AN ACT concerning prescription drug benefits.

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

Section 1. Short title. This Act may be cited as the Prescription Drugs Benefits Act.

Section 5. Definitions.

(a) In this Act:

"Department" means the Department on Aging.

"Director" means the Director of Aging.

"Disabled person" means a person unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months.

"Eligible person" means a resident of this State who:

(1) is 65 years of age or older; or

(2) has a gross annual household income of not more than 188% of the federal poverty level, does not work more than 40 hours per month, and is a disabled person.

"Enrollee" means an eligible person who has applied and enrolled in the program established by this Act.

"Mail service program" means a program to dispense prescription drugs by postal delivery service designated and administered by the Department, and any entity with which it contracts, upon an enrollee's submission of a prescription and the applicable co-payment.

"Maintenance drug" means a prescription drug prescribed to an individual for a chronic condition, the use of which is medically necessary for a consecutive period of 90 days or longer.

"Pharmacy benefit manager" means an entity under contract with the Department, whether organized on a for-profit or a not-for-profit basis, contracted to manage the program established by this Act.

"Program" means the subsidized catastrophic prescription drug insurance program.

"Review commission" means the prescription drug review commission.

(b) The Department shall administer a subsidized catastrophic prescription drug insurance program designed to provide eligible persons with prescription drug coverage. The program shall be actuarially sound. Enrollment in the program shall be voluntary and shall be funded each fiscal year, subject to appropriation, from the Tobacco Settlement Recovery Fund.

(c) The Director, in conjunction with the Director of Insurance, shall enter into a competitively procured contract with one or more entities including, but not limited to, a pharmacy benefit manager, to administer benefits under the program. The Director shall take all necessary steps to ensure that the program is structured in a way that maximizes savings, efficiencies, affordability, benefits, and coverage.

No prescription drug shall be excluded from any formulary established for the program unless another prescription drug is available on the formulary that is therapeutically equivalent to the excluded prescription drug. Not less than 90 days before procuring a contract with an existing pharmacy benefit manager, the Department shall file a report with the review commission detailing the cost savings associated with the Department's decision to procure that existing pharmacy benefit manager's services. The Department shall contract with entities to perform marketing, enrollment, billing, claims processing, claims management, or any other function it deems necessary.

(d) Notwithstanding any law to the contrary, the

Department shall, subject to appropriation, engage in outreach marketing efforts to maximize enrollment in the program for the purpose of spreading the risk of the program.

(e) Not later than 30 days before enrolling eligible persons in the program, and annually thereafter, the Department shall establish schedules of monthly premiums and annual deductibles based on a sliding income scale payable by enrollees whose gross annual household income is greater than 188% of the federal poverty level. The Department shall also establish schedules of monthly premiums and deductibles based on a sliding income scale payable by married applicants whose gross annual household income is greater than 188% of the federal poverty level. The State is liable for the cost of the monthly premium and annual deductible established by the schedule for all enrollees including, but not limited to, married applicants, whose gross annual household income is less than or equal to 188% of the federal poverty level. The schedules shall provide for not less than 6 separate categories of premiums and deductibles, on a sliding scale basis, for all income levels above 188% of the federal poverty level. During the first 12 months of the program, the schedule shall provide for monthly premiums of (1) not more than $15 for enrollees including, but not limited to, married applicants whose gross annual household income is between 188% and 200% of the federal poverty level; and (2) not more than $25 for enrollees including, but not limited to, married applicants whose gross annual household income is between 200% and 225% of the federal poverty level; and (3) not more than $82 for enrollees whose gross annual household income exceeds 500% of the federal poverty level. Annual deductibles shall range between $100 and $500. Eligibility for the program shall be determined based on an enrollee's gross annual household income. Each enrollee shall separately pay the monthly premium and annual deductible applicable to the sliding scale income category for the household, as determined by the Department.

(f) The Department or its designee shall verify income for the program based on the submission of the most recently required federal income tax return for the household or, if an applicant is not required to file a return, the submission of copies of monthly checks or other easily obtainable means of income verification. Residency shall be verified by the submission of such documentation as the Department deems reasonable.

(g) Subject to this Section, the program shall pay the costs of all prescription drugs for an enrollee whose out-of-pocket expenditures on prescription drugs exceeds the lesser of (1) 10% of such enrollee's gross annual household income or (2) $2,000 in out-of-pocket expenditures made by an enrollee for co-payments and deductibles in a fiscal year. For purposes of this subsection, out-of-pocket expenditures shall not include monthly premiums for which an enrollee shall remain responsible. The program shall pay the costs of any prescription drug in excess of the co-payment amount applicable to the drug after the deductible established for the enrollee has been reached.

(h) An enrollee whose gross annual household income is greater than 200% of the federal poverty level shall be responsible for a co-payment for each prescription of (1) $10 per prescription for a generic drug, (2) $25 per prescription for a preferred drug, and (3) the greater of $25 or 50% of the cost per prescription for a nonpreferred drug. The co-payment for maintenance drugs shall be (1) $20 for each 90-day supply of a prescription for a generic drug, (2) $50 for each 90-day supply of a preferred drug, and (3) the greater of $50 or 50% of the cost per prescription of a nonpreferred drug.

(i) An enrollee whose gross annual household income is less than or equal to 200% of the federal poverty level shall be responsible for a co-payment for each prescription of (1) $5 per prescription for a generic drug, (2) $12 per prescription for a preferred drug; and (3) the greater of $25 or 50% of the cost per prescription for a nonpreferred drug. The co-payment for maintenance drugs shall be (1) $ 10 for each 90-day supply of a prescription for a generic drug, (2) $25 for each 90-day supply of a preferred drug, and (3) the greater of $50 or 50% of the cost per prescription of a nonpreferred drug.

