. Plan restrictions should be addressed during the
14 claims adjudication process either through the rejection
15 of the claim or a rejection of the claim with direction to
16 obtain a prior authorization and may not be the basis for a
17 retrospective recoupment of a paid claim.

18 (12) A finding of an overpayment or underpayment must
19 be based on the actual overpayment or underpayment and may
20 not be a projection based on the number of patients served
21 having a similar diagnosis or on the number of similar
22 orders or refills for similar drugs.

23 (13) With the exception of overpayments, if a PBM
24 approves a claim through adjudication, the PBM may not
25 retroactively deny or modify reimbursement based on
26 information accompanying the original claim or information

1 available to the PBM at the time of adjudication, unless
2 the claim was fraudulent, the pharmacy or pharmacist had
3 been reimbursed for the claim previously, or the services
4 reimbursed were not rendered by the pharmacy or pharmacist.

5 (14) A PBM may not require more information to be
6 written on a prescription than is required by State or
7 federal law. Nor may a PBM require more stringent records
8 to validate a prescription order than is required by State
9 or federal law.

10 (15) Electronic records, including electronic
11 beneficiary signature logs, electronic tracking of
12 prescriptions, electronic prescriber prescription
13 transmissions and imagery of hard copy prescriptions,
14 electronically scanned store, patient records maintained
15 at or accessible to the offices of an audited pharmacy's
16 central operations, and any other reasonably clear and
17 accurate electronic documentation shall be acceptable for
18 auditing under the same terms and conditions and for the
19 same purposes as their paper analogs.

20 If paper logs are used, auditors must look at least 14
21 days past the dispense date to check for patient pickup.

22 Point of sale electronic register data shall qualify as
23 proof of delivery to the patient.

24 (16) A pharmacy may use the records of a hospital,
25 physician, or other authorized practitioner of the healing
26 arts for drugs or medicinal supplies written or transmitted

1 by any means of communication for purposes of validating
2 the pharmacy record with respect to orders or refills of a
3 legend drug or other controlled substance.

4 (17) Validation of appropriate day's supply and drug
5 dosing must be based on manufacturer guidelines and
6 definitions or, in the case of topical products or titrated
7 products, the professional judgment of the pharmacist
8 based upon communication with the patient or prescriber.

9 (18) A pharmacy's usual and customary price for
10 compounded medications is considered the reimbursable cost
11 unless an alternate price is published in the provider
12 contract and signed by both parties.

13 (19) A PBM may not require a pharmacy to agree to
14 recoupments deducted against future remittances and shall
15 invoice the pharmacy for payment if the pharmacy elects.
16 Recoupment may be deducted against future remittances
17 without mutual consent when the pharmacy is considered
18 delinquent in payment of the invoice per the contractual
19 arrangement.

20 (20) Interest shall not accrue during the audit period.

21 (21) Notwithstanding any other provision in this
22 subsection (a), the entity conducting the audit shall not
23 use the accounting practice of extrapolation in
24 calculating recoupments or penalties for audits. A finding
25 of overpayment or underpayment must be based on the actual
26 overpayment or underpayment and not on a projection based

1 on the number of patients served having a similar diagnosis
2 or on the number of similar orders or refills for similar
3 drugs.

4 (22) A finding of an overpayment shall not include the
5 dispensing fee amount.

6 (23) The preliminary audit report shall be delivered to
7 the pharmacy and pharmacy corporate office within 30 days,
8 with reasonable extensions allowed, after conclusion of
9 the audit and shall contain claim level information for any
10 discrepancy found and total dollar amount of claims subject
11 to recovery.

12 (24) A pharmacy shall be allowed at least 30 days
13 following receipt of the preliminary audit report in which
14 to produce documentation to address any discrepancy found
15 during an audit or to file an appeal.

