Rep. Kelly M. Cassidy

Filed: 3/10/2025

AMENDMENT TO HOUSE BILL 2584

AMENDMENT NO. _____. Amend House Bill 2584 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Insurance Code is amended by changing Section 356z.60 as follows:

(215 ILCS 5/356z.60)

Sec. 356z.60. Coverage for abortifacients, hormonal therapy, and human immunodeficiency virus pre-exposure prophylaxis and post-exposure prophylaxis.

(a) As used in this Section:

"Abortifacients" means any medication administered to terminate a pregnancy as prescribed or ordered by a health care professional.

"Health care professional" means a physician licensed to practice medicine in all of its branches, licensed advanced practice registered nurse, or physician assistant.

"Hormonal therapy medication" means hormonal treatment administered to treat gender dysphoria.

"Therapeutic equivalent version" means drugs, devices, or products that can be expected to have the same clinical effect and safety profile when administered to patients under the conditions specified in the labeling and that satisfy the following general criteria:

(1) it is approved as safe and effective;

(2) it is a pharmaceutical equivalent in that it:

(A) contains identical amounts of the same active drug ingredient in the same dosage form and route of administration; and

(B) meets compendial or other applicable standards of strength, quality, purity, and identity;

(3) it is bioequivalent in that:

(A) it does not present a known or potential bioequivalence problem and it meets an acceptable in vitro standard; or

(B) if it does present such a known or potential problem, it is shown to meet an appropriate bioequivalence standard;

(4) it is adequately labeled; and

(5) it is manufactured in compliance with Current Good Manufacturing Practice regulations adopted by the United States Food and Drug Administration.

(b) An individual or group policy of accident and health

insurance amended, delivered, issued, or renewed in this State on or after January 1, 2024 shall provide coverage for all abortifacients, hormonal therapy medication, human immunodeficiency virus pre-exposure prophylaxis, and post-exposure prophylaxis drugs approved by the United States Food and Drug Administration, and follow-up services related to that coverage, including, but not limited to, management of side effects, medication self-management or adherence counseling, risk reduction strategies, and mental health counseling. This coverage shall include drugs approved by the United States Food and Drug Administration that are prescribed or ordered for off-label use for the purposes described in this Section. On or after the effective date of this amendatory Act of the 104th General Assembly, this coverage shall include pre-PrEP HIV screening, sexually transmitted infection screening, kidney function analysis, routine laboratory testing, and routine provider visits.

(c) The coverage required under subsection (b) is subject to the following conditions:

(1) If the United States Food and Drug Administration has approved one or more therapeutic equivalent versions of an abortifacient drug, a policy is not required to include all such therapeutic equivalent versions in its formulary so long as at least one is included and covered without cost sharing and in accordance with this Section.

(2) If an individual's attending provider recommends a

particular drug approved by the United States Food and Drug Administration based on a determination of medical necessity with respect to that individual, the plan or issuer must defer to the determination of the attending provider and must cover that service or item without cost sharing.

(3) If a drug is not covered, plans and issuers must have an easily accessible, transparent, and sufficiently expedient process that is not unduly burdensome on the individual or a provider or other individual acting as a patient's authorized representative to ensure coverage without cost sharing.

The conditions listed under this subsection (c) also apply to drugs prescribed for off-label use as abortifacients.

(d) Except as otherwise provided in this Section, a policy subject to this Section shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided. The provisions of this subsection do not apply to coverage of procedures to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to the federal Internal Revenue Code, 26 U.S.C. 223.

(e) Except as otherwise authorized under this Section, a policy shall not impose any restrictions or delays on the coverage required under this Section.

(f) The coverage requirements in this Section for

abortifacients do not, pursuant to 42 U.S.C. 18054(a)(6), apply to a multistate plan that does not provide coverage for abortion.

(g) If the Department concludes that enforcement of any coverage requirement of this Section for abortifacients may adversely affect the allocation of federal funds to this State, the Department may grant an exemption to that requirement, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

(Source: P.A. 102-1117, eff. 1-13-23; 103-462, eff. 8-4-23.)

Section 10. The Prior Authorization Reform Act is amended by adding Section 52 as follows:

(215 ILCS 200/52 new)

Sec. 52. Prior authorization for certain prescription drugs; prohibited. A health insurance issuer may not require prior authorization for the following prescription drug types and their therapeutic equivalents approved by the United States Food and Drug Administration: human immunodeficiency virus pre-exposure prophylaxis and post-exposure prophylaxis medication or human immunodeficiency virus treatment medication.

Section 15. The Illinois Public Aid Code is amended by changing Section 5-5.12 and by adding Section 5-54 as follows:

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

Sec. 5-5.12. Pharmacy payments.

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

(b) Pharmacies providing prescription drugs under this Article shall be reimbursed at a rate which shall include a professional dispensing fee as determined by the Illinois Department, plus the current acquisition cost of the prescription drug dispensed. The Illinois Department shall update its information on the acquisition costs of all prescription drugs no less frequently than every 30 days. However, the Illinois Department may set the rate of reimbursement for the acquisition cost, by rule, at a percentage of the current average wholesale acquisition cost.