(j) Subject to this Section, the Department may offer a mail service program and may require the use of a mail service program for maintenance drugs. No such mail order program for maintenance drugs shall be required unless the Director determines in writing that material savings will result to the State or enrollees without compromising the health or safety of enrollees. In making the determination, the Director shall consider the impact of any mail order program on the value of the retail pharmacy services in the communities. Before making any determination, the Director shall hold at least one public hearing in order to hear testimony from members of the public. Any mail service program shall be administered by the Department and the contracted pharmacy benefit manager.

(k) In order to maintain the fiscal viability of the program, after the first 12 months of the program, cost sharing required of enrollees in the form of co-payments, premiums and deductibles, or any combination thereof, shall be adjusted annually by the Department to reflect price trends for prescription drugs, as determined by the Director. The review commission shall evaluate the actuarial assumptions and the appropriateness of adjustments and make an annual written determination whether the adjustments are necessary for all or any combination of the cost sharing requirements. Not later than 90 days before making any adjustments, the Director shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives, the written determination made by the commission and all actuarial assumptions and other supporting materials upon which the adjustments are based.

(l) During the initial 12-month period the program is in effect, an eligible person may enroll at any time, after which, application to the program shall be made during an open enrollment period established by the Department, but a person shall be eligible to enroll in the program at any time within the year of reaching age 65. The Department shall establish a surcharge for any eligible person whose gross annual household income is not less than 188% of the federal poverty level and who fails to enroll within his or her first year of eligibility.

(m) Coverage shall be effective as of the date an application for enrollment is approved by the Department. The Director shall close the open enrollment period or modify income eligibility levels upon a written determination by the Director that program expenditures are projected to exceed the amount appropriated for the program or, based on not less than 9 months of claims and enrollment data for the current fiscal year, expenditures in the subsequent fiscal year are clearly projected to annualize beyond the expenditures projected by the Department in the subsequent fiscal year. If the projection is based on expenditures in the subsequent fiscal year, the Director shall not modify income eligibility levels or close open enrollment until not earlier than the beginning of the subsequent fiscal year.

(n) The Department, and any entity with which it contracts, shall inform enrollees in writing of the program's scope, coverage, cost sharing requirements, and any limitations on access to prescription drugs. The Department, and any entity with which it contracts, shall provide for a clear and timely process by which enrollees can appeal a decision by the Department or any contracted entity to deny or limit coverage or benefits under this Act.

(o) The appeal process shall, at a minimum, provide enrollees with the opportunity to (1) obtain a nonpreferred drug at the co-payment level of a preferred drug, or to obtain any prescription drug excluded by the program, upon a separate written certification by the enrollee's physician, satisfactory to the Department, that the nonpreferred or excluded drug is medically necessary and there is no therapeutically equivalent preferred drug available to the enrollee; (2) appeal the exclusion of any prescription drug from any formulary established for the program. An enrollee may apply to be exempt from any mail service requirement of the program upon a separate written certification by the enrollee's physician, satisfactory to the Department, that due to a disability or other significant limiting factor, the use of a mail service program would be medically inappropriate for the enrollee. A retail pharmacy shall not be required to dispense a prescription upon the failure of an enrollee to make the required co-payment.

(p) The Department must adopt rules that are necessary to implement and administer the program.

Section 10. Prescription drug review commission.

(a) There shall be a prescription drug review commission to oversee the program established by this Act. The commission shall consist of the Speaker of the House of Representatives or his or her designee, the President of the Senate or his or her designee, the Director of Aging or his or her designee, and 9 members to be appointed by the Governor, including 2 representatives of senior citizens' advocacy organizations, 2 representatives of disability advocacy organizations, a health care economist from a university or college within the State, 2 representatives from retail pharmacies, an individual who is a full-time employee of a pharmaceutical manufacturer, and an individual who is a full-time employee of a biotechnology manufacturer. A representative of the contracted pharmacy benefit manager shall also participate, but shall not be a voting member of the commission.

(b) Members of the commission shall select a chair. The commission shall adopt such rules and establish such procedures as it deems necessary for the oversight of the program established by this Act. No action of the commission shall be considered approved unless it is endorsed by a majority vote of the commission.

(c) The commission shall meet quarterly and shall, not less than biannually, submit written recommendations to the Governor and the General Assembly regarding changes to the administration, management, eligibility criteria, benefits, funding, or any other aspect of the program.

(d) To facilitate the commission's development of the recommendations, the Department, and any entity with which it contracts, shall review the operations of the program and, not less than quarterly, prepare and submit the following summary information to said commission:

(1) financial reports of the program, including actual and projected costs and revenues and an analysis of the adequacy of appropriated funding;

(2) enrollment information, including enrollee demographics and benefit utilization data;

(3) specific problems associated with the program and suggested strategies to resolve those problems;

(4) a review of the pharmacy benefit manager's designated formulary for the program and any proposed changes;

(5) an analysis of current and future technological advancements that may result in cost savings or otherwise affect the program;

(6) an analysis of the program's cost sharing requirements including, but not limited to, co-payments, premiums, and deductibles, in relation to actual market trends in prescription drug costs, prescription drug inflation, and any proposed changes;

(7) an analysis of the disabled enrollees' drug utilization pattern including, but not limited to, the cost associated with that utilization and the implications for expanding benefits to all disabled individuals who reside in the State; and

(8) all other information requested by the commission. In developing its recommendations, the commission shall consult with representatives of parties who may be affected by the commission's recommendations.