Sen. David Koehler

Filed: 3/17/2025

AMENDMENT TO SENATE BILL 1390

AMENDMENT NO. _____. Amend Senate Bill 1390 by replacing everything after the enacting clause with the following:

"Section 1. This Act may be referred to as the Prescription Drug Affordability Act.

Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Section 6.11 as follows:

(5 ILCS 375/6.11)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356u.10,

356w, 356x, 356z.2, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, ~~and~~ 356z.70, ~~and~~ 356z.71, 356z.74, 356z.76, and 356z.77 of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1 and Article XXXIIB of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Section 356m of the Illinois Insurance Code and, for the employees of the State Employee Group Insurance Program only, the coverage as also provided in Section 6.11B of this Act. The Department of Insurance shall enforce the requirements of this Section with respect to Sections 370c and 370c.1 and Article XXXIIB of the Illinois Insurance Code; all other requirements of this Section shall be enforced by the Department of Central Management Services.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22;

102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-768, eff. 1-1-24; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-8, eff. 1-1-24; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24; 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-870, eff. 1-1-25; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-951, eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

Section 10. The School Code is amended by changing Section 10-22.3f as follows:

(105 ILCS 5/10-22.3f)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356u.10, 356w, 356x, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60,

356z.61, 356z.62, 356z.64, 356z.67, 356z.68, ~~and~~ 356z.70, ~~and~~ 356z.71, 356z.74, and 356z.77 of the Illinois Insurance Code. Insurance policies shall comply with Section 356z.19 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, and 370c and Article XXXIIB of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 102-30, eff. 1-1-22; 102-103, eff. 1-1-22; 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665, eff. 10-8-21; 102-731, eff. 1-1-23; 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff. 1-1-23; 102-860, eff. 1-1-23; 102-1093, eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24; 103-91, eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24; 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; revised 11-26-24.)

Section 15. The Illinois Insurance Code is amended by changing Sections 513b1 and 513b3 and by adding Section

513b1.1 as follows:

(215 ILCS 5/513b1)

Sec. 513b1. Pharmacy benefit manager contracts.

(a) As used in this 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.

"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.

"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.

"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.

"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 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 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 use only a pharmacy, including a mail-order or specialty pharmacy, in

which the pharmacy benefit manager or its affiliate maintains an ownership interest or control;

(2) offering or implementing a plan design that encourages a covered individual to use a pharmacy in which the pharmacy benefit manager or an affiliate maintains an ownership interest or control, if such 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.

(3) reimbursing a pharmacy or pharmacist for a drug and pharmacist service in an amount less than the amount that the pharmacy benefit manager 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.

(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 subject to 29 U.S.C. 1144.

(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 or insurer whose coverage is administered by the ~~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. 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 ~~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 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 ~~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 a covered individual ~~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;

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

(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 health benefit plan for covered individuals ~~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.

(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.

(f-15) A pharmacy benefit manager or rebate aggregator

must remit no less than 90% 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.

(f-20) A pharmacy benefit manager must not reimburse a critical access pharmacy for a drug or pharmacy service in an amount less than the national average drug acquisition cost for the drug or pharmacy service at the time the drug is administered or dispensed, plus the current Medicaid critical access pharmacy dispensing fee. If the national average drug acquisition cost is not available at the time a drug is administered or dispensed, a pharmacy benefit manager must not reimburse a critical access pharmacy for any drug at a rate that is less than the amount established by the Department of Healthcare and Family Services for the drug or service under the Medicaid program, as set forth in the applicable administrative rule, plus the current Medicaid critical access pharmacy dispensing fee.

(f-25) 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, including by designating the covered drug as a specialty drug contrary to the definition in this Section.

(f-30) 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.

(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 between a 340B entity and the plan sponsor of a self-funded, single-employer employee welfare benefit plan subject to 29 U.S.C. 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 and, unless provided otherwise in this Section or in the Illinois Public Aid Code, applies to pharmacy benefit managers that are contracted with a Medicaid managed care entity on or after January 1, 2026.

