SB3642

LRB100 24035 SMS 43132 b

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

SB3642

Introduced 11/7/2018, by Sen. Wm. Sam McCann

SYNOPSIS AS INTRODUCED:

215 ILCS 5/512-2	from Ch. 73, par. 1065.59-2
215 ILCS 5/Art. XXXIIB heading new	
215 ILCS 5/513b1 new	
215 ILCS 5/513b5 new	
215 ILCS 5/513b10 new	
215 ILCS 5/513b15 new	
215 ILCS 5/513b20 new	
215 ILCS 5/513b25 new	
215 ILCS 5/513b30 new	
215 ILCS 5/513b35 new	
215 ILCS 5/513b40 new	
215 ILCS 5/513b45 new	
215 ILCS 5/513b50 new	
215 ILCS 5/513b55 new	
215 ILCS 5/513b60 new	
215 ILCS 5/513b65 new	
215 ILCS 5/513b70 new	
215 ILCS 5/513b75 new	
215 ILCS 5/513b80 new	
215 ILCS 5/513b85 new	
215 ILCS 5/513b90 new	
215 ILCS 5/513b95 new	
215 ILCS 5/513b100 new	
215 ILCS 5/513b105 new	
215 ILCS 5/513b110 new	

Amends the Illinois Insurance Code. Provides that the Third Party Prescription Program Act does not apply to pharmacy benefits managers. Creates the Pharmacy Benefits Managers Article in the Code. Requires all pharmacy benefits managers doing business in the State to register with the Director of Insurance. Includes provisions on applications for registration, discipline of registered pharmacy benefits managers, examinations, fines, multi-source generic lists, reimbursements, restricted pharmacy fees, audits, and review by the Director.

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A BILL FOR

AN ACT concerning regulation.

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

Section 5. The Illinois Insurance Code is amended by changing Section 512-2 and adding Article XXXIIB as follows:

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

Sec. 512-2. Purpose and applicability. It is hereby determined and declared that the purpose of this Article is to regulate certain practices engaged in by third-party prescription program administrators. This Article does not apply to pharmacy benefits managers.

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

(215 ILCS 5/Art. XXXIIB heading new)

ARTICLE XXXIIB. PHARMACY BENEFITS MANAGERS

(215 ILCS 5/513b1 new)

Sec. 513b1. Short title. This Article shall be known and may be cited as the Pharmacy Benefits Manager Regulation Act.

(215 ILCS 5/513b5 new)

Sec. 513b5. Purpose. It is hereby determined and declared that the purpose of this Article is to regulate certain

practices engaged in by pharmacy benefits managers.

(215 ILCS 5/513b10 new)

Sec. 513b10. Definitions.

As used in this Article, unless the context indicates otherwise:

"Audit" means an on-site or remote review of the records of a pharmacy by an independent third party.

"Clerical error" means a minor error (i) in the keeping, recording, or transcribing of records or documents or in the handling of electronic or hard copies of correspondence, (ii) that does not result in financial harm to a pharmacy benefits manager, and (iii) that does not involve dispensing an incorrect dose, amount or type of medication, or dispensing a prescription drug to the wrong person.

"Entity" means an independent third party that audits claims.

"Multi-source generic list" means the list of drugs used by a pharmacy benefits manager that sets the maximum cost on which reimbursement to a pharmacy is based.

"Pharmacy" means a pharmacy licensed under the Pharmacy Practice Act.

"Pharmacist" means a pharmacist licensed under the Pharmacy Practice Act.

"Pharmacy benefits manager" means a person who processes claims for a contracted fee per transaction on behalf of an

insurer, third-party administrator, or plan sponsor to process claims for prescription drugs, provide retail network management for pharmacies, and pay pharmacies for prescription drugs.

"Pharmacy benefits manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefits manager.

(215 ILCS 5/513b15 new)

Sec. 513b15. Registration.

(a) All pharmacy benefits managers doing business in the State shall register with the Director and annually renew that registration.

(b) The Director shall adopt rules establishing criteria for registration and renewal, including, but not limited to, annual fees, in accordance with the terms of this Article.

(c) The application form for pharmacy benefits manager registration shall include, but is not limited to:

(1) the address and contact telephone number for the pharmacy benefits manager;

(2) the name and address of the pharmacy benefits manager's agent for service of process in the State;

(3) the name, address, and official positions of the individuals who are responsible for the conduct of the

affairs of the pharmacy benefits manager, including, but not limited to, all members of the board of directors, board of trustees, executive committee, other governing board or committee, the principal officers in the case of a corporation, or the partners or members in the case of a partnership or association, and any other persons who exercise control or influence over the affairs of the pharmacy benefits manager; and

(4) a statement concerning any activity, policy, practice, or personnel of the pharmacy benefits manager that directly or indirectly present a conflict of interest with the Director or any pharmacy.