(c) (Blank).

(d) The Department shall review utilization of narcotic medications in the medical assistance program and impose utilization controls that protect against abuse.

(e) When making determinations as to which drugs shall be on a prior approval list, the Department shall include as part of the analysis for this determination, the degree to which a drug may affect individuals in different ways based on factors

including the gender of the person taking the medication.

(f) The Department shall cooperate with the Department of Public Health and the Department of Human Services Division of Mental Health in identifying psychotropic medications that, when given in a particular form, manner, duration, or frequency (including "as needed") in a dosage, or in conjunction with other psychotropic medications to a nursing home resident or to a resident of a facility licensed under the ID/DD Community Care Act or the MC/DD Act, may constitute a chemical restraint or an "unnecessary drug" as defined by the Nursing Home Care Act or Titles XVIII and XIX of the Social Security Act and the implementing rules and regulations. The Department shall require prior approval for any such medication prescribed for a nursing home resident or to a resident of a facility licensed under the ID/DD Community Care Act or the MC/DD Act, that appears to be a chemical restraint or an unnecessary drug. The Department shall consult with the Department of Human Services Division of Mental Health in developing a protocol and criteria for deciding whether to grant such prior approval.

(g) The Department may by rule provide for reimbursement of the dispensing of a 90-day supply of a generic or brand name, non-narcotic maintenance medication in circumstances where it is cost effective.

(g-5) On and after July 1, 2012, the Department may require the dispensing of drugs to nursing home residents be

in a 7-day supply or other amount less than a 31-day supply. The Department shall pay only one dispensing fee per 31-day supply.

(h) Effective July 1, 2011, the Department shall discontinue coverage of select over-the-counter drugs, including analgesics and cough and cold and allergy medications.

(h-5) The ~~On and after July 1, 2012, the~~ Department shall impose utilization controls, including, but not limited to, prior approval on specialty drugs, oncolytic drugs, ~~drugs for the treatment of HIV or AIDS,~~ immunosuppressant drugs, and biological products in order to maximize savings on these drugs. The Department may adjust payment methodologies for non-pharmacy billed drugs in order to incentivize the selection of lower-cost drugs. ~~For drugs for the treatment of AIDS, the Department shall take into consideration the potential for non adherence by certain populations, and shall develop protocols with organizations or providers primarily serving those with HIV/AIDS, as long as such measures intend to maintain cost neutrality with other utilization management controls such as prior approval.~~ For hemophilia, the Department shall develop a program of utilization review and control which may include, in the discretion of the Department, prior approvals. The Department may impose special standards on providers that dispense blood factors which shall include, in the discretion of the Department, staff training

and education; patient outreach and education; case management; in-home patient assessments; assay management; maintenance of stock; emergency dispensing timeframes; data collection and reporting; dispensing of supplies related to blood factor infusions; cold chain management and packaging practices; care coordination; product recalls; and emergency clinical consultation. The Department may require patients to receive a comprehensive examination annually at an appropriate provider in order to be eligible to continue to receive blood factor.

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

(j) On and after July 1, 2012, the Department shall impose limitations on prescription drugs such that the Department shall not provide reimbursement for more than 4 prescriptions, including 3 brand name prescriptions, for distinct drugs in a 30-day period, unless prior approval is received for all prescriptions in excess of the 4-prescription limit. Drugs in the following therapeutic classes shall not be subject to prior approval as a result of the 4-prescription limit: immunosuppressant drugs, oncolytic drugs, anti-retroviral drugs, and, on or after July 1, 2014, antipsychotic drugs. On or after July 1, 2014, the Department may exempt children with

complex medical needs enrolled in a care coordination entity contracted with the Department to solely coordinate care for such children, if the Department determines that the entity has a comprehensive drug reconciliation program.

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

(l) Any provider enrolled with the Department that bills the Department for outpatient drugs and is eligible to enroll in the federal Drug Pricing Program under Section 340B of the federal Public Health Service Act shall enroll in that program. No entity participating in the federal Drug Pricing Program under Section 340B of the federal Public Health Service Act may exclude fee-for-service Medicaid from their participation in that program, however, entities defined in Section 1905(l)(2)(B) of the Social Security Act are excluded from this requirement. This subsection does not apply to outpatient drugs billed to Medicaid managed care organizations.

(Source: P.A. 102-558, eff. 8-20-21; 102-778, eff. 7-1-22.)

(305 ILCS 5/5-54 new)

Sec. 5-54. Prior authorization for certain prescription drugs; prohibited. The fee-for-service medical assistance program and a Medicaid managed care organization may not require prior authorization for the following prescription

drug types and their therapeutic equivalents approved by the United States Food and Drug Administration: human immunodeficiency virus pre-exposure prophylaxis and post-exposure prophylaxis medication or human immunodeficiency virus treatment medication.

Section 99. Effective date. This Act takes effect January 1, 2027.".