(k) This Section applies to any health benefit ~~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. The changes made to this Section by 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 a third party with an affiliation or a direct or indirect contractual relationship.

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

(215 ILCS 5/513b1.1 new)

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) number of covered individuals;

(C) number of drug-related claims;

(D) dosage units;

(E) dispensing channel used;

(F) 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, spread pricing, 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;

(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.

(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.

(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.

(215 ILCS 5/513b3)

Sec. 513b3. Examination.

(a) The Director, or his or her designee, may examine a registered pharmacy benefit manager related to all of its lines of business, including government programs, under the Director's jurisdiction in accordance with Sections 132-132.7. If the Director or the examiners find that the pharmacy benefit manager has violated this Article or any other insurance-related or health benefits-related laws, rules, or regulations under the Director's jurisdiction because of the manner in which the pharmacy benefit manager has conducted business on behalf of a health insurer or plan sponsor, then, unless the health insurer or plan sponsor is included in the examination and has been afforded the same opportunity to request or participate in a hearing on the examination report, the examination report shall not allege a violation by the health insurer or plan sponsor and the Director's order based on the report shall not impose any requirements, prohibitions, or penalties on the health insurer or plan sponsor. Nothing in this Section shall prevent the Director from using any information obtained during the examination of an administrator to examine, investigate, or take other appropriate regulatory or legal action with respect to a

health insurer or plan sponsor.

(b) The examination requirement for the pharmacy benefit manager to provide convenient and free access to all books and records under Sections 132 and 132.4 of this Code includes, at the Director's discretion, unredacted copies furnished electronically to the Director's market conduct surveillance personnel or examiners. Access must include information related to third-party entities affiliated or contracted with the pharmacy benefit manager, including, but not limited, to, rebate aggregators and pharmacy services administrative organizations.

(Source: P.A. 103-897, eff. 1-1-25.)

Section 20. The Illinois Public Aid Code is amended by changing Sections 5-5.12b and 5-36 as follows:

(305 ILCS 5/5-5.12b)

Sec. 5-5.12b. Critical access care pharmacy program.

(a) As used in this Section:

"Critical access care pharmacy" means ~~an Illinois-based~~ brick and mortar pharmacy ~~that is~~ located in Illinois that is owned by a person or entity with an ownership or control interest in ~~a county with fewer than 50,000 residents and that owns~~ fewer than 10 pharmacies, and is either located in a county with fewer than 50,000 residents or in a county with 50,000 or more residents and in an area within Illinois that is

designated as a Medically Underserved Area by the Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services, or at the discretion of the Department of Healthcare and Family Services, as set forth in administrative rule.

"Critical access care pharmacy program payment" means the number of individual prescriptions a critical access care pharmacy fills during that quarter multiplied by the lesser of the individual payment amount or the dispensing reimbursement rate made by the Department under the medical assistance program as of April 1, 2018.

"Individual payment amount" means the dividend of 1/4 of the annual amount appropriated for the critical access care pharmacy program by the number of prescriptions filled by all critical access care pharmacies reimbursed by Medicaid managed care organizations that quarter.

(b) Subject to appropriations, the Department shall establish a critical access care pharmacy program to ensure the sustainability of critical access pharmacies throughout the State of Illinois.

(c) The critical access care pharmacy program shall not exceed $10,000,000 annually and individual payment amounts per prescription shall not exceed the dispensing rate that the Department would have reimbursed under the Medical Assistance Program as of April 1, 2018.

(d) Quarterly, the Department shall determine the number

of prescriptions filled by critical access care pharmacies reimbursed by Medicaid managed care organizations utilizing encounter data available to the Department. The Department shall determine the individual payment amount per prescription by dividing 1/4 of the annual amount appropriated for the critical access care pharmacy program by the number of prescriptions filled by all critical access care pharmacies reimbursed by Medicaid managed care organizations that quarter. If the individual payment amount per prescription as calculated using quarterly prescription amounts exceeds the reimbursement rate under the medical assistance program as of April 1, 2018, then the individual payment amount per prescription shall be the dispensing reimbursement rate under the medical assistance program as of April 1, 2018.

