SB2515

LRB09919599EGJ43994b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

SB2515

Introduced 2/16/2016, by Sen. Antonio Muñoz

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 may 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, 2017.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning insurance.

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

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

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

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

"Department" means the Department of Insurance.

"Director" means the Director of Insurance.

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

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

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

160.103.

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

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

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

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

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

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

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

(3) separately sold or marketed in the United States

during the same calendar quarter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 512-4. Registration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 512-7. Contractual provisions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 512-8. Cancellation procedures.

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

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

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

pursuant to any improper use of the identification card.

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

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

Sec. 512-9. Denial of Payment.

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

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

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

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

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

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

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

(215 ILCS 5/512-11 new)

Sec. 512-11. Pricing.

(a) A MAC shall be:

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

(2) determined using comparable drug prices obtained

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

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

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

5 business days.

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

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

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

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

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

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

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

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

(215 ILCS 5/512-12 new)

Sec. 512-12. PBM networks.

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

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

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

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

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

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

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

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

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

(215 ILCS 5/512-13 new)

Sec. 512-13. Audit of pharmacy records.

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

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

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

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

prescription numbers during an initial audit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

claim level.

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

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

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

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

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

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

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

shall be refunded to the plan sponsor.

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

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

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

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

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

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

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

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

(215 ILCS 5/512-14 new)

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

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

(215 ILCS 5/512-15 new)

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

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

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

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

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

(215 ILCS 5/512-16 new)

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

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

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

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

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

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

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

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

(215 ILCS 5/512-17 new)

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

(1) claims processing;

(2) pharmacy network management;

(3) pharmacy discount card, employer sponsored plan, managed care Medicaid, and workers compensation management;

(4) payment of claims to pharmacies for prescription drugs, medical devices, and durable medical equipment dispensed to covered individuals;

(5) payment of claims to pharmacists for pharmacist-provided services to covered individuals, including, but not limited to, medication therapy management services;

(6) clinical formulary development and management services, including, but not limited to, utilization management and quality assurance programs;

(7) rebate contracting and administration;

(8) conducting audits of contracted pharmacies;

(9) setting pharmacy reimbursement pricing and methodologies, including MAC, and determining single source and multiple source drugs; and

(10) retention of any differential between what is received from health plans as reimbursement for prescription drugs or services and what is paid to pharmacies or pharmacists by the PBM for such drugs.

(215 ILCS 5/512-18 new)

Sec. 512-18. Enforcement.

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

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

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

Section 99. Effective date. This Act takes effect January 1, 2017.

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Statutes amended in order of appearance