AN ACT concerning regulation.

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

Section 5. The Civil Administrative Code of Illinois is amended by changing Section 5-235 as follows:

(20 ILCS 5/5-235) (was 20 ILCS 5/7.03)

Sec. 5-235. In the Department of Public Health.

(a) The Director of Public Health shall be either a physician licensed to practice medicine in all of its branches in Illinois or a person who has administrative experience in public health work at the local, state, or national level in accordance with subsection (b).

If the Director is not a physician licensed to practice medicine in all its branches, then a Medical Director shall be appointed who shall be a physician licensed to practice medicine in all its branches. The Medical Director shall report directly to the Director. If the Director is not a physician, the Medical Director shall have primary responsibility for overseeing the following regulatory and policy areas:

(1) Department responsibilities concerning hospital and health care facility regulation, emergency services, ambulatory surgical treatment centers, health care

professional regulation and credentialing, advising the Board of Health, patient safety initiatives, and the State's response to disease prevention and outbreak management and control.

(2) Advising the Director on the control of diseases for which an immunization is licensed by the United States Food and Drug Administration. The advice may include guidance for the use of immunizations or medical countermeasures based on medical and scientific evidence, if circumstances warrant. The Medical Director may issue guidance and recommendations on immunizations or medical countermeasures in the absence of such recommendations from the Director or to further supplement recommendations as necessary.

(3) ~~(2)~~ Any other duties assigned by the Director or required by law.

(b) A Director of Public Health who is not a physician licensed to practice medicine in all its branches shall at a minimum have the following education and experience:

(1) 5 years of full-time administrative experience in public health and a master's degree in public health from (i) a college or university accredited by the North Central Association or (ii) any other nationally recognized regional accrediting agency; or

(2) 5 years of full-time administrative experience in public health and a graduate degree in a related field

from (i) a college or university accredited by the North Central Association or (ii) any other nationally recognized regional accrediting agency. For the purposes of this item (2), "a graduate degree in a related field" includes, but is not limited to, a master's degree in public administration, nursing, environmental health, community health, or health education.

(c) The Assistant Director of Public Health shall be a person who has administrative experience in public health work.

(Source: P.A. 97-798, eff. 7-13-12.)

Section 10. The Department of Commerce and Economic Opportunity Law of the Civil Administrative Code of Illinois is amended by changing Section 605-60 and adding Section 605-70 as follows:

(20 ILCS 605/605-60)

(Text of Section before amendment by P.A. 104-27)

Sec. 605-60. DCEO Projects Fund. The DCEO Projects Fund is created as a trust fund in the State treasury. The Department is authorized to accept and deposit into the Fund moneys received from any gifts, grants, transfers, or other sources, public or private, unless deposit into a different fund is otherwise mandated. Subject to appropriation, the Department shall use moneys in the Fund to make grants or loans to and

enter into contracts with units of local government, local and regional economic development corporations, and not-for-profit organizations for municipal development projects, for the specific purposes established by the terms and conditions of the gift, grant, or award, and for related administrative expenses. As used in this Section, the term "municipal development projects" includes, but is not limited to, grants for reducing food insecurity in urban and rural areas.

(Source: P.A. 103-588, eff. 6-5-24.)

(Text of Section after amendment by P.A. 104-27)

Sec. 605-60. DCEO Projects Fund.

(a) The DCEO Projects Fund is created as a trust fund in the State treasury. The Department is authorized to accept and deposit into the Fund moneys received from any gifts, grants, transfers, or other sources, public or private, unless deposit into a different fund is otherwise mandated.

(b) Subject to appropriation, the Department shall use moneys in the Fund to make grants or loans to and enter into contracts with units of local government, local and regional economic development corporations, retail associations, and not-for-profit organizations for municipal development projects, for the specific purposes established by the terms and conditions of the gift, grant, or award, and for related administrative expenses. As used in this Section, the term "municipal development projects" includes, but is not limited

to, grants for reducing food insecurity in urban and rural areas.

~~(c) In this subsection, "rural tract" and "urban tract" have the meanings given to those terms in Section 5 of the Grocery Initiative Act.~~

~~Subject to appropriation, the Department shall use moneys deposited into the Fund pursuant to Section 513b2 of the Illinois Insurance Code to make a grant to a statewide retail association representing pharmacies to promote access to pharmacies and pharmacist services. Grant funds under this subsection shall be made available to the following beneficiaries:~~

~~(1) critical access care pharmacies as defined in Section 5-5.12b of the Illinois Public Aid Code;~~

~~(2) retail pharmacies with a physical location in Illinois owned by a person or entity with an ownership or control interest in fewer than 10 pharmacies;~~

~~(3) retail pharmacies with a physical location in a county in Illinois with fewer than 50,000 residents;~~

~~(4) retail pharmacies with a physical location in a county in Illinois with 50,000 or more residents and in an area within Illinois that is designated by the United States Department of Health and Human Services as either: (A) a Medically Underserved Area, including Governor's Exceptions; or (B) a Medically Underserved Population, including Governor's Exceptions;~~

~~(5) pharmacies whose claims constitute 65% or greater for Medicaid services and at least 80% of their total claims are for pharmacy services administered in Illinois;~~

~~(6) a pharmacy located in an Illinois census tract that meets both of the following poverty and population density and pharmacy accessibility standards:~~

~~(A) the census tract has either: (i) 20% or more of its population living below the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2); or (ii) a median household income of less than 80% of the median income of the nearest metropolitan area; and~~

~~(B) the census tract has at least 33% of its population living one mile or more from the pharmacy for urban tracts or more than 10 miles from the pharmacy for rural tracts.~~

~~At least annually, the Department shall file with the Governor and the General Assembly a report that includes:~~

~~(1) the number of beneficiaries who applied for funding;~~

~~(2) the number of beneficiaries who received funding; and~~

~~(3) the pharmacies that were awarded funding, including the location, the amount of funding, and the subsection category or categories under which the pharmacy~~

~~qualified.~~

(Source: P.A. 103-588, eff. 6-5-24; 104-27, eff. 1-1-26.)

(20 ILCS 605/605-70 new)

Sec. 605-70. Pharmacy support program.

(a) Subject to appropriation, the Department shall use moneys deposited into the DCEO Projects Fund pursuant to Section 513b2 of the Illinois Insurance Code to make a grant to a statewide retail association representing pharmacies to promote access to pharmacies and pharmacist services.

(b) Grant funds under subsection (a) shall be made available to the following beneficiaries:

(1) critical access care pharmacies as defined in Section 5-5.12b of the Illinois Public Aid Code;

(2) retail pharmacies with a physical location in Illinois owned by a person or entity with an ownership or control interest in fewer than 10 pharmacies;

(3) retail pharmacies with a physical location in a county in Illinois with fewer than 50,000 residents;

(4) retail pharmacies with a physical location in a county in Illinois with 50,000 or more residents and in an area within Illinois that is designated by the United States Department of Health and Human Services as either:

(A) a Medically Underserved Area, including Governor's Exceptions; or

(B) a Medically Underserved Population, including

Governor's Exceptions;

(5) pharmacies whose claims constitute 65% or greater for Medicaid services and at least 80% of their total claims are for pharmacy services administered in Illinois;

(6) a pharmacy located in an Illinois census tract that meets both of the following poverty and population density and pharmacy accessibility standards:

(A) the census tract has either: (i) 20% or more of its population living below the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2); or (ii) a median household income of less than 80% of the median income of the nearest metropolitan area; and

(B) the census tract has at least 33% of its population living one mile or more from the pharmacy for urban tracts or more than 10 miles from the pharmacy for rural tracts.

(c) In subsection (b), "rural tract" and "urban tract" have the meanings given to those terms in Section 5 of the Grocery Initiative Act.

(d) Grant funds under subsection (a) shall be disbursed in equal amounts to each beneficiary eligible under subsection (b) that applies for an award. To determine the equal amount available for each beneficiary eligible under subsection (b) each State fiscal year, the total amount appropriated from the

DCEO Projects Fund using moneys deposited under Section 513b2 of the Illinois Insurance Code less any amount provided to a statewide retail association for administrative expenses shall be divided by the total number of nonduplicate beneficiaries eligible under subsection (b) that apply for an award in the same fiscal year. A beneficiary may only receive one award per fiscal year even if the beneficiary may qualify under multiple beneficiary categories in subsection (b).

(e) At least annually, the Department shall file with the Governor and the General Assembly a report on the implementation of subsections (a) through (d) that includes:

(1) the number of beneficiaries who applied for funding;

(2) the number of beneficiaries who received funding; and

(3) the pharmacies that were awarded funding, including the location, the amount of funding, and the subsection (b) category or categories under which the pharmacy qualified.

Section 15. The Department of Public Health Act is amended by changing Section 8.4 as follows:

(20 ILCS 2305/8.4)

Sec. 8.4. Immunization Advisory Committee.

(a) Definitions. For the purposes of this Section:

"Committee" means the Immunization Advisory Committee.

"Immunization" means the treatment of an individual with any vaccine or immunologic drug licensed, approved, or authorized for use by the United States Food and Drug Administration, including emergency use authorization agents, or meeting World Health Organization requirements, and designed for the purpose of producing or enhancing an immune response against a vaccine-preventable disease.

"Medical countermeasures" means products regulated by the United States Food and Drug Administration that may be used in a public health emergency, stemming from a terrorist attack or accidental release of a biological, chemical, or radiological/nuclear agent or a naturally occurring emerging infectious disease.

(b) The Director of Public Health shall appoint an Immunization Advisory Committee to advise the Director on immunization issues, including:

(1) The control of diseases for which an immunization or medical countermeasure is licensed or regulated in the United States by the United States Food and Drug Administration. The advice shall address the use of immunizations or medical countermeasures shown to be effective in controlling a disease for which an immunization is available. Advice for the use of unlicensed but regulated immunizations or medical countermeasures may be provided based on medical and

scientific evidence, if circumstances warrant. For each immunization or medical countermeasure, the Committee shall advise on population groups or circumstances in which it is recommended. The Committee shall also provide recommendations on contraindications and precautions for the use of the immunization or medical countermeasures and provide information on recognized adverse events. The Committee may provide recommendations that address the general use of immunizations or medical countermeasures and special situations or populations that may warrant modification of the routine recommendations.

(2) The use of immunizations or medical countermeasures to control disease in Illinois, which shall include consideration of disease epidemiology and burden of disease, immunization or medical countermeasure safety, immunization or medical countermeasure efficacy and effectiveness, the quality of evidence reviewed, economic analyses, and implementation issues. The Committee may revise or withdraw its recommendations regarding a particular immunization or medical countermeasure as new information on disease epidemiology, vaccine effectiveness or safety, economic considerations, or other data become available.

(3) The Department of Public Health shall publish any recommendations issued by the Immunization Advisory Committee on the Department's website.

(c) The Director shall take into consideration any comments or recommendations made by the Immunization Advisory Committee.

(d) The Immunization Advisory Committee shall be composed of no more than 21 ~~the following~~ members with knowledge of immunization issues. Members shall serve for terms totaling 6 years for a maximum of 2 terms. On the effective date of this amendatory Act of the 104th General Assembly, existing members and any members appointed after the effective date of this amendatory Act of the 104th General Assembly shall be assigned equally into one of 3 classes. Members of the first class shall vacate their seats after 2 years; the second class shall vacate their seats after 4 years; and the third class shall vacate their seats after 6 years so that one-third of members may be appointed every 2 years. Any members serving on the effective date of this amendatory Act of the 104th General Assembly shall continue as members for whatever remainder of time left for the class they are assigned until the completion of that class's term. Members serving on the effective date of this amendatory Act of the 104th General Assembly may serve 2 terms after their current term expires.