(e) Quarterly, the Department shall distribute to critical access care pharmacies a critical access care pharmacy program payment. The first payment shall be calculated utilizing the encounter data from the last quarter of State fiscal year 2018.

(f) The Department may adopt rules permitting an Illinois-based brick and mortar pharmacy that owns fewer than 10 pharmacies to receive critical access care pharmacy program payments in the same manner as a critical access care pharmacy, regardless of whether the pharmacy is located in a county with a population of less than 50,000.

(Source: P.A. 100-587, eff. 6-4-18.)

(305 ILCS 5/5-36)

Sec. 5-36. Pharmacy benefits.

(a)(1) The Department may enter into a contract with a third party on a fee-for-service reimbursement model for the purpose of administering pharmacy benefits as provided in this Section for members not enrolled in a Medicaid managed care organization; however, these services shall be approved by the Department. The Department shall ensure coordination of care between the third-party administrator and managed care organizations as a consideration in any contracts established in accordance with this Section. Any managed care techniques, principles, or administration of benefits utilized in accordance with this subsection shall comply with State law.

(2) The following shall apply to contracts between entities contracting relating to the Department's third-party administrators and pharmacies:

(A) the Department shall approve any contract between a third-party administrator and a pharmacy;

(B) the Department's third-party administrator shall not change the terms of a contract between a third-party administrator and a pharmacy without written approval by the Department; and

(C) the Department's third-party administrator shall not create, modify, implement, or indirectly establish any fee on a pharmacy, pharmacist, or a recipient of medical

assistance without written approval by the Department.

(b) The provisions of this Section shall not apply to outpatient pharmacy services provided by a health care facility registered as a covered entity pursuant to 42 U.S.C. 256b or any pharmacy owned by or contracted with the covered entity. A Medicaid managed care organization shall, either directly or through a pharmacy benefit manager, administer and reimburse outpatient pharmacy claims submitted by a health care facility registered as a covered entity pursuant to 42 U.S.C. 256b, its owned pharmacies, and contracted pharmacies in accordance with the contractual agreements the Medicaid managed care organization or its pharmacy benefit manager has with such facilities and pharmacies and in accordance with subsection (h-5).

(b-5) Any pharmacy benefit manager that contracts with a Medicaid managed care organization to administer and reimburse pharmacy claims as provided in this Section must be registered with the Director of Insurance in accordance with Section 513b2 of the Illinois Insurance Code. A pharmacy benefit manager must comply with all provisions of Article XXXIIB of the Illinois Insurance Code to the extent that they do not prevent the application of any provision of this Article or applicable federal law. Nothing in this Section shall be construed to limit the authority of the Illinois Department or the Inspector General to administer or enforce any provisions of this Section or any other Section in the Illinois Public Aid

Code related to pharmacy benefit managers or Medicaid managed care entity.

(c) On at least an annual basis, the Director of the Department of Healthcare and Family Services shall submit a report beginning no later than one year after January 1, 2020 (the effective date of Public Act 101-452) that provides an update on any contract, contract issues, formulary, dispensing fees, and maximum allowable cost concerns regarding a third-party administrator and managed care. The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report with the Speaker, the Minority Leader, and the Clerk of the House of Representatives and with the President, the Minority Leader, and the Secretary of the Senate. The Department shall take care that no proprietary information is included in the report required under this Section.