(d) Within 30 days after a change in any of the information disclosed to the Director on an application for registration or renewal, the pharmacy benefits manager shall notify the Director of that change in writing.

(215 ILCS 5/513b20 new)

Sec. 513b20. Registration suspension, revocation, or denial.

(a) The Director may suspend, revoke, or refuse to issue or renew any registration for: (i) conduct of a character likely to mislead, deceive, or defraud the public or the Director; (ii) unfair or deceptive business practices; or (iii) nonpayment of the renewal fee, after notice and an opportunity for a hearing.

(b) Denial of an application or suspension or revocation of a registration pursuant to this Section shall be by written order sent to the applicant or registered pharmacy benefits manager by certified or registered mail at the address specified in the records of the Department. The written order shall state the grounds, charges, or conduct upon which the denial, suspension, or revocation is based. The pharmacy benefits manager may in writing request a hearing within 30 days from the date of mailing. Upon receipt of such a request, the Director shall issue an order setting: (i) a specific date and time for the hearing, which may not be less than 20 nor more than 30 days after receipt of the request, and (ii) a specific place for the hearing, which may be in the office of the Department in Springfield or Chicago. If no written request is received by the Director, the order of the Director shall be final upon the expiration of 30 days.

(c) Upon revocation of a registration, the pharmacy benefits manager shall deliver it to the Director in person or by mail within 30 days after such revocation.

(d) Any pharmacy benefits manager whose registration is revoked or whose application is denied under this Section shall be ineligible to submit an application for registration for 2 years. A suspension under this Section may be for a period of up to 2 years.

(215 ILCS 5/513b25 new)

Sec. 513b25. Examination.

(a) The Director, or his or her designee, may examine a registered pharmacy benefits manager.

(b) Any pharmacy benefits manager being examined shall provide to the Director, or his or her designee, convenient and free access to all books, records, documents, and other papers relating to such pharmacy benefits manager's business affairs at all reasonable hours at its offices.

(c) The Director, or his or her designee, may administer oaths and thereafter examine any individual about the business of the pharmacy benefits manager.

(d) The examiners designated by the Director under this Section may make reports to the Director. Any report alleging substantive violations of this Article, any applicable provisions of this Code, or any applicable Part of Title 50 of the Illinois Administrative Code shall be in writing and be based upon facts obtained by the examiners. The report shall be verified by the examiners.

(e) If a report is made, the Director shall either deliver a duplicate report to the pharmacy benefits manager being examined or send such duplicate by certified or registered mail to the pharmacy benefits manager's address specified in the records of the Department. The Director shall afford the pharmacy benefits manager an opportunity to request a hearing to object to the report. The pharmacy benefits manager may request a hearing within 30 days after receipt of the duplicate

report by giving the Director written notice of such request together with written objections to the report. Any hearing shall be conducted in accordance with Sections 402 and 403 of this Code. The right to a hearing is waived if the delivery of the report is refused or the report is otherwise undeliverable or the pharmacy benefits manager does not timely request a hearing. After the hearing or upon expiration of the time period during which a pharmacy benefits manager may request a hearing, if the examination reveals that the pharmacy benefits manager is operating in violation of any applicable provision of this Code, any applicable Part of Title 50 of the Illinois Administrative Code, a provision of this Article, or prior order, the Director, in the written order, may require the pharmacy benefits manager to take any action the Director considers necessary or appropriate in accordance with the report or examination hearing. If the Director issues an order, it shall be issued within 90 days after the report is filed, or if there is a hearing, within 90 days after the conclusion of the hearing. The order is subject to review under the Administrative Review Law.

(215 ILCS 5/513b30 new)

Sec. 513b30. Administrative fine.

(a) If the Director finds that one or more grounds exist for the revocation or suspension of a registration issued under this Article, the Director may, in lieu of or in addition to

such suspension or revocation, impose a fine upon the pharmacy benefits manager as provided under subsection (b).

(b) With respect to any knowing and willful violation of a lawful order of the Director, any applicable portion of this Code, Part of Title 50 of the Illinois Administrative Code, or provision of this Article, the Director may impose a fine upon the pharmacy benefits manager in an amount not to exceed $100,000 for each violation.