Members of the Immunization Advisory Committee appointed after the effective date of this amendatory Act of the 104th General Assembly shall include: (i) the Medical Director of the Department of Public Health or the Medical Director's delegate, (ii) a representative from an Illinois local health

department, (iii) a certified school nurse or a registered nurse working in a public school, (iv) a public health officer or administrator, (v) a representative of an immunization advocacy organization, (vi) a representative from the State Board of Education, and (vii) licensed health care professionals with knowledge of immunization issues in good standing with the Department of Financial and Professional Regulation, including, but not limited to, a pediatrician, a family physician, an internal medicine physician, an obstetrician-gynecologist, a pharmacist, an academic infectious disease clinician, a public health medical provider, and at least one registered nurse. Physician members must be licensed to practice medicine in all its branches. The Department of Public Health may adopt rules and bylaws, as necessary, on membership eligibility, voting procedures, and other administrative matters for the Immunization Advisory Committee in accordance with the Illinois Administrative Procedure Act and any other applicable laws~~: a pediatrician, a physician licensed to practice medicine in all its branches, a family physician, an infectious disease specialist from a university based center, 2 representatives of a local health department, a registered nurse, a school nurse, a public health provider, a public health officer or administrator, a representative of a children's hospital, 2 representatives of immunization advocacy organizations, a representative from the State Board of Education, a person with expertise in~~

~~bioterrorism issues, and any other individuals or organization representatives designated by the Director~~. The Director shall designate one of the Advisory Committee members with a degree of doctor of medicine or doctor of osteopathy to serve as the Chairperson of the Advisory Committee.

(e) If, in the opinion of the Chairperson of the Immunization Advisory Committee, the Director of Public Health does not adequately consider the recommendations of the Immunization Advisory Committee in issuing the State Guidelines for Communicable Disease Prevention pursuant to Section 1.2 of the Communicable Disease Prevention Act, the Chairperson may call for an override vote. If two-thirds of the Immunization Advisory Committee vote to override the Director's published State Guidelines for Communicable Disease Prevention, the Immunization Advisory Committee may republish recommendations to serve as the State Guidelines for Communicable Disease Prevention. These recommendations shall serve as the State Guidelines for Communicable Disease Prevention for not less than 6 months.

(Source: P.A. 92-561, eff. 6-24-02.)

Section 20. The Illinois Insurance Code is amended by changing Sections 356z.62, 356z.77, and 424 as follows:

(215 ILCS 5/356z.62)

Sec. 356z.62. Coverage of preventive health services.

(a) A policy of group health insurance coverage or individual health insurance coverage as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act shall, at a minimum, provide coverage for and shall not impose any cost-sharing requirements, including a copayment, coinsurance, or deductible, for:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; ~~and~~

(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) of this subsection (a) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph; and ~~.~~

(5) immunizations and medical countermeasures that have in effect a recommendation within the State

Guidelines for Communicable Disease Prevention issued by the Director of Public Health pursuant to Section 1.2 of the Communicable Disease Prevention Act, with respect to the individual involved. For this paragraph, the prohibition on cost-sharing requirements does not apply if and to the extent that the coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to Section 223 of the Internal Revenue Code.

(b) For purposes of this Section, and for purposes of any other provision of State law, recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(c) For office visits:

(1) if an item or service described in subsection (a) is billed separately or is tracked as individual encounter data separately from an office visit, then a policy may impose cost-sharing requirements with respect to the office visit;

(2) if an item or service described in subsection (a) is not billed separately or is not tracked as individual encounter data separately from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a policy may not impose cost-sharing requirements with respect to the office

visit; and

(3) if an item or service described in subsection (a) is not billed separately or is not tracked as individual encounter data separately from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a policy may impose cost-sharing requirements with respect to the office visit.

(d) A policy must provide coverage pursuant to subsection (a) for plan or policy years that begin on or after the date that is one year after the date the recommendation or guideline is issued. If a recommendation or guideline is in effect on the first day of the plan or policy year, or if a recommendation becomes effective for an in-force policy under the circumstances described in subsection (d-5), the policy shall cover the items and services specified in the recommendation or guideline through the last day of the plan or policy year unless either:

(1) a recommendation under paragraph (1) of subsection (a) is downgraded to a "D" rating; or

(2) the item or service is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during the plan or policy year.

(d-5) Notwithstanding subsection (d), a policy, including an in-force policy, must provide coverage pursuant to

paragraph (5) of subsection (a) within 15 business days after the date the State Guidelines for Communicable Disease Prevention are issued if the Guidelines reinstate any recommendation or portion thereof under paragraph (2) of subsection (a) that the Advisory Committee on Immunization Practices has reduced or withdrawn.

(e) Network limitations.

(1) Subject to paragraph (3) of this subsection, nothing in this Section requires coverage for items or services described in subsection (a) that are delivered by an out-of-network provider under a health maintenance organization health care plan, other than a point-of-service contract, or under a voluntary health services plan that generally excludes coverage for out-of-network services except as otherwise required by law.

(2) Subject to paragraph (3) of this subsection, nothing in this Section precludes a policy with a preferred provider program under Article XX-1/2 of this Code, a health maintenance organization point-of-service contract, or a similarly designed voluntary health services plan from imposing cost-sharing requirements for items or services described in subsection (a) that are delivered by an out-of-network provider.

(3) If a policy does not have in its network a provider who can provide an item or service described in subsection

(a), then the policy must cover the item or service when performed by an out-of-network provider and it may not impose cost-sharing with respect to the item or service.

(f) Nothing in this Section prevents a company from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in subsection (a) to the extent not specified in the recommendation or guideline.

(g) Nothing in this Section shall be construed to prohibit a policy from providing coverage for items or services in addition to those required under subsection (a) or from denying coverage for items or services that are not required under subsection (a). Unless prohibited by other law, a policy may impose cost-sharing requirements for a treatment not described in subsection (a) even if the treatment results from an item or service described in subsection (a). Nothing in this Section shall be construed to limit coverage requirements provided under other law.

(h) The Director may develop guidelines to permit a company to utilize value-based insurance designs. In the absence of guidelines developed by the Director, any such guidelines developed by the Secretary of the U.S. Department of Health and Human Services that are in force under 42 U.S.C. 300gg-13 shall apply.

(i) For student health insurance coverage as defined at 45 CFR 147.145, student administrative health fees are not

considered cost-sharing requirements with respect to preventive services specified under subsection (a). As used in this subsection, "student administrative health fee" means a fee charged by an institution of higher education on a periodic basis to its students to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health insurance coverage.

(j) For any recommendation or guideline specifically referring to women or men, a company shall not deny or limit the coverage required or a claim made under subsection (a) based solely on the individual's recorded sex or actual or perceived gender identity, or for the reason that the individual is gender nonconforming, intersex, transgender, or has undergone, or is in the process of undergoing, gender transition, if, notwithstanding the sex or gender assigned at birth, the covered individual meets the conditions for the recommendation or guideline at the time the item or service is furnished.

(k) This Section does not apply to grandfathered health plans, excepted benefits, or short-term, limited-duration health insurance coverage.

(Source: P.A. 103-551, eff. 8-11-23.)

(215 ILCS 5/356z.77)

Sec. 356z.77 ~~356z.71~~. Coverage of vaccination

administration fees.

(a) A group or individual policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after January 1, 2026 shall provide coverage for vaccinations for COVID-19, influenza, and respiratory syncytial virus, including the administration of the vaccine by a pharmacist or health care provider authorized to administer such a vaccine, without imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement, if the following conditions are met:

(1) the vaccine is authorized or licensed by the United States Food and Drug Administration; and

(2) the vaccine is ordered and administered according to the State Guidelines for Communicable Disease Prevention issued by the Director of Public Health pursuant to Section 1.2 of the Communicable Disease Prevention Act or the Advisory Committee on Immunization Practices standard immunization schedule.

(b) If the vaccinations provided for in subsection (a) are not otherwise available to be administered by a contracted pharmacist or health care provider, the group or individual policy of accident and health insurance or a managed care plan shall cover the vaccination, including administration fees, without imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement.

(c) The coverage required in this Section does not apply

to the extent that the coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to Section 223 of the Internal Revenue Code of 1986.

(Source: P.A. 103-918, eff. 1-1-25; revised 12-3-24.)

(215 ILCS 5/424) (from Ch. 73, par. 1031)

(Text of Section before amendment by P.A. 104-55)

Sec. 424. Unfair methods of competition and unfair or deceptive acts or practices defined. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) The commission by any person of any one or more of the acts defined or prohibited by Sections 134, 143.24c, 147, 148, 149, 151, 155.22, 155.22a, 155.42, 236, 237, 364, 469, and 513b1 of this Code.

(2) Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(3) Making or permitting, in the case of insurance of the types enumerated in Classes 1, 2, and 3 of Section 4, any unfair discrimination between individuals or risks of the same class or of essentially the same hazard and expense element because of the race, color, religion, or

national origin of such insurance risks or applicants. The application of this Article to the types of insurance enumerated in Class 1 of Section 4 shall in no way limit, reduce, or impair the protections and remedies already provided for by Sections 236 and 364 of this Code or any other provision of this Code.

(4) Engaging in any of the acts or practices defined in or prohibited by Sections 154.5 through 154.8 of this Code.

(5) Making or charging any rate for insurance against losses arising from the use or ownership of a motor vehicle which requires a higher premium of any person by reason of his physical disability, race, color, religion, or national origin.

(6) Failing to meet any requirement of the Unclaimed Life Insurance Benefits Act with such frequency as to constitute a general business practice.

(Source: P.A. 102-778, eff. 7-1-22.)

(Text of Section after amendment by P.A. 104-55)

Sec. 424. Unfair methods of competition and unfair or deceptive acts or practices defined. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) The commission by any person of any one or more of the acts defined or prohibited by Sections 134, 143.24c,

147, 148, 149, 151, 155.22, 155.22a, 155.42, 236, 237, 364, 469, and 513b1 of this Code.

(2) Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(3) Making or permitting, in the case of insurance of the types enumerated in Classes 1, 2, and 3 of Section 4, any unfair discrimination between individuals or risks of the same class or of essentially the same hazard and expense element because of the race, color, religion, or national origin of such insurance risks or applicants. The application of this Article to the types of insurance enumerated in Class 1 of Section 4 shall in no way limit, reduce, or impair the protections and remedies already provided for by Sections 236 and 364 of this Code or any other provision of this Code.

(4) Engaging in any of the acts or practices defined in or prohibited by Sections 154.5 through 154.8 of this Code.

(5) Making or charging any rate for insurance against losses arising from the use or ownership of a motor vehicle which requires a higher premium of any person by reason of his physical disability, race, color, religion, or national origin.

(6) Failing to meet any requirement of the Unclaimed Life Insurance Benefits Act with such frequency as to constitute a general business practice.

(7) Soliciting either an individual who is a resident of a nursing home or long-term care facility or an individual who is over the age of 65, as described in paragraph (8) of this Section, to purchase accident or health insurance, unless the person who is selling the insurance:

(A) advises the potential enrollee of the benefit of examining the potential enrollee's current insurance plan, discusses all proposed insurance-related changes with a family member, friend, or other advisor of the potential enrollee, and then waits 48 hours before making any insurance-related changes concerning the potential enrollee;

(B) provides a phone number that may be called if the potential enrollee or the potential enrollee's family members, friends, or other advisors have any questions; and

(C) allows the potential enrollee to opt out of any future communications with the person.

(8) Entering into or amending an accident or health insurance policy with an individual who is over the age of 65 and who has executed a health care power of attorney or

has a medical condition, such as dementia, that reduces the person's capacity to make informed decisions independently, unless the potential enrollee's agent under a health care power of attorney executes the agreement and the agreement is reduced to writing.

(Source: P.A. 104-55, eff. 1-1-26.)

Section 25. The Illinois Insurance Code is amended by changing Section 513b1, 513b1.1, and 513b2 as follows:

(215 ILCS 5/513b1)

(Text of Section before amendment by P.A. 104-27)

Sec. 513b1. Pharmacy benefit manager contracts.

(a) As used in this Article ~~Section~~:

"340B drug discount program" means the program established under Section 340B of the federal Public Health Service Act, 42 U.S.C. 256b.