16 (25) A final audit report containing claim level
17 information for any discrepancy found and total dollar
18 amount of claims subject to recovery shall be delivered to
19 the pharmacy and pharmacy corporate office within 45 days
20 after the audited pharmacy's receipt of the preliminary
21 audit report if the audited pharmacy does not file an
22 appeal or offers no documentation to address a discrepancy
23 found during an audit, or within 60 days after the auditing
24 entity receives the audited pharmacy's appeal or
25 documentation to address a discrepancy. The final audit
26 results shall be reflected in the remittance advice at the

1 claim level.

2 (26) The entity shall establish an appeals process that
3 meets the following requirements:

4 (A) The National Council for Prescription Drug
5 Programs or any other recognized national industry
6 standard shall be used to evaluate claims submission
7 and product size disputes.

8 (B) Each entity conducting an audit shall
9 establish a written appeals process under which a
10 pharmacy may appeal an unfavorable preliminary audit
11 report to the entity.

12 (C) If, following the appeal, the entity finds that
13 an unfavorable audit report or any portion thereof is
14 unsubstantiated, the entity shall dismiss the audit
15 report or said portion without the necessity of any
16 further action.

17 (27) A PBM may not recover payment of claims from the
18 pharmacy which is identified through the audit process to
19 be the responsibility of another payer. The PBM must
20 reconcile directly with the other payer for any monies owed
21 without requiring the pharmacy to reverse and rebill the
22 original claim in the retail setting.

23 (28) Each entity conducting an audit shall provide a
24 copy of the final audit report, after completion of any
25 review process, to the plan sponsor.

26 (29) The full amount of any recoupment on an audit

1 shall be refunded to the plan sponsor.

2 (30) Neither the agency conducting the audit nor its
3 agents shall receive payment based on a percentage of the
4 amount recovered. This Section does not prevent the entity
5 conducting the audit from charging or assessing the
6 responsible party, directly or indirectly, based on
7 amounts recouped if both of the following conditions are
8 met:

9 (A) the plan sponsor and the entity conducting the
10 audit have a contract that explicitly states the
11 percentage charge or assessment to the plan sponsor;
12 and

13 (B) a commission to an agent or employee of the
14 entity conducting the audit is not based, directly or
15 indirectly, on amounts recouped.

16 (31) The entity conducting the audit shall not base
17 compensation of any employees of the entity involved with
18 the audit process on a percentage of the amount recovered
19 or audit findings.

20 (b) Recoupments of any disputed funds shall occur after
21 final internal disposition of the audit, including the appeals
22 process as set forth in subsection (c) of this Section.

23 (c) Notwithstanding any other law, each entity conducting
24 an audit shall establish an appeals process under which a
25 pharmacy may appeal a preliminary audit report to the entity.

26 (d) This Section does not apply to any audit, review, or

1 investigation that involves allegations of fraud, willful
2 misrepresentation, or abuse.

3 (215 ILCS 5/512-14 new)

4 Sec. 512-14. 90-day supplies at community pharmacies. A
5 health plan must permit its enrollees to receive benefits,
6 which may include a 90-day supply of covered prescription
7 drugs, at any of its network community pharmacies. A health
8 insurance policy or government program providing benefits for
9 prescriptions may not impose on a covered individual utilizing
10 a community pharmacy a copayment, deductible, fee, limitation
11 on benefits, or other condition or requirement not otherwise
12 imposed on the covered individual when using a mail order
13 pharmacy.

14 Nothing in this Section shall prohibit a pharmacist who is
15 exercising his or her professional judgment from dispensing
16 additional quantities of medication up to the total number of
17 dosage units authorized by the prescriber on the original
18 prescription and any refills.

19 (215 ILCS 5/512-15 new)

20 Sec. 512-15. Medication synchronization. All entities
21 providing prescription drug coverage shall permit and apply a
22 prorated daily cost-sharing rate to prescriptions that are
23 dispensed by a pharmacy for less than a 30-day supply if the
24 prescriber or pharmacist indicates the fill or refill could be

1 in the best interest of the patient or is for the purpose of
2 synchronizing the patient's chronic medications.