(215 ILCS 5/513b35 new)

Sec. 513b35. Failure to register. Any pharmacy benefits manager that operates without a registration or fails to register with the Director and pay the fee prescribed by this Article is an unauthorized insurer as defined in Article VII of this Code and shall be subject to all penalties provided for therein.

(215 ILCS 5/513b40 new)

Sec. 513b40. Insurance Producer Administration Fund. All fees and fines paid to and collected by the Director under this Article shall be paid promptly after receipt thereof, together with a detailed statement of such fees, into the Insurance Producer Administration Fund. The moneys deposited into the Insurance Producer Administration Fund may be transferred to the Professions Indirect Cost Fund, as authorized under Section 2105-300 of the Department of Professional Regulation Law of

the Civil Administrative Code of Illinois.

(215 ILCS 5/513b45 new)

Sec. 513b45. Multi-source generic list.

(a) At the time it enters into a contract with a pharmacy and subsequently upon request, a pharmacy benefits manager shall provide the pharmacy with the sources used to determine the pricing for the multi-source generic list.

(b) The multi-source generic list shall be the same for all pharmacies and shall include all A-B rated national drug code numbers.

(c) The pharmacy benefits manager shall:

(1) review and update the price information for each drug on the multi-source generic list at least once every 5 business days to reflect any modification of pricing;

(2) establish a process for eliminating products from the multi-source generic list in a timely manner to remain consistent with pricing changes and product availability in the marketplace; and

(3) provide a process for a pharmacy to readily access the multi-source generic list specific to the pharmacy in a searchable and usable format.

(d) In order to place a prescription drug on a multi-source generic list, a pharmacy benefits manager shall ensure that:

(1) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug

Administration's approved drug products with therapeutic equivalence evaluations, also known as the Orange Book, or has an "NR" or "NA" rating by a nationally recognized reference;

(2) the price of the drug listed is the same, for all pharmacists or pharmacies the pharmacy benefits manager contracts with, as the price of equivalent drugs;

(3) the drug is generally available for purchase by pharmacies in the State from a national wholesaler at the multi-source generic price; and

(4) is not obsolete.

(215 ILCS 5/513b50 new)

Sec. 513b50. Multi-source generic; appeals process.

(a) Each contract between a pharmacy benefits manager and a pharmacy must include a process to appeal, investigate, and resolve disputes resolving multi-source generic pricing by an independent third party that includes:

(1) a procedure by which a pharmacy may appeal the price of a drug on the multi-source generic list;

(2) a telephone number at which a pharmacy may contact the pharmacy benefits manager to discuss the status of the pharmacy's appeal; and

(3) a final determination of an appeal within 7 business days.

(b) If the final determination is denial of the pharmacy's

appeal, the pharmacy benefits manager shall state the reason for the denial and provide the national drug code of an equivalent drug that is available for purchase by pharmacies in the State from national wholesalers at a price that is equal to or less than the multi-source generic for that drug.

(c) If a pharmacy's appeal is determined to be valid by the pharmacy benefits manager, the pharmacy benefits manager shall:

(1) make an adjustment in the drug price effective on the date the appeal is resolved; and

(2) permit the appealing pharmacy to reverse and rebill the claim in question, using the dates of the original claim or claims.

(d) A pharmacy benefits manager shall make price adjustments to all similarly situated pharmacies within 3 days.

(e) Within 30 days after a final determination denying an appeal, a pharmacy may submit a written request that the Director review the determination and examine the pharmacy benefits manager in accordance with Section 513b25 of this Article.

(f) If a final determination of an appeal is not issued within 7 business days as set forth above, within 30 days thereafter, a pharmacy may submit a written request that the Director review the appeal and examine the pharmacy benefits manager in accordance with Section 513b25 of this Article.

(215 ILCS 5/513b55 new)

Sec. 513b55. Reimbursement.

(a) A pharmacy benefits manager shall reimburse a pharmacy or pharmacist for drugs subject to multi-source generic drug pricing based upon pricing information that has been updated within 5 business days as set forth in subsection (c) of Section 513b45 of this Article. Such amount shall not be subject to: (i) any fee, including, but no limited to, charges or withholdings related to the adjudication process or performance standards; or (ii) any recoupment without first complying the audit requirements set forth in Section 513b75.

(b) A pharmacy benefits manager shall not reimburse a pharmacy or pharmacist in the State an amount less than the amount that the pharmacy benefits manager reimburses: (i) a pharmacy benefits manager affiliate, (ii) another pharmacist or pharmacy in the State, or (iii) an out-of-State mail order or specialty pharmacy that provides services to individuals who reside in or are employed in this State, for providing the same products, goods, or services.