"340B entity" means a covered entity as defined in 42 U.S.C. 256b(a)(4) authorized to participate in the 340B drug discount program.

"340B pharmacy" means any pharmacy used to dispense 340B drugs for a covered entity, whether entity-owned or external.

"Affiliate" means a person or entity that directly or indirectly through one or more intermediaries controls or is controlled by, or is under common control with, the person or entity specified. The location of a person or entity's

domicile, whether in Illinois or a foreign or alien jurisdiction, does not affect the person or entity's status as an affiliate.

"Biological product" has the meaning ascribed to that term in Section 19.5 of the Pharmacy Practice Act.

"Brand name drug" means a drug that has been approved under 42 U.S.C. 262 or 21 U.S.C. 355(c), as applicable, and is marketed, sold, or distributed under a proprietary, trademark-protected name.

"Complex or chronic medical condition" means a physical, behavioral, or developmental condition that has no known cure, is progressive, or can be debilitating or fatal if unmanaged or untreated.

"Covered individual" means a member, participant, enrollee, contract holder, policyholder, or beneficiary of a health benefit plan who is provided a drug benefit by the health benefit plan.

"Critical access pharmacy" means a critical access care pharmacy as defined in Section 5-5.12b of the Illinois Public Aid Code.

"Drugs" has the meaning ascribed to that term in Section 3 of the Pharmacy Practice Act and includes biological products.

"Employee welfare benefit plan" has the meaning given to that term in 29 U.S.C. 1002(1), without regard for whether the employee welfare benefit plan is covered under 29 U.S.C. 1003.

"Federal governmental plan" has the meaning given to that

term in 42 U.S.C. 300gg-91(d)(8)(B).

"Generic drug" means a drug that has been approved under 42 U.S.C. 262 or 21 U.S.C. 355(c), as applicable, and is marketed, sold, or distributed directly or indirectly to the retail class of trade with labeling, packaging (other than repackaging as the listed drug in blister packs, unit doses, or similar packaging for use in institutions), product code, labeler code, trade name, or trademark that differs from that of the brand name drug.

"Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of physical, mental, or behavioral health care services. Notwithstanding Sections 122-1 through 122-4 of this Code, "health benefit plan" includes self-funded employee welfare benefit plans except for self-funded multiemployer plans that are not nonfederal government plans.

"Health benefit plan" does not include:

(1) workers compensation insurance, a federal governmental plan, Medicare Advantage, Medicare Part D, a Medicare demonstration program, or Tricare; or

(2) any program for dually eligible Medicare-Medicaid beneficiaries enrolled in a program under which Medicare pays for most or all of the covered drugs.

"Health benefit plan sponsor" or "plan sponsor" means:

(1) a plan sponsor, as defined in 29 U.S.C.

1002(16)(B), without regard for whether the employee welfare benefit plan is covered under 29 U.S.C. 1003. Except as provided by subsection (m), "plan sponsor" includes the plan sponsor of a nonfederal governmental plan, including a joint insurance pool described in Section 6 of the Intergovernmental Cooperation Act; and

(2) any other governmental unit or public agency to which any State law grants the rights of a plan sponsor when incorporating this Article by reference.

"Maximum allowable cost" means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a drug.

"Maximum allowable cost list" means a list of drugs for which a maximum allowable cost has been established by a pharmacy benefit manager.

"Multiemployer plan" has the meaning given to that term in 29 U.S.C. 1002(37).

"Nonfederal governmental plan" has the meaning given to that term in 42 U.S.C. 300gg-91(d)(8)(C).

"Pharmacy benefit manager" means a person, business, or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other ~~prescription~~ drug or device services, or both, for health benefit plans.

"Pharmacy" has the meaning given to that term in Section 3 of the Pharmacy Practice Act.

"Pharmacy services" means the provision of any services listed within the definition of "practice of pharmacy" under subsection (d) of Section 3 of the Pharmacy Practice Act.

"Rare medical condition" means a physical, behavioral, or developmental condition that affects fewer than 200,000 individuals in the United States or approximately 1 in 1,500 individuals worldwide.

"Rebate" means a discount or pricing concession based on drug utilization or administration that is paid by the manufacturer to a pharmacy benefit manager or its client.

"Rebate aggregator" means a person or entity, including group purchasing organizations, that negotiate rebates or other fees with drug manufacturers on behalf or for the benefit of a pharmacy benefit manager or its client and may also be involved in contracts that entitle the rebate aggregator or its client to receive rebates or other fees from drug manufacturers based on drug utilization or administration.

"Retail price" means the price an individual without ~~prescription~~ drug coverage would pay at a retail pharmacy, not including a pharmacist dispensing fee.

"Specialty drug" means a drug that:

(1) is prescribed for a person with a complex or chronic medical condition or a rare medical condition;

(2) has limited or exclusive distribution; and

(3) requires both:

(A) specialized product handling by the dispensing pharmacy or administration by the dispensing pharmacy; and

(B) specialized clinical care, including frequent dosing adjustments, intensive clinical monitoring, or expanded services for patients, including intensive patient counseling, education, or ongoing clinical support beyond traditional dispensing activities, such as individualized disease and therapy management to support improved health outcomes.

"Spread pricing" means the model of drug pricing in which the pharmacy benefit manager charges a health benefit plan a contracted price for drugs, and the contracted price for the drugs differs from the amount the pharmacy benefit manager directly or indirectly pays the pharmacist or pharmacy for the drugs, pharmacist services, or drug and dispensing fees.

"Steer" includes, but is not limited to:

(1) requiring a covered individual to only use a pharmacy, including a mail-order or specialty pharmacy, in which the pharmacy benefit manager or its affiliate, or an insurer or its affiliate, maintains an ownership interest or control;

(2) offering or implementing a plan design that encourages a covered individual to only use a pharmacy in which the pharmacy benefit manager or an affiliate, or an insurer or its affiliate, maintains an ownership interest

or control, if the plan design increases costs for the covered individual. This includes a plan design that requires a covered individual to pay higher costs or an increased share of costs for a drug or drug-related service if the covered individual uses a pharmacy that is not owned or controlled by the pharmacy benefit manager or its affiliate or an insurer or its affiliate; and

(3) reimbursing a pharmacy or pharmacist for a drug and pharmacist service in an amount less than the amount that the pharmacy benefit manager or an insurer reimburses itself or an affiliate, including affiliated manufacturers or joint ventures for providing the same drug or service.

"Third-party payer" means any entity that pays for ~~prescription~~ drugs on behalf of a patient other than a health care provider or sponsor of a plan subject to regulation under Medicare Part D, 42 U.S.C. 1395w-101 et seq.

The changes made to this subsection by this amendatory Act of the 104th General Assembly shall be deemed to be operative on and after July 1, 2025.

(a-5) In this Article, references to an "insurer" or "health insurer" shall include commercial private health insurance issuers, managed care organizations, managed care community networks, and any other third-party payer that contracts with pharmacy benefit managers or with the Department of Healthcare and Family Services to provide benefits or services under the Medicaid program or to

otherwise engage in the administration or payment of pharmacy benefits. However, the terms do not refer to the plan sponsor of a self-funded, single-employer employee welfare benefit plan or self-funded multiemployer plan if either plan is covered by 29 U.S.C. 1003. This subsection shall be deemed to be operative on and after July 1, 2025.

(b) A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager:

(1) Update maximum allowable cost pricing information at least every 7 calendar days.

(2) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(3) Provide access to its maximum allowable cost list to each pharmacy or pharmacy services administrative organization subject to the maximum allowable cost list. Access may include a real-time pharmacy website portal to be able to view the maximum allowable cost list. As used in this Section, "pharmacy services administrative organization" means an entity operating within the State that contracts with independent pharmacies to conduct business on their behalf with third-party payers. A pharmacy services administrative organization may provide

administrative services to pharmacies and negotiate and enter into contracts with third-party payers or pharmacy benefit managers on behalf of pharmacies.

(4) Provide a process by which a contracted pharmacy can appeal the provider's reimbursement for a drug subject to maximum allowable cost pricing. The appeals process must, at a minimum, include the following:

(A) A requirement that a contracted pharmacy has 14 calendar days after the applicable fill date to appeal a maximum allowable cost if the reimbursement for the drug is less than the net amount that the network provider paid to the supplier of the drug.

(B) A requirement that a pharmacy benefit manager must respond to a challenge within 14 calendar days of the contracted pharmacy making the claim for which the appeal has been submitted.

(C) A telephone number and e-mail address or website to network providers, at which the provider can contact the pharmacy benefit manager to process and submit an appeal.

(D) A requirement that, if an appeal is denied, the pharmacy benefit manager must provide the reason for the denial and the name and the national drug code number from national or regional wholesalers.

(E) A requirement that, if an appeal is sustained, the pharmacy benefit manager must make an adjustment

in the drug price effective the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the managed care organization or pharmacy benefit manager.

(5) Allow a plan sponsor contracting with a pharmacy benefit manager an annual right to audit compliance with the terms of the contract by the pharmacy benefit manager, including, but not limited to, full disclosure of any and all rebate amounts secured, whether product specific or generalized rebates, that were provided to the pharmacy benefit manager by a pharmaceutical manufacturer.

(6) Allow a plan sponsor contracting with a pharmacy benefit manager to request that the pharmacy benefit manager disclose the actual amounts paid by the pharmacy benefit manager to the pharmacy.

(7) Provide notice to the party contracting with the pharmacy benefit manager of any consideration that the pharmacy benefit manager receives from the manufacturer for dispense as written prescriptions once a generic or biologically similar product becomes available.

(c) In order to place a particular prescription drug on a maximum allowable cost list, the pharmacy benefit manager must, at a minimum, ensure that:

(1) if the drug is a generically equivalent drug, it is listed as therapeutically equivalent and

pharmaceutically equivalent "A" or "B" rated in the United States Food and Drug Administration's most recent version of the "Orange Book" or have an NR or NA rating by Medi-Span, Gold Standard, or a similar rating by a nationally recognized reference;

(2) the drug is available for purchase by each pharmacy in the State from national or regional wholesalers operating in Illinois; and

(3) the drug is not obsolete.

(d) A pharmacy benefit manager is prohibited from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, if one is available in accordance with Section 42 of the Pharmacy Practice Act.

(e) A health insurer or pharmacy benefit manager shall not require an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(1) the applicable cost-sharing amount; or

(2) the retail price of the drug in the absence of prescription drug coverage.

(f) Unless required by law, a contract between a pharmacy benefit manager or third-party payer and a 340B entity or 340B pharmacy shall not contain any provision that:

(1) distinguishes between drugs purchased through the 340B drug discount program and other drugs when

determining reimbursement or reimbursement methodologies, or contains otherwise less favorable payment terms or reimbursement methodologies for 340B entities or 340B pharmacies when compared to similarly situated non-340B entities;

(2) imposes any fee, chargeback, or rate adjustment that is not similarly imposed on similarly situated pharmacies that are not 340B entities or 340B pharmacies;

(3) imposes any fee, chargeback, or rate adjustment that exceeds the fee, chargeback, or rate adjustment that is not similarly imposed on similarly situated pharmacies that are not 340B entities or 340B pharmacies;

(4) prevents or interferes with an individual's choice to receive a covered prescription drug from a 340B entity or 340B pharmacy through any legally permissible means, except that nothing in this paragraph shall prohibit the establishment of differing copayments or other cost-sharing amounts within the benefit plan for covered persons who acquire covered prescription drugs from a nonpreferred or nonparticipating provider;

(5) excludes a 340B entity or 340B pharmacy from a pharmacy network on any basis that includes consideration of whether the 340B entity or 340B pharmacy participates in the 340B drug discount program;

(6) prevents a 340B entity or 340B pharmacy from using a drug purchased under the 340B drug discount program; or

(7) any other provision that discriminates against a 340B entity or 340B pharmacy by treating the 340B entity or 340B pharmacy differently than non-340B entities or non-340B pharmacies for any reason relating to the entity's participation in the 340B drug discount program.