3 No entity providing prescription drug coverage shall deny
4 coverage for the dispensing of any drug prescribed for the
5 treatment of a chronic illness that is made in accordance with
6 a plan among the insured, the prescriber, and a pharmacist to
7 synchronize the refilling of multiple prescriptions for the
8 insured.

9 No entity providing prescription drug coverage shall use
10 payment structures incorporating prorated dispensing fees
11 determined by calculation of the days' supply of medication
12 dispensed. Dispensing fees shall be determined exclusively on
13 the total number of prescriptions dispensed.

14 The provisions of this Section shall not apply to a
15 supplemental insurance policy, including a life care contract,
16 accident-only policy, specified-disease policy, hospital
17 policy providing a fixed daily benefit only, Medicare
18 supplement policy, long-term care policy, or short-term major
19 medical policy of 6 months or less in duration or any other
20 supplemental policy.

21 (215 ILCS 5/512-16 new)

22 Sec. 512-16. Treatment of data. A PBM must adhere to the
23 following criteria when handling personally identifiable
24 utilization and claims data or other sensitive patient data:

25 (1) A PBM shall notify the health plan sponsor if it

1 intends to sell utilization or claims data that the PBM
2 possesses.

3 (2) A PBM shall notify the health plan sponsor 30 days
4 before selling, leasing, or renting claims data, along with
5 the name of the potential purchaser of the data and the
6 expected use.

7 (3) A PBM may not sell, lease, or rent utilization or
8 claims data without written approval from the health plan
9 sponsor. The PBM must also allow each individual covered
10 the option to opt out.

11 (4) A PBM may not use a pharmacy's usual and customary
12 claims information for purposes other than determining
13 reimbursement and may not sell, lease, or rent a pharmacy's
14 usual and customary information without the pharmacy's
15 express written consent.

16 (5) A PBM may not contact covered individuals without
17 express written permission of the health plan sponsor and
18 the covered individual.

19 (6) A PBM may not transmit any personally identifiable
20 utilization or claims data to a pharmacy owned by a PBM if
21 the patient has not voluntarily elected in writing to fill
22 that particular prescription at the PBM-owned pharmacy.

23 (215 ILCS 5/512-17 new)

24 Sec. 512-17. Regulated activities. The Department may
25 adopt rules to regulate the following activities of PBMs:

- 1 (1) claims processing;
- 2 (2) pharmacy network management;
- 3 (3) pharmacy discount card, employer sponsored plan,
4 managed care Medicaid, and workers compensation
5 management;
- 6 (4) payment of claims to pharmacies for prescription
7 drugs, medical devices, and durable medical equipment
8 dispensed to covered individuals;
- 9 (5) payment of claims to pharmacists for
10 pharmacist-provided services to covered individuals,
11 including, but not limited to, medication therapy
12 management services;
- 13 (6) clinical formulary development and management
14 services, including, but not limited to, utilization
15 management and quality assurance programs;
- 16 (7) rebate contracting and administration;
- 17 (8) conducting audits of contracted pharmacies;
- 18 (9) setting pharmacy reimbursement pricing and
19 methodologies, including MAC, and determining single
20 source and multiple source drugs; and
- 21 (10) retention of any differential between what is
22 received from health plans as reimbursement for
23 prescription drugs or services and what is paid to
24 pharmacies or pharmacists by the PBM for such drugs.

1 Sec. 512-18. Enforcement.

2 (a) Enforcement of this Act shall be the responsibility of
3 the Department and the Director.

4 (b) The Director shall have the authority to adopt any
5 rules necessary for the implementation and administration of
6 this Article.

7 (c) The Director shall take action or impose penalties to
8 bring non-complying entities into full compliance with this
9 Article.

10 Section 99. Effective date. This Act takes effect January
11 1, 2016.

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