(c) The amount shall be calculated on a per unit basis based on the same generic product identifier or generic code number.

(d) If a pharmacy benefits manager fails to comply with this Section, a pharmacy or pharmacist may submit a written request that the Director review the determination and examine the pharmacy benefits manager in accordance with Section 513b25

of this Article.

(215 ILCS 5/513b60 new)

Sec. 513b60. Prohibited pharmacy fees.

(a) A pharmacy benefits manager shall not charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including: (i) the receipt and processing of a pharmacy claim; (ii) the development or management of a claim processing or adjudication network; or (iii) participation in a claim processing or claim adjudication network.

(b) A pharmacy benefits manager shall not charge fees to a pharmacy or pharmacist in the State that is greater than the amount the pharmacy benefits manager charges to a (i) a pharmacy benefits manager affiliate, (ii) another pharmacist or pharmacy in the State, or (iii) an out-of-State mail order or specialty pharmacy that provides services to individuals who reside in or are employed in this State, for providing the same products, goods, or services. Such fees include, but are not limited to, transaction fees or performance fees. Along with reimbursing all pharmacies the same cost for medication, all pharmacies shall be paid the same dispensing fees. No other positive form of reimbursement shall be paid to any pharmacy, unless equally paid to all pharmacies.

(215 ILCS 5/513b65 new)

Sec. 513b65. Purchaser choice; mail order or specialty

pharmacy. A contract entered into between a pharmacy benefits manager and a pharmacy shall not:

(1) require an individual purchasing prescription medication to use a mail order or a specialty pharmacy;

(2) require an individual to pay a different co-payment, fee, or other condition not imposed upon individuals using a mail order or specialty pharmacy;

(3) subject any prescription dispensed by a pharmacy to a minimum or maximum quantity length, length of script, restriction on refills, or requirement to obtain refills not imposed upon a mail order or specialty pharmacy;

(4) require an individual in whole or part to pay for any prescription dispensed by a pharmacy and seek reimbursement if the individual is not required to pay for and seek reimbursement in the same manner for a prescription dispensed by a mail order or specialty pharmacy;

(5) subject an individual to any administrative requirement to use a pharmacy that is not imposed upon the use of a mail order or specialty pharmacy; or

(6) impose any other term, condition, or requirement pertaining to the use of the services of a pharmacy that materially and unreasonably interferes with or impairs the right of an individual to obtain prescriptions from a pharmacy of the individual's choice.

(215 ILCS 5/513b70 new)

Sec. 513b70. Disclosure of prescription information to purchaser. No contract entered into between a pharmacy benefits manager and a pharmacy shall contain a provision prohibiting a pharmacist from disclosing any relevant information to an individual purchasing prescription medication, including, but not limited to, the cost of the prescription medication, actual reimbursement for a particular prescription, efficacy of the prescription medication, and the availability of any alternative medications that are less expensive than the prescription medication.

(215 ILCS 5/513b75 new)

Sec. 513b75. Audits. For purposes of Sections 513b75 through 513b95, an entity that audits claims:

(1) must establish, in writing, a procedure for a pharmacy to appeal the entity's findings with respect to a claim and must provide a pharmacy with a notice regarding the procedure, in writing or electronically, prior to conducting an audit of the pharmacy's claims;

(2) may not conduct an audit of a claim more than 24 months after the date the claim was adjudicated by the entity;

(3) must give at least 15 days' advance written notice of an on-site audit to the pharmacy or corporate headquarters of the pharmacy, the written notice shall

provide a date range of prescriptions to be audited;

(4) may not conduct an on-site audit during the first 5 days of any month without the pharmacy's consent;

(5) must conduct the audit in consultation with a pharmacist who is licensed by this State or another state if the audit involves clinical or professional judgment;

(6) may not conduct an on-site audit of more than 250 unique prescriptions of a pharmacy in any 12-month period, except in cases of alleged fraud supported by preliminary findings;

(7) may not conduct more than one on-site audit of a pharmacy in any 12-month period;

(8) must audit each pharmacy under the same standards and parameters that the entity uses to audit all other pharmacies;

(9) must pay any outstanding claims of a pharmacy no more than 45 days after the earlier of the date all appeals are concluded or the date a final report is issued under Section 513b95 of this Article;

(10) may not include dispensing fees or interest in the amount of any overpayment assessed on a claim unless the overpaid claim was for a prescription that was not filled correctly;

(11) may not recoup costs associated with a clerical error or other errors that do not result in financial harm to the entity or a consumer;

(12) may not charge a pharmacy for a denied or disputed claim until the audit and the appeals procedure established under subsection (a) of this Section are final;

(13) must allow the pharmacy to provide supplemental documentation that corresponds to a claim; and

(14) must provide written notice that the pharmacy may request the Director review a final report provided under this Article.