As used in this subsection, "pharmacy benefit manager" and "third-party payer" do not include pharmacy benefit managers and third-party payers acting on behalf of a Medicaid program.

(g) A violation of this Section by a pharmacy benefit manager constitutes an unfair or deceptive act or practice in the business of insurance under Section 424.

(h) A provision that violates subsection (f) in a contract between a pharmacy benefit manager or a third-party payer and a 340B entity that is entered into, amended, or renewed after July 1, 2022 shall be void and unenforceable.

(i)(1) A pharmacy benefit manager may not retaliate against a pharmacist or pharmacy for disclosing information in a court, in an administrative hearing, before a legislative commission or committee, or in any other proceeding, if the pharmacist or pharmacy has reasonable cause to believe that the disclosed information is evidence of a violation of a State or federal law, rule, or regulation.

(2) A pharmacy benefit manager may not retaliate against a pharmacist or pharmacy for disclosing information to a government or law enforcement agency, if the pharmacist or pharmacy has reasonable cause to believe that the disclosed

information is evidence of a violation of a State or federal law, rule, or regulation.

(3) A pharmacist or pharmacy shall make commercially reasonable efforts to limit the disclosure of confidential and proprietary information.

(4) Retaliatory actions against a pharmacy or pharmacist include cancellation of, restriction of, or refusal to renew or offer a contract to a pharmacy solely because the pharmacy or pharmacist has:

(A) made disclosures of information that the pharmacist or pharmacy has reasonable cause to believe is evidence of a violation of a State or federal law, rule, or regulation;

(B) filed complaints with the plan or pharmacy benefit manager; or

(C) filed complaints against the plan or pharmacy benefit manager with the Department.

(j) This Section applies to contracts entered into or renewed on or after July 1, 2022.

(k) This Section applies to any group or individual policy of accident and health insurance or managed care plan that provides coverage for prescription drugs and that is amended, delivered, issued, or renewed on or after July 1, 2020.

(m) This Article applies in relation to plan sponsors of self-funded nonfederal governmental plans only when a State law organizing the governmental unit incorporates this Article

by reference. Nothing shall be construed to exclude a joint self-insurance pool created under Section 6 of the Intergovernmental Cooperation Act from references to a plan sponsor if any pool member's organizing State law incorporates this Article by reference, but a pharmacy benefit manager is not subject to the requirements of this Article in relation to any pool member whose organizing State law does not incorporate this Article. This subsection shall be deemed to be operative on and after July 1, 2025.

(n) Regardless of whether a health benefit plan is insurance, the applicability of this Article to a health benefit plan shall be determined in the same manner as the determination of whether a person is transacting insurance in this State under Sections 121-2.03, 121-2.04, and 121-2.05 and subsections (a), (c), and (e) of Section 121-3. For any health benefit plan subject to this Article, unless specifically provided otherwise, this Article applies to all covered individuals under the health benefit plan, regardless of the individual's residence. The exemption for group accident and health insurance described in subsection (c) of Section 352, as implemented by Department regulation, extends in the same manner to all other health benefit plans with respect to the requirements of this Article. This subsection shall be deemed to be operative on and after July 1, 2025.

(Source: P.A. 102-778, eff. 7-1-22; 103-154, eff. 6-30-23; 103-453, eff. 8-4-23.)

(Text of Section after amendment by P.A. 104-27)

Sec. 513b1. Pharmacy benefit manager contracts.

(a) As used in this Article ~~Section~~:

"340B drug discount program" means the program established under Section 340B of the federal Public Health Service Act, 42 U.S.C. 256b.

"340B entity" means a covered entity as defined in 42 U.S.C. 256b(a)(4) authorized to participate in the 340B drug discount program.

"340B pharmacy" means any pharmacy used to dispense 340B drugs for a covered entity, whether entity-owned or external.

"Affiliate" means a person or entity that directly or indirectly through one or more intermediaries controls or is controlled by, or is under common control with, the person or entity specified. The location of a person or entity's domicile, whether in Illinois or a foreign or alien jurisdiction, does not affect the person or entity's status as an affiliate.

"Biological product" has the meaning ascribed to that term in Section 19.5 of the Pharmacy Practice Act.

"Brand name drug" means a drug that has been approved under 42 U.S.C. 262 or 21 U.S.C. 355(c), as applicable, and is marketed, sold, or distributed under a proprietary, trademark-protected name.

"Complex or chronic medical condition" means a physical,

behavioral, or developmental condition that has no known cure, is progressive, or can be debilitating or fatal if unmanaged or untreated.

"Covered individual" means a member, participant, enrollee, contract holder, policyholder, or beneficiary of a health benefit plan who is provided a drug benefit by the health benefit plan.

"Critical access pharmacy" means a critical access care pharmacy as defined in Section 5-5.12b of the Illinois Public Aid Code.

"Drugs" has the meaning ascribed to that term in Section 3 of the Pharmacy Practice Act and includes biological products.

"Employee welfare benefit plan" has the meaning given to that term in 29 U.S.C. 1002(1), without regard for whether the employee welfare benefit plan is covered under 29 U.S.C. 1003.

"Federal governmental plan" has the meaning given to that term in 42 U.S.C. 300gg-91(d)(8)(B).

"Generic drug" means a drug that has been approved under 42 U.S.C. 262 or 21 U.S.C. 355(c), as applicable, and is marketed, sold, or distributed directly or indirectly to the retail class of trade with labeling, packaging (other than repackaging as the listed drug in blister packs, unit doses, or similar packaging for use in institutions), product code, labeler code, trade name, or trademark that differs from that of the brand name drug.

"Health benefit plan" means a policy, contract,

certificate, or agreement entered into, offered, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of physical, mental, or behavioral health care services. ~~Notwithstanding Sections 122-1 through 122-4 of this Code, "health benefit plan" includes self-funded employee welfare benefit plans.~~ Notwithstanding Sections 122-1 through 122-4 of this Code, "health benefit plan" includes self-funded employee welfare benefit plans except for self-funded multiemployer plans that are not nonfederal government plans. "Health benefit plan" does not include:

(1) workers compensation insurance, a federal governmental plan, Medicare Advantage, Medicare Part D, a Medicare demonstration program, or Tricare; or

(2) any program for dually eligible Medicare-Medicaid beneficiaries enrolled in a program under which Medicare pays for most or all of the covered drugs.

"Health benefit plan sponsor" or "plan sponsor" means:

(1) a plan sponsor, as defined in 29 U.S.C. 1002(16)(B), without regard for whether the employee welfare benefit plan is covered under 29 U.S.C. 1003. Except as provided by subsection (m), "plan sponsor" includes the plan sponsor of a nonfederal governmental plan, including a joint insurance pool described in Section 6 of the Intergovernmental Cooperation Act; and

(2) any other governmental unit or public agency to which any State law grants the rights of a plan sponsor

when incorporating this Article by reference.

"Maximum allowable cost" means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a drug.

"Maximum allowable cost list" means a list of drugs for which a maximum allowable cost has been established by a pharmacy benefit manager.

"Multiemployer plan" has the meaning given to that term in 29 U.S.C. 1002(37).

"Nonfederal governmental plan" has the meaning given to that term in 42 U.S.C. 300gg-91(d)(8)(C).

"Pharmacy benefit manager" means a person, business, or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other drug or device services, or both, for health benefit plans.

"Pharmacy" has the meaning given to that term in Section 3 of the Pharmacy Practice Act.

"Pharmacy services" means the provision of any services listed within the definition of "practice of pharmacy" under subsection (d) of Section 3 of the Pharmacy Practice Act.

"Rare medical condition" means a physical, behavioral, or developmental condition that affects fewer than 200,000 individuals in the United States or approximately 1 in 1,500 individuals worldwide.

"Rebate" means a discount or pricing concession based on

drug utilization or administration that is paid by the manufacturer to a pharmacy benefit manager or its client.

"Rebate aggregator" means a person or entity, including group purchasing organizations, that negotiate rebates or other fees with drug manufacturers on behalf or for the benefit of a pharmacy benefit manager or its client and may also be involved in contracts that entitle the rebate aggregator or its client to receive rebates or other fees from drug manufacturers based on drug utilization or administration.

"Retail price" means the price an individual without drug coverage would pay at a retail pharmacy, not including a pharmacist dispensing fee.

"Specialty drug" means a drug that:

(1) is prescribed for a person with a complex or chronic medical condition or a rare medical condition;

(2) has limited or exclusive distribution; and

(3) requires both:

(A) specialized product handling by the dispensing pharmacy or administration by the dispensing pharmacy; and

(B) specialized clinical care, including frequent dosing adjustments, intensive clinical monitoring, or expanded services for patients, including intensive patient counseling, education, or ongoing clinical support beyond traditional dispensing activities, such

as individualized disease and therapy management to support improved health outcomes.

"Spread pricing" means the model of drug pricing in which the pharmacy benefit manager charges a health benefit plan a contracted price for drugs, and the contracted price for the drugs differs from the amount the pharmacy benefit manager directly or indirectly pays the pharmacist or pharmacy for the drugs, pharmacist services, or drug and dispensing fees.

"Steer" includes, but is not limited to:

(1) requiring a covered individual to only use a pharmacy, including a mail-order or specialty pharmacy, in which the pharmacy benefit manager or its affiliate, or an insurer or its affiliate, maintains an ownership interest or control;

(2) offering or implementing a plan design that encourages a covered individual to only use a pharmacy in which the pharmacy benefit manager or an affiliate, or an insurer or its affiliate, maintains an ownership interest or control, if the plan design increases costs for the covered individual. This includes a plan design that requires a covered individual to pay higher costs or an increased share of costs for a drug or drug-related service if the covered individual uses a pharmacy that is not owned or controlled by the pharmacy benefit manager or its affiliate or an insurer or its affiliate; and.

(3) reimbursing a pharmacy or pharmacist for a drug

and pharmacist service in an amount less than the amount that the pharmacy benefit manager or an insurer reimburses itself or an affiliate, including affiliated manufacturers or joint ventures for providing the same drug or service.

"Third-party payer" means any entity that pays for drugs on behalf of a patient other than a health care provider or sponsor of a plan subject to regulation under Medicare Part D, 42 U.S.C. 1395w-101 et seq.

The changes made to this subsection by this amendatory Act of the 104th General Assembly shall be deemed to be operative on and after July 1, 2025.

(a-5) In this Article, references to an "insurer" or "health insurer" shall include commercial private health insurance issuers, managed care organizations, managed care community networks, and any other third-party payer that contracts with pharmacy benefit managers or with the Department of Healthcare and Family Services to provide benefits or services under the Medicaid program or to otherwise engage in the administration or payment of pharmacy benefits. However, the terms do not refer to the plan sponsor of a self-funded, single-employer employee welfare benefit plan or self-funded multiemployer plan if either plan is covered by 29 U.S.C. 1003 ~~subject to 29 U.S.C. 1144~~. This subsection shall be deemed to be operative on and after July 1, 2025.

(b) A contract between a health insurer or plan sponsor

and a pharmacy benefit manager must require that the pharmacy benefit manager:

(1) Update maximum allowable cost pricing information at least every 7 calendar days.

(2) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(3) Provide access to its maximum allowable cost list to each pharmacy or pharmacy services administrative organization subject to the maximum allowable cost list. Access may include a real-time pharmacy website portal to be able to view the maximum allowable cost list. As used in this Section, "pharmacy services administrative organization" means an entity operating within the State that contracts with independent pharmacies to conduct business on their behalf with third-party payers. A pharmacy services administrative organization may provide administrative services to pharmacies and negotiate and enter into contracts with third-party payers or pharmacy benefit managers on behalf of pharmacies.

(4) Provide a process by which a contracted pharmacy can appeal the provider's reimbursement for a drug subject to maximum allowable cost pricing. The appeals process must, at a minimum, include the following:

(A) A requirement that a contracted pharmacy has 14 calendar days after the applicable fill date to appeal a maximum allowable cost if the reimbursement for the drug is less than the net amount that the network provider paid to the supplier of the drug.

(B) A requirement that a pharmacy benefit manager must respond to a challenge within 14 calendar days of the contracted pharmacy making the claim for which the appeal has been submitted.

(C) A telephone number and e-mail address or website to network providers, at which the provider can contact the pharmacy benefit manager to process and submit an appeal.

(D) A requirement that, if an appeal is denied, the pharmacy benefit manager must provide the reason for the denial and the name and the national drug code number from national or regional wholesalers.

(E) A requirement that, if an appeal is sustained, the pharmacy benefit manager must make an adjustment in the drug price effective the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the managed care organization or pharmacy benefit manager.

(5) Allow a plan sponsor or insurer whose coverage is administered by the pharmacy benefit manager an annual

right to audit compliance with the terms of the contract by the pharmacy benefit manager, including, but not limited to, full disclosure of any and all rebate amounts secured, whether product specific or generalized rebates, that were provided to the pharmacy benefit manager by a pharmaceutical manufacturer. The cost of the audit shall be borne exclusively by the pharmacy benefit manager.

(6) Allow a plan sponsor or insurer whose coverage is administered by the pharmacy benefit manager to request that the pharmacy benefit manager disclose the actual amounts paid by the pharmacy benefit manager to the pharmacy.

(7) Provide notice to the plan sponsor or the insurer party contracting with the pharmacy benefit manager of any consideration that the pharmacy benefit manager receives from the manufacturer for dispense as written once a generic or biologically similar product becomes available.

(c) In order to place a particular drug on a maximum allowable cost list, the pharmacy benefit manager <u>described in subsection (b)</u> must, at a minimum, ensure that:

(1) if the drug is a generically equivalent drug, it is listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the United States Food and Drug Administration's most recent version of the "Orange Book" or have an NR or NA rating by Medi-Span, Gold Standard, or a similar rating by a

nationally recognized reference;

(2) the drug is available for purchase by each pharmacy in the State from national or regional wholesalers operating in Illinois; and

(3) the drug is not obsolete.

(d) A pharmacy benefit manager <u>or an insurer</u> is prohibited from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered drug, and the availability of a more affordable alternative drug, if one is available in accordance with Section 42 of the Pharmacy Practice Act.

(e) A health insurer or pharmacy benefit manager shall not require a covered individual to make a payment for a drug at the point of sale in an amount that exceeds the lesser of:

(1) the applicable cost-sharing amount;

(2) the retail price of the drug in the absence of drug coverage;

(3) the discounted price presented by the covered individual through a no-cost drug program or drug manufacturer voucher provided by or for the covered individual at the point of sale; or

(4) the discounted price presented by the covered individual through a discounted health care services plan provided by or for the covered individual at the point of sale.

<u>This subsection applies to any covered individual of a</u>

health benefit plan from an insurer, a nonfederal governmental plan sponsor, or any other governmental unit or public agency to which any State law grants the rights of a plan sponsor when incorporating this Article by reference.

(f) Unless required by law, a contract between a pharmacy benefit manager or third-party payer and a 340B entity or 340B pharmacy shall not contain any provision that:

(1) distinguishes between drugs purchased through the 340B drug discount program and other drugs when determining reimbursement or reimbursement methodologies, or contains otherwise less favorable payment terms or reimbursement methodologies for 340B entities or 340B pharmacies when compared to similarly situated non-340B entities;

(2) imposes any fee, chargeback, or rate adjustment that is not similarly imposed on similarly situated pharmacies that are not 340B entities or 340B pharmacies;

(3) imposes any fee, chargeback, or rate adjustment that exceeds the fee, chargeback, or rate adjustment that is not similarly imposed on similarly situated pharmacies that are not 340B entities or 340B pharmacies;

(4) prevents or interferes with an individual's choice to receive a covered drug from a 340B entity or 340B pharmacy through any legally permissible means, except that nothing in this paragraph shall prohibit the establishment of differing copayments or other

cost-sharing amounts within the health benefit plan for covered individuals who acquire covered drugs from a nonpreferred or nonparticipating provider;

(5) excludes a 340B entity or 340B pharmacy from a pharmacy network on any basis that includes consideration of whether the 340B entity or 340B pharmacy participates in the 340B drug discount program;

(6) prevents a 340B entity or 340B pharmacy from using a drug purchased under the 340B drug discount program; or

(7) any other provision that discriminates against a 340B entity or 340B pharmacy by treating the 340B entity or 340B pharmacy differently than non-340B entities or non-340B pharmacies for any reason relating to the entity's participation in the 340B drug discount program.

As used in this subsection, "pharmacy benefit manager" and "third-party payer" do not include pharmacy benefit managers and third-party payers acting on behalf of a Medicaid program.

(f-5) A pharmacy benefit manager or an affiliate acting on its behalf shall not conduct spread pricing.

(f-10) A pharmacy benefit manager or an affiliate acting on its behalf shall not steer a covered individual. <u>This prohibition also applies to an insurer and its affiliates.</u> Existing agreements entered into before the effective date of this amendatory Act of the 104th General Assembly shall supersede this subsection until the termination of the current term of such agreement.

(f-15) A pharmacy benefit manager or affiliated rebate aggregator must remit no less than 100% of any amounts paid by a pharmaceutical manufacturer, wholesaler, or other distributor of a drug, including, but not limited to, rebates, group purchasing fees, and other fees, to the health benefit plan sponsor, covered individual, or employer. Records of rebates and fees remitted from the pharmacy benefit manager or rebate aggregator must be disclosed to the Department annually in a format to be specified by the Department. The records received by the Department shall be considered confidential and privileged for all purposes, including for purposes of the Freedom of Information Act, shall not be subject to subpoena from any private party, and shall not be admissible as evidence in a civil action.

(f-20) A pharmacy benefit manager or an affiliate acting on its behalf is prohibited from limiting a covered individual's access to drugs from a pharmacy or pharmacist enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage area by designating the covered drug as a specialty drug contrary to the definition in this Section. <u>This prohibition also applies to an insurer and its affiliates.</u>

(f-25) The contract between the pharmacy benefit manager and the insurer or health benefit plan sponsor must allow and provide for the pharmacy benefit manager's compliance with an audit at least once per calendar year of the rebate and fee

records remitted from a pharmacy benefit manager or its affiliated party to a health benefit plan. This audit may be incorporated into the audit under paragraph (5) of subsection (b) of this Section. Contracts with rebate aggregators, pharmacy services administrative organizations, pharmacies, or drug manufacturers must be available for audit by health benefit plan sponsors, insurers, or their designees at least once per plan year. Audits shall be performed by an auditor selected by the health benefit plan sponsor, insurer, or its designee. Health benefit plan sponsors and insurers shall give the pharmacy benefit manager a complete copy of the audit and the pharmacy benefit manager shall provide a complete copy of those findings to the Department within 60 days of initial receipt. Rebate contracts with rebate aggregators, pharmacy services administrative organizations, pharmacies, or drug manufacturers shall be available for audit by health benefit plan sponsor, insurer, or designee. Nothing in this Section shall limit the Department's ability to access the books and records and any and all copies thereof of pharmacy benefit managers, their affiliates, or affiliated rebate aggregators. The records received by the Department shall be considered confidential and privileged for all purposes, including for purposes of the Freedom of Information Act, shall not be subject to subpoena from any private party, and shall not be admissible as evidence in a civil action.

(g) A violation of this Section by a pharmacy benefit

manager constitutes an unfair or deceptive act or practice in the business of insurance under Section 424.

(h) A provision that violates subsection (f) in a contract between a pharmacy benefit manager or a third-party payer and a 340B entity that is entered into, amended, or renewed after July 1, 2022 shall be void and unenforceable. This subsection and subsection (f) do not apply to a contract directly between a 340B entity and the plan sponsor of a self-funded, single-employer or multiemployer employee welfare benefit plan subject to 29 U.S.C. 1003 ~~1144~~.

(i)(1) A pharmacy benefit manager may not retaliate against a pharmacist or pharmacy for disclosing information in a court, in an administrative hearing, before a legislative commission or committee, or in any other proceeding, if the pharmacist or pharmacy has reasonable cause to believe that the disclosed information is evidence of a violation of a State or federal law, rule, or regulation.

(2) A pharmacy benefit manager may not retaliate against a pharmacist or pharmacy for disclosing information to a government or law enforcement agency, if the pharmacist or pharmacy has reasonable cause to believe that the disclosed information is evidence of a violation of a State or federal law, rule, or regulation.

(3) A pharmacist or pharmacy shall make commercially reasonable efforts to limit the disclosure of confidential and proprietary information.

(4) Retaliatory actions against a pharmacy or pharmacist include cancellation of, restriction of, or refusal to renew or offer a contract to a pharmacy solely because the pharmacy or pharmacist has:

(A) made disclosures of information that the pharmacist or pharmacy has reasonable cause to believe is evidence of a violation of a State or federal law, rule, or regulation;

(B) filed complaints with the plan or pharmacy benefit manager; or

(C) filed complaints against the plan or pharmacy benefit manager with the Department.

(j) This Section applies to contracts entered into or renewed on or after July 1, 2022. Unless ~~and, unless~~ provided otherwise in this Section or in the Illinois Public Aid Code, this Section applies to pharmacy benefit managers that are contracted with a Medicaid managed care entity on or after January 1, 2026. To the extent not otherwise provided, this Section applies to contracts entered into, renewed, or amended on or after January 1, 2026.

(k) This Section applies to any health benefit plan that provides coverage for drugs and that is amended, delivered, issued, or renewed on or after July 1, 2020. The changes made to this Section by Public Act 104-27 ~~this amendatory Act of the 104th General Assembly~~ shall apply with respect to any health benefit plan that provides coverage for drugs that is amended,

delivered, issued, or renewed on or after January 1, 2026.

(l) A pharmacy benefit manager is responsible for compliance with all State requirements applicable to pharmacy benefit managers even if an action or responsibility of a pharmacy benefit manager is delegated to or completed by an affiliate.

(m) This Article applies in relation to plan sponsors of self-funded nonfederal governmental plans only when a State law organizing the governmental unit incorporates this Article by reference. Nothing shall be construed to exclude a joint self-insurance pool created under Section 6 of the Intergovernmental Cooperation Act from references to a plan sponsor if any pool member's organizing State law incorporates this Article by reference, but a pharmacy benefit manager is not subject to the requirements of this Article in relation to any pool member whose organizing State law does not incorporate this Article. This subsection shall be deemed to be operative on and after July 1, 2025.

(n) Regardless of whether a health benefit plan is insurance, the applicability of this Article to a health benefit plan shall be determined in the same manner as the determination of whether a person is transacting insurance in this State under Sections 121-2.03, 121-2.04, and 121-2.05 and subsections (a), (c), and (e) of Section 121-3. For any health benefit plan subject to this Article, unless specifically provided otherwise, this Article applies to all covered

individuals under the health benefit plan, regardless of the individual's residence. The exemption for group accident and health insurance described in subsection (c) of Section 352, as implemented by Department regulation, extends in the same manner to all other health benefit plans with respect to the requirements of this Article. This subsection shall be deemed to be operative on and after July 1, 2025.

(Source: P.A. 103-154, eff. 6-30-23; 103-453, eff. 8-4-23; 104-27, eff. 1-1-26.)

(215 ILCS 5/513b1.1)

(This Section may contain text from a Public Act with a delayed effective date)

Sec. 513b1.1. Pharmacy benefit manager reporting requirements.