(215 ILCS 5/513b80 new)

Sec. 513b80. Audit findings. An entity's finding that a claim was incorrectly presented or paid must be based on identified transactions and not based on probability sampling, extrapolation, or other means that project an error using the number of patients served who have a similar diagnosis or the number of similar prescriptions or refills for similar drugs.

(215 ILCS 5/513b85 new)

Sec. 513b85. Restrictions. A pharmacy benefits manager may not:

(1) agree to compensate an entity based on a percentage of the amount of overpayments recovered; or

(2) disclose information obtained during an audit except to the entity, the pharmacy subject to the audit, or the holder of the policy or certificate of insurance that paid the claim.

(215 ILCS 5/513b90 new)

Sec. 513b90. Evidence of validation of a claim. For purposes of Sections 513b75 through 513b95 of this Article, an entity must allow as evidence of validation of a claim:

(1) an electronic or physical copy of a prescription that complies with the Pharmacy Practice Act if the prescribed drug was, within 14 days after the dispensing date:

(A) picked up by the patient or the patient's designee;

(B) delivered by the pharmacy to the patient; or

(C) sent by the pharmacy to the patient using the United States Postal Service or other common carrier;

(2) point of sale electronic register data showing purchase of the prescribed drug, medical supply, or service by the patient or the patient's designee; or

(3) written or electronic records, including electronic beneficiary signature logs, electronically scanned and stored patient records maintained at or accessible to the audited pharmacy's central operations, and any other reasonably clear and accurate written or electronic documentation that corresponds to a claim.

(215 ILCS 5/513b95 new)

Sec. 513b95. Audit reports.

(a) After conducting an audit, an entity must provide the pharmacy that is the subject of the audit with a preliminary report of the audit. The preliminary report must be received by the pharmacy no later than 45 days after the date on which the audit was completed and must be sent:

(1) by mail or common carrier with a return receipt requested; or

(2) electronically with electronic receipt confirmation.

(b) An entity shall provide a pharmacy receiving a preliminary report under subsection (a) no fewer than 45 days after receiving the report to contest the report or any findings in the report in accordance with the appeals procedure established under Section 513b75 of this Article and to provide additional documentation in support of the claim. The entity shall consider a reasonable request for an extension of time to submit documentation to contest the report or any findings in the report.

(c) If an audit results in the dispute or denial of a claim, the entity conducting the audit shall allow the pharmacy to resubmit the claim using any commercially reasonable method, including mail or electronic mail.

(d) An entity must provide a pharmacy that is the subject of an audit with a final report of the audit no later than 60 days after the later of the date the preliminary report was received or the date the pharmacy contested the report using

the appeals procedure established under Section 513b75 of this Article. The final report must include a final accounting of all moneys to be recovered by the entity.

(e) Recoupment of disputed funds from a pharmacy or repayment of funds by a pharmacy, unless otherwise agreed to by the entity and the pharmacy, shall occur after the audit and the appeals procedure established under Section 513b75 of this Article are final. If the identified discrepancy for an individual audit exceeds $40,000, any future payments to the pharmacy may be withheld until the audit and the appeals procedure established under Section 513b75 of this Article are final.

(215 ILCS 5/513b100 new)

Sec. 513b100. Director review of final report.

(a) Within 30 days after an entity provides a pharmacy a final report, a pharmacy may request the Director review the audit report.

(b) The Director shall adopt rules establishing criteria for this review of audit reports, in accordance with the terms of this Article.

(215 ILCS 5/513b105 new)

Sec. 513b105. Application of Sections 513b75 through 513b95. Sections 513b75 through 513b95 of this Article do not:

(1) preclude a person from instituting an action for

fraud against a pharmacy;

(2) apply to an audit of pharmacy records when fraud or other intentional and willful misrepresentation is evidenced by physical review, review of claims data, or statements or other investigative methods; or

(3) apply to a State agency that is conducting audits or a person that has contracted with a State agency to conduct audits of a pharmacy.

(215 ILCS 5/513b110 new)

Sec. 513b110. Severability. The provisions of this Article are severable under Section 1.31 of the Statute on Statutes.