(a) A pharmacy benefit manager that provides services for a health benefit plan must submit an annual report no later than September 1, to the Department, each health benefit plan sponsor, and each insurer that includes the following:

(1) data on the health benefit plan including:

(A) a list of drugs including corresponding information on therapeutic class, brand name, generic name, or specialty drug name;

(B) the total number of covered individuals and number of Illinois residents who are covered individuals;

(C) number of drug-related claims;

(D) dosage units;

(E) dispensing channel used;

(F) average wholesale acquisition cost per drug; and

(G) total out-of-pocket spending by deidentified covered individual per drug, per transaction;

(2) amount received by the health benefit plan in rebates, fees, or discounts related to drug utilization or spending;

(3) total gross spending on drugs by the health benefit plan;

(4) total net spending, gross spending less administrative portion of the medical loss ratio, on drugs by the health benefit plan;

(5) the amount paid by the health benefit plan to the pharmacy benefit manager for reimbursement cost of a drug and service per transaction;

(6) the amount a pharmacy benefit manager paid for pharmacists' services and drugs rendered related to the health benefit plan per transaction, including, but not limited to, any dispensing fee;

(7) the specific rebate amount received by the pharmacy benefit manager per transaction, the amount of the rebates passed through to the health benefit plan per transaction, and the amount of the rebates passed on to

covered individuals at the point of sale that reduced the covered individuals' applicable deductible, copayment, coinsurance, or other cost-sharing amount per transaction;

(8) any information collected from drug manufacturers pertaining to copayment assistance to the extent such information is collected;

(9) any compensation paid to brokers, consultants, advisors, or any other individual or firm for referrals, consideration, or retention by the health benefit plan;

(10) explanation of benefit design parameters encouraging or requiring covered individuals to use affiliated pharmacies, percentage of drugs charged by these pharmacies, and a list of drugs dispensed by affiliated pharmacies with their associated costs; and

(11) a complete copy of each unredacted contract the pharmacy benefit manager has with the health benefit plan sponsor or insurer.

(b) Annual reports pursuant to subsection (a):

(1) must be written in plain language to ensure ease of reading and accessibility;

(2) must only contain summary health information to ensure plan, coverage, or covered individual information remains private and confidential;

(3) upon request by a covered individual, must be available in summary format and provide aggregated information to help covered individuals understand their

health benefit plan's drug coverage; and

(4) must be filed with the Department no later than September 1 of each year via the Systems for Electronic Rates & Forms Filing (SERFF). The filing shall include the summary version of the report described in paragraph (3) of this subsection, which shall be marked for public access.

The Department may share all reports with an established institution of higher education in this State for the creation of a pharmacist dispensing cost report to be produced annually. This annual pharmacist dispensing cost report shall provide a survey of the average cost of dispensing a prescription for pharmacists in Illinois. The institution of higher education shall have the ability to request additional information from pharmacists for its analysis. The institution of higher education shall issue the report to the General Assembly no later than December 31, 2026 and annually thereafter.

(c) A pharmacy benefit manager may petition the Department for a filing submission extension. The Director may grant or deny the extension within 5 business days.

(d) Failure by a pharmacy benefit manager to submit all required elements in an annual report to the Department may result in a fine levied by the Director not to exceed $10,000 per day, per offense. Funds derived from fines levied shall be deposited into the Insurance Producer Administration Fund.

Fine information shall be posted on the Department's website.

(e) A pharmacy benefit manager found in violation of subsection (a) or paragraph (4) of subsection (b) may request a hearing from the Director within 10 days of receipt of the Director's order, or, if the violation is found in a market conduct examination, as provided in Section 132 of this Code.

(f) Except for the summary version, the annual reports submitted by pharmacy benefit managers shall be considered confidential and privileged for all purposes, including for purposes of the Freedom of Information Act, shall not be subject to subpoena from any private party, and shall not be admissible as evidence in a civil action.

(g) A copy of an adverse decision against a pharmacy benefit manager for failing to submit an annual report to the Department must be posted to the Department's website.

(h) Nothing in this Section shall be construed as permitting a pharmacy benefit manager to avoid or otherwise fail to comply with the reporting requirements set forth in Section 5-36 of the Illinois Public Aid Code.

(Source: P.A. 104-27, eff. 1-1-26.)

(215 ILCS 5/513b2)

Sec. 513b2. Licensure requirements.

(a) Beginning on July 1, 2020, to conduct business in this State, a pharmacy benefit manager must register with the Director. To initially register or renew a registration, a

pharmacy benefit manager shall submit:

(1) A nonrefundable fee not to exceed $500.

(2) A copy of the registrant's corporate charter, articles of incorporation, or other charter document.

(3) A completed registration form adopted by the Director containing:

(A) The name and address of the registrant.

(B) The name, address, and official position of each officer and director of the registrant.

(b) The registrant shall report any change in information required under this Section to the Director in writing within 60 days after the change occurs.

(c) Upon receipt of a completed registration form, the required documents, and the registration fee, the Director shall issue a registration certificate. The certificate may be in paper or electronic form, and shall clearly indicate the expiration date of the registration. Registration certificates are nontransferable.

(d) A registration certificate is valid for 2 years after its date of issue. The Director shall adopt by rule an initial registration fee not to exceed $500 and a registration renewal fee not to exceed $500, both of which shall be nonrefundable. Total fees may not exceed the cost of administering this Section.

(e) The Department shall adopt any rules necessary to implement this Section.

(f) On or before August 1, 2025, the pharmacy benefit manager shall submit a report to the Department that lists the name of each health benefit plan it administers, provides the number of Illinois residents who are covered individuals for each health benefit plan as of the date of submission, and provides the total number of Illinois residents who are covered individuals across all health benefit plans the pharmacy benefit manager administers. On or before September 1, 2025, a registered pharmacy benefit manager, as a condition of its authority to transact business in this State, must submit to the Department an amount equal to $15 or an alternate amount as determined by the Director by rule per covered individual enrolled by the pharmacy benefit manager in this State, as detailed in the report submitted to the Department under this subsection, during the preceding calendar year. On or before September 1, 2026 and each September 1 thereafter, payments submitted under this subsection shall be based on the number of Illinois residents who are covered individuals reported to the Department in Section 513b1.1.

If a pharmacy benefit manager submitted a payment or failed to submit a payment under this subsection by September 2, 2025, and if the amount paid or the failure to pay was based on the pharmacy benefit manager's determination of applicability or inapplicability to any of its health benefit plans or covered individuals in a manner contrary to the requirements clarified by this amendatory Act of the 104th

General Assembly, then the pharmacy benefit manager shall submit a revised report under this subsection by December 1, 2025 in conformity with these clarified requirements. The revised report shall relate to health benefit plans and Illinois residents who were covered individuals as of the date of the previous report. When submitting the revised report, the pharmacy benefit manager shall identify the types of health benefit plans and covered individuals that it has added or removed from its previous report because of the clarification of applicability. Additionally:

(1) If the revised report indicates that the total number of Illinois residents who were covered individuals was too low in the previous report, the pharmacy benefit manager shall pay the difference to the Department by January 2, 2026.

(2) If the revised report indicates that the total number of Illinois residents who were covered individuals was too high in the previous report, the pharmacy benefit manager may request a refund from the Department to the extent provided in subsection (h). The refund request shall be included with the submission of the revised report on or before December 1, 2025.

(g) All amounts collected under this Section shall be deposited into the Prescription Drug Affordability Fund, which is hereby created as a special fund in the State treasury. Of the amounts collected under this Section each fiscal year, at

the direction of the Department, the Comptroller shall direct and the Treasurer shall transfer the first $25,000,000 into the DCEO Projects Fund for grants to support pharmacies under Section 605-70 ~~605-60~~ of the Department of Commerce and Economic Opportunity Law; then, at the direction of the Department, the Comptroller shall direct and the Treasurer shall transfer the remainder of the amounts collected under this Section into the General Revenue Fund.

(h) Whenever it appears to the satisfaction of the Director that because of some mistake of fact, error in calculation, or erroneous interpretation of a statute of this State that any pharmacy benefit manager has paid to the Department an amount under subsection (f) in excess of the amount required by subsection (f), the Director shall have the power to refund to the pharmacy benefit manager the amount of the excess. No refund shall be paid in relation to any health benefit plan to which State law makes this Article applicable. No refund shall be paid without the pharmacy benefit manager first submitting a revised version of the report described in subsection (f) along with an explanation of the mistake of fact, error in calculation, or erroneous interpretation of State statute that caused the overpayment. No refund shall be paid for any request submitted after December 1, or in a year when that date falls on a Saturday or Sunday, the first working day after December 1, of the same calendar year for which a report was due under subsection (f) that the pharmacy benefit

manager claims to have been the basis for an overpayment. If the Director approves a refund, it shall be paid:

(1) by applying the amount thereof toward the payment of fees or other charges already due to the Department, or which may thereafter become due to the Department, from that pharmacy benefit manager until the excess has been fully refunded; or

(2) upon a written request from the pharmacy benefit manager, the Director shall provide a cash refund within 120 days after receipt of the written request if all necessary information has been filed with the Department in order for it to perform an audit of the report described in subsection (f) or in Section 513b1.1 for the year in which the overpayment occurred; or within 120 days after the date the Department receives all the necessary information to perform the audit.

(A) The Director shall not provide a cash refund if there are insufficient funds in the Prescription Drug Affordability Fund to provide a cash refund or if the amount of the overpayment is less than $100. Funds shall not be deemed sufficient if the transfer to the DCEO Projects Fund described in subsection (g) of Section 513b2 cannot be fully satisfied for the year of the overpayment.

(B) Any cash refund shall be paid from the Prescription Drug Affordability Fund.

(3) In the absence of a rule specific to pharmacy benefit managers, paragraphs (1) and (2) shall be implemented in the same manner as provided by Department rules enacted under Section 412 of this Code to the extent the rules do not conflict with this subsection.

(Source: P.A. 104-2, eff. 7-1-25; 104-27, eff. 7-1-25.)

Section 30. The Pharmacy Practice Act is amended by changing Sections 3 and 9.6 as follows:

(225 ILCS 85/3)

(Section scheduled to be repealed on January 1, 2028)

Sec. 3. Definitions. For the purpose of this Act, except where otherwise limited therein:

(a) "Pharmacy" or "drugstore" means and includes every store, shop, pharmacy department, or other place where pharmacist care is provided by a pharmacist (1) where drugs, medicines, or poisons are dispensed, sold or offered for sale at retail, or displayed for sale at retail; or (2) where prescriptions of physicians, dentists, advanced practice registered nurses, physician assistants, veterinarians, podiatric physicians, or optometrists, within the limits of their licenses, are compounded, filled, or dispensed; or (3) which has upon it or displayed within it, or affixed to or used in connection with it, a sign bearing the word or words "Pharmacist", "Druggist", "Pharmacy", "Pharmaceutical Care",

"Apothecary", "Drugstore", "Medicine Store", "Prescriptions", "Drugs", "Dispensary", "Medicines", or any word or words of similar or like import, either in the English language or any other language; or (4) where the characteristic prescription sign (Rx) or similar design is exhibited; or (5) any store, or shop, or other place with respect to which any of the above words, objects, signs or designs are used in any advertisement.

(b) "Drugs" means and includes (1) articles recognized in the official United States Pharmacopoeia/National Formulary (USP/NF), or any supplement thereto and being intended for and having for their main use the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals, as approved by the United States Food and Drug Administration, but does not include devices or their components, parts, or accessories; and (2) all other articles intended for and having for their main use the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals, as approved by the United States Food and Drug Administration, but does not include devices or their components, parts, or accessories; and (3) articles (other than food) having for their main use and intended to affect the structure or any function of the body of man or other animals; and (4) articles having for their main use and intended for use as a component or any articles specified in clause (1), (2) or (3); but does not include devices or their components, parts or accessories.

(c) "Medicines" means and includes all drugs intended for human or veterinary use approved by the United States Food and Drug Administration.

(d) "Practice of pharmacy" means:

(1) the interpretation and the provision of assistance in the monitoring, evaluation, and implementation of prescription drug orders;

(2) the dispensing of prescription drug orders;

(3) participation in drug and device selection;

(4) drug administration limited to the administration of oral, topical, injectable, intranasal, and inhalation as follows:

(A) in the context of patient education on the proper use or delivery of medications;

(B) vaccination of patients 3 ~~7~~ years of age and older pursuant to a valid prescription or standing order, by a physician licensed to practice medicine in all its branches, ~~except for vaccinations covered by paragraph (15),~~ upon completion of appropriate training, including how to address contraindications and adverse reactions set forth by rule, with notification to the patient's primary care provider ~~physician~~ and appropriate record retention, or pursuant to hospital pharmacy and therapeutics committee policies and procedures. Eligible vaccines are those listed on the U.S. Centers for Disease

Control and Prevention (CDC) Recommended Immunization Schedule, the CDC's Health Information for International Travel, ~~or~~ the U.S. Food and Drug Administration's Vaccines Licensed and Authorized for Use in the United States, or the State Guidelines for Communicable Disease Prevention issued by the Director of Public Health pursuant to Section 1.2 of the Communicable Disease Prevention Act, except that a pharmacist shall not administer to patients below the age of 7 any vaccine required to be administered under 77 Ill. Adm. Code 665. All vaccines administered in accordance with this subsection shall be reported to the Department of Public Health's Immunization Information System. As applicable to the State's Medicaid program and other payers, vaccines ordered and administered in accordance with this subsection shall be covered and reimbursed at no less than the rate that the vaccine is reimbursed when ordered and administered by a physician;

(B-5) (blank);

(C) administration of injections of alpha-hydroxyprogesterone caproate, pursuant to a valid prescription, by a physician licensed to practice medicine in all its branches, upon completion of appropriate training, including how to address contraindications and adverse reactions set forth by

rule, with notification to the patient's physician and appropriate record retention, or pursuant to hospital pharmacy and therapeutics committee policies and procedures; and

(D) administration of long-acting injectables for mental health or substance use disorders pursuant to a valid prescription by the patient's physician licensed to practice medicine in all its branches, advanced practice registered nurse, or physician assistant upon completion of appropriate training conducted by an Accreditation Council of Pharmaceutical Education accredited provider, including how to address contraindications and adverse reactions set forth by rule, with notification to the patient's physician and appropriate record retention, or pursuant to hospital pharmacy and therapeutics committee policies and procedures;

(5) (blank);

(6) drug regimen review;

(7) drug or drug-related research;

(8) the provision of patient counseling;

(9) the practice of telepharmacy;

(10) the provision of those acts or services necessary to provide pharmacist care;

(11) medication therapy management;

(12) the responsibility for compounding and labeling

of drugs and devices (except labeling by a manufacturer, repackager, or distributor of non-prescription drugs and commercially packaged legend drugs and devices), proper and safe storage of drugs and devices, and maintenance of required records;

(13) the assessment and consultation of patients and dispensing of hormonal contraceptives;

(14) the initiation, dispensing, or administration of drugs, laboratory tests, assessments, referrals, and consultations for human immunodeficiency virus pre-exposure prophylaxis and human immunodeficiency virus post-exposure prophylaxis under Section 43.5;

(15) without a valid prescription or standing order, vaccination of patients 3 ~~7~~ years of age and older for COVID-19 or influenza ~~subcutaneously,~~ intramuscularly~~,~~ or intranasally ~~orally as authorized, approved, or licensed by the United States Food and Drug Administration,~~ pursuant to the following conditions:

(A) the vaccine must be authorized or licensed by the United States Food and Drug Administration;

(B) the vaccine must be ordered and administered according to the recommendations of the Advisory Committee on Immunization Practices as adopted by the United States Centers for Disease Control and Prevention or the State Guidelines for Communicable Disease Prevention issued by the Director of Public

Health pursuant to Section 1.2 of the Communicable Disease Prevention Act ~~standard immunization schedule~~;

(C) the pharmacist must complete a course of training accredited by the Accreditation Council on Pharmacy Education or a similar health authority or professional body approved by the Division of Professional Regulation;

(D) the pharmacist must have a current certificate in basic cardiopulmonary resuscitation;

(E) the pharmacist must complete, during each State licensing period, a minimum of 2 hours of immunization-related continuing pharmacy education approved by the Accreditation Council on Pharmacy Education;

(F) the pharmacist must report all vaccines administered to the Department of Public Health Immunization Information System in addition to complying ~~comply~~ with recordkeeping and reporting requirements of the jurisdiction in which the pharmacist administers vaccines, including informing the patient's primary-care provider, when available, and complying with requirements whereby the person administering a vaccine must review the vaccine registry or other vaccination records prior to administering the vaccine; and

(G) the pharmacist must inform the pharmacist's

patients who are less than 18 years old, as well as the adult caregiver accompanying the child, of the importance of a well-child visit with a pediatrician or other licensed primary-care provider and must refer patients as appropriate;

(16) the ordering and administration of COVID-19 therapeutics subcutaneously, intramuscularly, or orally with notification to the patient's physician and appropriate record retention or pursuant to hospital pharmacy and therapeutics committee policies and procedures. Eligible therapeutics are those approved, authorized, or licensed by the United States Food and Drug Administration and must be administered subcutaneously, intramuscularly, or orally in accordance with that approval, authorization, or licensing; and

(17) the ordering and administration of point of care tests, screenings, and treatments for (i) influenza, (ii) SARS-CoV-2, (iii) Group A Streptococcus, (iv) respiratory syncytial virus, (v) adult-stage head louse, and (vi) health conditions identified by a statewide public health emergency, as defined in the Illinois Emergency Management Agency Act, with notification to the patient's physician, if any, and appropriate record retention or pursuant to hospital pharmacy and therapeutics committee policies and procedures. Eligible tests and screenings are those approved, authorized, or licensed by the United States

Food and Drug Administration and must be administered in accordance with that approval, authorization, or licensing.

A pharmacist who orders or administers tests or screenings for health conditions described in this paragraph may use a test that may guide clinical decision-making for the health condition that is waived under the federal Clinical Laboratory Improvement Amendments of 1988 and regulations promulgated thereunder or any established screening procedure that is established under a statewide protocol.

A pharmacist may delegate the administrative and technical tasks of performing a test for the health conditions described in this paragraph to a registered pharmacy technician or student pharmacist acting under the supervision of the pharmacist.

The testing, screening, and treatment ordered under this paragraph by a pharmacist shall not be denied reimbursement under health benefit plans that are within the scope of the pharmacist's license and shall be covered as if the services or procedures were performed by a physician, an advanced practice registered nurse, or a physician assistant.

A pharmacy benefit manager, health carrier, health benefit plan, or third-party payor shall not discriminate against a pharmacy or a pharmacist with respect to

participation referral, reimbursement of a covered service, or indemnification if a pharmacist is acting within the scope of the pharmacist's license and the pharmacy is operating in compliance with all applicable laws and rules.

A pharmacist who performs any of the acts defined as the practice of pharmacy in this State must be actively licensed as a pharmacist under this Act.

(e) "Prescription" means and includes any written, oral, facsimile, or electronically transmitted order for drugs or medical devices, issued by a physician licensed to practice medicine in all its branches, dentist, veterinarian, podiatric physician, or optometrist, within the limits of his or her license, by a physician assistant in accordance with subsection (f) of Section 4, or by an advanced practice registered nurse in accordance with subsection (g) of Section 4, containing the following: (1) name of the patient; (2) date when prescription was issued; (3) name and strength of drug or description of the medical device prescribed; and (4) quantity; (5) directions for use; (6) prescriber's name, address, and signature; and (7) DEA registration number where required, for controlled substances. The prescription may, but is not required to, list the illness, disease, or condition for which the drug or device is being prescribed. DEA registration numbers shall not be required on inpatient drug orders. A prescription for medication other than controlled

substances shall be valid for up to 15 months from the date issued for the purpose of refills, unless the prescription states otherwise.

(f) "Person" means and includes a natural person, partnership, association, corporation, government entity, or any other legal entity.

(g) "Department" means the Department of Financial and Professional Regulation.

(h) "Board of Pharmacy" or "Board" means the State Board of Pharmacy of the Department of Financial and Professional Regulation.

(i) "Secretary" means the Secretary of Financial and Professional Regulation.

(j) "Drug product selection" means the interchange for a prescribed pharmaceutical product in accordance with Section 25 of this Act and Section 3.14 of the Illinois Food, Drug and Cosmetic Act.

(k) "Inpatient drug order" means an order issued by an authorized prescriber for a resident or patient of a facility licensed under the Nursing Home Care Act, the ID/DD Community Care Act, the MC/DD Act, the Specialized Mental Health Rehabilitation Act of 2013, the Hospital Licensing Act, or the University of Illinois Hospital Act, or a facility which is operated by the Department of Human Services (as successor to the Department of Mental Health and Developmental Disabilities) or the Department of Corrections.

(k-5) "Pharmacist" means an individual health care professional and provider currently licensed by this State to engage in the practice of pharmacy.

(l) "Pharmacist in charge" means the licensed pharmacist whose name appears on a pharmacy license and who is responsible for all aspects of the operation related to the practice of pharmacy.

(m) "Dispense" or "dispensing" means the interpretation, evaluation, and implementation of a prescription drug order, including the preparation and delivery of a drug or device to a patient or patient's agent in a suitable container appropriately labeled for subsequent administration to or use by a patient in accordance with applicable State and federal laws and regulations. "Dispense" or "dispensing" does not mean the physical delivery to a patient or a patient's representative in a home or institution by a designee of a pharmacist or by common carrier. "Dispense" or "dispensing" also does not mean the physical delivery of a drug or medical device to a patient or patient's representative by a pharmacist's designee within a pharmacy or drugstore while the pharmacist is on duty and the pharmacy is open.

(n) "Nonresident pharmacy" means a pharmacy that is located in a state, commonwealth, or territory of the United States, other than Illinois, that delivers, dispenses, or distributes, through the United States Postal Service, commercially acceptable parcel delivery service, or other

common carrier, to Illinois residents, any substance which requires a prescription.

(o) "Compounding" means the preparation and mixing of components, excluding flavorings, (1) as the result of a prescriber's prescription drug order or initiative based on the prescriber-patient-pharmacist relationship in the course of professional practice or (2) for the purpose of, or incident to, research, teaching, or chemical analysis and not for sale or dispensing. "Compounding" includes the preparation of drugs or devices in anticipation of receiving prescription drug orders based on routine, regularly observed dispensing patterns. Commercially available products may be compounded for dispensing to individual patients only if all of the following conditions are met: (i) the commercial product is not reasonably available from normal distribution channels in a timely manner to meet the patient's needs and (ii) the prescribing practitioner has requested that the drug be compounded.

(p) (Blank).

(q) (Blank).

(r) "Patient counseling" means the communication between a pharmacist or a student pharmacist under the supervision of a pharmacist and a patient or the patient's representative about the patient's medication or device for the purpose of optimizing proper use of prescription medications or devices. "Patient counseling" may include without limitation (1)

obtaining a medication history; (2) acquiring a patient's allergies and health conditions; (3) facilitation of the patient's understanding of the intended use of the medication; (4) proper directions for use; (5) significant potential adverse events; (6) potential food-drug interactions; and (7) the need to be compliant with the medication therapy. A pharmacy technician may only participate in the following aspects of patient counseling under the supervision of a pharmacist: (1) obtaining medication history; (2) providing the offer for counseling by a pharmacist or student pharmacist; and (3) acquiring a patient's allergies and health conditions.

(s) "Patient profiles" or "patient drug therapy record" means the obtaining, recording, and maintenance of patient prescription information, including prescriptions for controlled substances, and personal information.

(t) (Blank).

(u) "Medical device" or "device" means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component part or accessory, required under federal law to bear the label "Caution: Federal law requires dispensing by or on the order of a physician". A seller of goods and services who, only for the purpose of retail sales, compounds, sells, rents, or leases medical devices shall not, by reasons thereof, be required to be a licensed pharmacy.

(v) "Unique identifier" means an electronic signature, handwritten signature or initials, thumbprint ~~thumb print~~, or other acceptable biometric or electronic identification process as approved by the Department.

(w) "Current usual and customary retail price" means the price that a pharmacy charges to a non-third-party payor.

(x) "Automated pharmacy system" means a mechanical system located within the confines of the pharmacy or remote location that performs operations or activities, other than compounding or administration, relative to storage, packaging, dispensing, or distribution of medication, and which collects, controls, and maintains all transaction information.

(y) "Drug regimen review" means and includes the evaluation of prescription drug orders and patient records for (1) known allergies; (2) drug or potential therapy contraindications; (3) reasonable dose, duration of use, and route of administration, taking into consideration factors such as age, gender, and contraindications; (4) reasonable directions for use; (5) potential or actual adverse drug reactions; (6) drug-drug interactions; (7) drug-food interactions; (8) drug-disease contraindications; (9) therapeutic duplication; (10) patient laboratory values when authorized and available; (11) proper utilization (including over or under utilization) and optimum therapeutic outcomes; and (12) abuse and misuse.

(z) "Electronically transmitted prescription" means a

prescription that is created, recorded, or stored by electronic means; issued and validated with an electronic signature; and transmitted by electronic means directly from the prescriber to a pharmacy. An electronic prescription is not an image of a physical prescription that is transferred by electronic means from computer to computer, facsimile to facsimile, or facsimile to computer.

(aa) "Medication therapy management services" means a distinct service or group of services offered by licensed pharmacists, physicians licensed to practice medicine in all its branches, advanced practice registered nurses authorized in a written agreement with a physician licensed to practice medicine in all its branches, or physician assistants authorized in guidelines by a supervising physician that optimize therapeutic outcomes for individual patients through improved medication use. In a retail or other non-hospital pharmacy, medication therapy management services shall consist of the evaluation of prescription drug orders and patient medication records to resolve conflicts with the following:

(1) known allergies;

(2) drug or potential therapy contraindications;

(3) reasonable dose, duration of use, and route of administration, taking into consideration factors such as age, gender, and contraindications;

(4) reasonable directions for use;

(5) potential or actual adverse drug reactions;

(6) drug-drug interactions;

(7) drug-food interactions;

(8) drug-disease contraindications;

(9) identification of therapeutic duplication;

(10) patient laboratory values when authorized and available;

(11) proper utilization (including over or under utilization) and optimum therapeutic outcomes; and

(12) drug abuse and misuse.

"Medication therapy management services" includes the following:

(1) documenting the services delivered and communicating the information provided to patients' prescribers within an appropriate time frame, not to exceed 48 hours;

(2) providing patient counseling designed to enhance a patient's understanding and the appropriate use of his or her medications; and

(3) providing information, support services, and resources designed to enhance a patient's adherence with his or her prescribed therapeutic regimens.

"Medication therapy management services" may also include patient care functions authorized by a physician licensed to practice medicine in all its branches for his or her identified patient or groups of patients under specified conditions or limitations in a standing order from the

physician.

"Medication therapy management services" in a licensed hospital may also include the following:

(1) reviewing assessments of the patient's health status; and

(2) following protocols of a hospital pharmacy and therapeutics committee with respect to the fulfillment of medication orders.

(bb) "Pharmacist care" means the provision by a pharmacist of medication therapy management services, with or without the dispensing of drugs or devices, intended to achieve outcomes that improve patient health, quality of life, and comfort and enhance patient safety.

(cc) "Protected health information" means individually identifiable health information that, except as otherwise provided, is:

(1) transmitted by electronic media;

(2) maintained in any medium set forth in the definition of "electronic media" in the federal Health Insurance Portability and Accountability Act; or

(3) transmitted or maintained in any other form or medium.

"Protected health information" does not include individually identifiable health information found in:

(1) education records covered by the federal Family Educational Right and Privacy Act; or

(2) employment records held by a licensee in its role as an employer.

(dd) "Standing order" means a specific order for a patient or group of patients issued by a physician licensed to practice medicine in all its branches in Illinois.

(ee) "Address of record" means the designated address recorded by the Department in the applicant's application file or licensee's license file maintained by the Department's licensure maintenance unit.

(ff) "Home pharmacy" means the location of a pharmacy's primary operations.

(gg) "Email address of record" means the designated email address recorded by the Department in the applicant's application file or the licensee's license file, as maintained by the Department's licensure maintenance unit.

(Source: P.A. 102-16, eff. 6-17-21; 102-103, eff. 1-1-22; 102-558, eff. 8-20-21; 102-813, eff. 5-13-22; 102-1051, eff. 1-1-23; 103-1, eff. 4-27-23; 103-593, eff. 6-7-24; 103-612, eff. 1-1-25; revised 11-26-24.)

(225 ILCS 85/9.6)

Sec. 9.6. Administration of vaccines and therapeutics by registered pharmacy technicians and student pharmacists.

(a) Under the supervision of an appropriately trained pharmacist, a registered pharmacy technician or student pharmacist may administer COVID-19, ~~SARS-CoV-2,~~ respiratory

syncytial virus, and influenza vaccines ~~subcutaneously,~~ intramuscularly~~,~~ or intranasally ~~or orally~~ as authorized, approved, or licensed by the United States Food and Drug Administration, subject to the following conditions:

(1) the vaccination must be ordered by the supervising pharmacist;

(2) the supervising pharmacist must be readily and immediately available to the immunizing pharmacy technician or student pharmacist;

(3) the pharmacy technician or student pharmacist must complete a practical training program that is approved by the Accreditation Council for Pharmacy Education and that includes hands-on injection technique training and training in the recognition and treatment of emergency reactions to vaccines;

(4) the pharmacy technician or student pharmacist must have a current certificate in basic cardiopulmonary resuscitation;

(5) the pharmacy technician or student pharmacist must complete, during the relevant licensing period, a minimum of 2 hours of immunization-related continuing pharmacy education that is approved by the Accreditation Council for Pharmacy Education;

(6) the supervising pharmacist must comply with all relevant recordkeeping and reporting requirements;

(7) the supervising pharmacist must be responsible for

complying with requirements related to reporting adverse events;

(8) the supervising pharmacist must review the vaccine registry or other vaccination records prior to ordering the vaccination to be administered by the pharmacy technician or student pharmacist;

(9) the pharmacy technician or student pharmacist must, if the patient is 18 years of age or younger, inform the patient and the adult caregiver accompanying the patient of the importance of a well-child visit with a pediatrician or other licensed primary-care provider and must refer patients as appropriate;

(10) in the case of a COVID-19 vaccine, the vaccination must be ordered and administered according to the Advisory Committee on Immunization Practices' COVID-19 vaccine recommendations or the State Guidelines for Communicable Disease Prevention issued by the Director of Public Health pursuant to Section 1.2 of the Communicable Disease Prevention Act;

(11) ~~in the case of a COVID-19 vaccine,~~ the supervising pharmacist must comply with any applicable requirements or conditions of use as set forth in ~~the Centers for Disease Control and Prevention COVID-19 vaccination provider agreement and~~ any ~~other~~ State or federal requirements that apply to the administration of the ~~COVID-19~~ vaccines being administered; and

(12) the registered pharmacy technician or student pharmacist and the supervising pharmacist must comply with all other requirements of this Act and the rules adopted thereunder pertaining to the administration of drugs.

(b) Under the supervision of an appropriately trained pharmacist, a registered pharmacy technician or student pharmacist may administer COVID-19 therapeutics ~~subcutaneously, intramuscularly, or orally as authorized, approved, or licensed by the United States Food and Drug Administration~~, subject to the following conditions:

(1) the COVID-19 therapeutic must be authorized, approved or licensed by the United States Food and Drug Administration;

(2) the COVID-19 therapeutic must be administered ~~subcutaneously, intramuscularly, or orally~~ in accordance with the United States Food and Drug Administration approval, authorization, or licensing;

(3) a pharmacy technician or student pharmacist practicing pursuant to this Section must complete a practical training program that is approved by the Accreditation Council for Pharmacy Education and that includes hands-on injection technique training, clinical evaluation of indications and contraindications of COVID-19 therapeutics training, training in the recognition and treatment of emergency reactions to COVID-19 therapeutics, and any additional training

required in the United States Food and Drug Administration approval, authorization, or licensing;

(4) the pharmacy technician or student pharmacist must have a current certificate in basic cardiopulmonary resuscitation;

(5) the pharmacy technician or student pharmacist must comply with any applicable requirements or conditions of use that apply to the administration of COVID-19 therapeutics;

(6) the supervising pharmacist must comply with all relevant recordkeeping and reporting requirements;

(7) the supervising pharmacist must be readily and immediately available to the pharmacy technician or student pharmacist; and

(8) the registered pharmacy technician or student pharmacist and the supervising pharmacist must comply with all other requirements of this Act and the rules adopted thereunder pertaining to the administration of drugs.

(Source: P.A. 103-1, eff. 4-27-23; 103-593, eff. 6-7-24.)

Section 35. The Communicable Disease Prevention Act is amended by adding Sections 0.05 and 1.2 as follows:

(410 ILCS 315/0.05 new)

Sec. 0.05. Definitions. For the purposes of this Act:

"Immunization" means treatment of an individual with any

vaccine or immunologic drug licensed, approved, or authorized for use by the United States Food and Drug Administration, including emergency use authorization agents, or meeting World Health Organization requirements, and designed for the purpose of producing or enhancing an immune response against a disease for which such immunization exists.

"Medical countermeasures" means products regulated by the United States Food and Drug Administration that may be used in a public health emergency stemming from a terrorist attack or accidental release of a biological, chemical, or radiological/nuclear agent or a naturally occurring emerging disease, pandemic, or other large-scale outbreak.

(410 ILCS 315/1.2 new)

Sec. 1.2. State Guidelines for Communicable Disease Prevention.

(a) The Director of Public Health shall provide State Guidelines for Communicable Disease Prevention for which there is an immunization or medical countermeasure. The Guidelines shall address the use of immunizations and may include recommendations for the administration of products such as vaccines or immune globulin preparations that are defined as immunizations or medical countermeasures and shown to be effective in controlling a disease for which an immunization is available. The Guidelines for the use of unlicensed but regulated immunizations or medical countermeasures may be

developed based on medical and scientific evidence if circumstances warrant. For each immunization or medical countermeasure, the Guidelines shall include population groups or circumstances in which a vaccine or related immunization agent is recommended. The Director of Public Health shall also provide recommendations on contraindications and precautions for the use of the immunizations and medical countermeasures and provide information on recognized adverse events. The Director also may provide recommendations that address the general use of immunization products and special situations or populations that may warrant modification of the routine recommendations.

(b) The Guidelines shall include consideration of disease epidemiology and the burden of disease, immunization safety, immunization efficacy and effectiveness, the quality of evidence reviewed, economic analyses, and implementation issues. The Director of Public Health may revise or withdraw recommendations regarding a particular immunization or medical countermeasure as new information on disease epidemiology, immunization effectiveness or safety, economic considerations, or other data become available.

(c) In developing these Guidelines, the Director may consider the advice, recommendations, and feedback of:

(1) the Medical Director of the Department of Public Health;

(2) the Immunization Advisory Committee;

(3) the Advisory Committee on Immunization Practices of the United States Centers for Disease Control and Prevention;

(4) medical and scientific experts in the field of disease prevention; and

(5) other widely accepted sources of medical and scientific evidence, such as recommendations from the United States Preventive Services Task Force.

(d) The Department of Public Health shall publish Guidelines or recommendations issued by the Director on the Department's website. The Department of Public Health or the Director shall not endanger the public health by publishing or endorsing public health guidelines or recommendations that significantly deviate from evidence-based immunization practices established by credible scientific and medical communities, experts, and practitioners.

Section 95. No acceleration or delay. Except for the changes made in subsections (a), (a-5), (m), and (n) of Section 513b1 of the Illinois Insurance Code, where this Act makes changes in a statute that is represented in this Act by text that is not yet or no longer in effect (for example, a Section represented by multiple versions), the use of that text does not accelerate or delay the taking effect of (i) the changes made by this Act or (ii) provisions derived from any other Public Act.

Section 99. Effective date. This Act takes effect upon becoming law, except that the changes to Section 424 of the Illinois Insurance Code take effect January 1, 2026.