(d) (Blank). ~~A pharmacy benefit manager shall notify the Department in writing of any activity, policy, or practice of the pharmacy benefit manager that directly or indirectly presents a conflict of interest that interferes with the discharge of the pharmacy benefit manager's duty to a managed care organization to exercise its contractual duties. "Conflict of interest" shall be defined by rule by the Department.~~

(e) A pharmacy benefit manager shall, upon request, disclose to the Department the following information:

(1) whether the pharmacy benefit manager has a contract, agreement, or other arrangement with a pharmaceutical manufacturer to exclusively dispense or provide a drug to a managed care organization's enrollees, and the aggregate amounts of consideration of economic benefits collected or received pursuant to that arrangement;

(2) the percentage of claims payments made by the pharmacy benefit manager to pharmacies owned, managed, or controlled by the pharmacy benefit manager or any of the pharmacy benefit manager's management companies, parent companies, subsidiary companies, or jointly held companies;

(3) the aggregate amount of the fees or assessments imposed on, or collected from, pharmacy providers;

(4) the average annualized percentage of revenue collected by the pharmacy benefit manager as a result of each contract it has executed with a managed care organization contracted by the Department to provide medical assistance benefits which is not paid by the pharmacy benefit manager to pharmacy providers and pharmaceutical manufacturers or labelers or in order to perform administrative functions pursuant to its contracts with managed care organizations;

(5) the total number of prescriptions dispensed under each contract the pharmacy benefit manager has with a

managed care organization (MCO) contracted by the Department to provide medical assistance benefits;

(6) the aggregate wholesale acquisition cost for drugs that were dispensed to enrollees in each MCO with which the pharmacy benefit manager has a contract by any pharmacy owned, managed, or controlled by the pharmacy benefit manager or any of the pharmacy benefit manager's management companies, parent companies, subsidiary companies, or jointly-held companies;

(7) the aggregate amount of administrative fees that the pharmacy benefit manager received from all pharmaceutical manufacturers for prescriptions dispensed to MCO enrollees;

(8) for each MCO with which the pharmacy benefit manager has a contract, the aggregate amount of payments received by the pharmacy benefit manager from the MCO;

(9) for each MCO with which the pharmacy benefit manager has a contract, the aggregate amount of reimbursements the pharmacy benefit manager paid to contracting pharmacies; and

(10) any other information considered necessary by the Department.

(f) The information disclosed under subsection (e) shall include all retail, mail order, specialty, and compounded prescription products. All information made available to the Department under subsection (e) is confidential and not

subject to disclosure under the Freedom of Information Act. All information made available to the Department under subsection (e) shall not be reported or distributed in any way that compromises its competitive, proprietary, or financial value. The information shall only be used by the Department to assess the contract, agreement, or other arrangements made between a pharmacy benefit manager and a pharmacy provider, pharmaceutical manufacturer or labeler, managed care organization, or other entity, as applicable.

(g) A pharmacy benefit manager shall disclose directly in writing to a pharmacy provider or pharmacy services administrative organization contracting with the pharmacy benefit manager of any material change to a contract provision that affects the terms of the reimbursement, the process for verifying benefits and eligibility, dispute resolution, procedures for verifying drugs included on the formulary, and contract termination at least 30 days prior to the date of the change to the provision. The terms of this subsection shall be deemed met if the pharmacy benefit manager posts the information on a website, viewable by the public. A pharmacy service administration organization shall notify all contract pharmacies of any material change, as described in this subsection, within 2 days of notification. 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.

(h) A pharmacy benefit manager shall not include the following in a contract with a pharmacy provider:

(1) a provision prohibiting the provider from informing a patient of a less costly alternative to a prescribed medication; or

(2) a provision that prohibits the provider from dispensing a particular amount of a prescribed medication, if the pharmacy benefit manager allows that amount to be dispensed through a pharmacy owned or controlled by the pharmacy benefit manager, unless the prescription drug is subject to restricted distribution by the United States Food and Drug Administration or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

(h-5) Unless required by law, a Medicaid managed care organization or pharmacy benefit manager administering or managing benefits on behalf of a Medicaid managed care organization shall not refuse to contract with a 340B entity or 340B pharmacy for refusing to accept less favorable payment terms or reimbursement methodologies when compared to similarly situated non-340B entities and shall not include in a contract with a 340B entity or 340B pharmacy a provision

that:

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

(2) 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;

(3) prevents or interferes with an individual's choice to receive a prescription drug from a 340B entity or 340B pharmacy through any legally permissible means;

(4) excludes a 340B entity or 340B pharmacy from a pharmacy network on the basis of whether the 340B entity or 340B pharmacy participates in the 340B drug discount program;

(5) prevents a 340B entity or 340B pharmacy from using a drug purchased under the 340B drug discount program so long as the drug recipient is a patient of the 340B entity; nothing in this Section exempts a 340B pharmacy from following the Department's preferred drug list or from any prior approval requirements of the Department or the Medicaid managed care organization that are imposed on the drug for all pharmacies; or

(6) any other provision that discriminates against a 340B entity or 340B pharmacy by treating a 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.

A provision that violates this subsection in any contract between a Medicaid managed care organization or its pharmacy benefit manager and a 340B entity entered into, amended, or renewed after July 1, 2022 shall be void and unenforceable.

In this subsection (h-5):

"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.

(i) Nothing in this Section shall be construed to prohibit a pharmacy benefit manager from requiring the same reimbursement and terms and conditions for a pharmacy provider as for a pharmacy owned, controlled, or otherwise associated with the pharmacy benefit manager.

(j) A pharmacy benefit manager shall establish and implement a process for the resolution of disputes arising out of this Section, which shall be approved by the Department.

(k) The Department shall adopt rules establishing reasonable dispensing fees for fee-for-service payments in accordance with guidance or guidelines from the federal Centers for Medicare and Medicaid Services.

(Source: P.A. 102-558, eff. 8-20-21; 102-778, eff. 7-1-22; 103-593, eff. 6-7-24.)

Section 25. The Juvenile Court Act of 1987 is amended by changing Section 5-515 as follows:

(705 ILCS 405/5-515)

Sec. 5-515. Medical, ~~and~~ dental, and pharmaceutical treatment and care.

(a) At all times during temporary custody, detention or shelter care, the court may authorize a physician, a hospital or any other appropriate health care provider to provide medical, dental or surgical procedures or pharmaceuticals if those procedures or pharmaceuticals are necessary to safeguard the minor's life or health. If the minor is covered under an existing medical or dental plan, the county shall be reimbursed for the expenses incurred for such services as if the minor were not held in temporary custody, detention, or shelter care.

(b) If a provider of temporary custody, detention, or shelter care has a contract with a pharmacy benefit manager or a contract with an insurance company, health maintenance organization, limited health service organization, administrative services organization, or any other managed care organization or health insurance issuer where a pharmacy benefit manager administers the provider's coverage of, payment for, or formulary design for drugs necessary to safeguard the minor's life or health, the contract with the

pharmacy benefit manager and the pharmacy benefit manager's activities shall be subject to Article XXXIIB of the Illinois Insurance Code and the authority of the Director of Insurance to enforce such provisions. The provider shall have all the rights of a plan sponsor under those provisions.

(Source: P.A. 90-590, eff. 1-1-99.)

Section 30. The Unified Code of Corrections is amended by changing Section 3-2-2 as follows:

(730 ILCS 5/3-2-2) (from Ch. 38, par. 1003-2-2)

Sec. 3-2-2. Powers and duties of the Department.

(1) In addition to the powers, duties, and responsibilities which are otherwise provided by law, the Department shall have the following powers:

(a) To accept persons committed to it by the courts of this State for care, custody, treatment, and rehabilitation, and to accept federal prisoners and noncitizens over whom the Office of the Federal Detention Trustee is authorized to exercise the federal detention function for limited purposes and periods of time.

(b) To develop and maintain reception and evaluation units for purposes of analyzing the custody and rehabilitation needs of persons committed to it and to assign such persons to institutions and programs under its control or transfer them to other appropriate agencies. In

consultation with the Department of Alcoholism and Substance Abuse (now the Department of Human Services), the Department of Corrections shall develop a master plan for the screening and evaluation of persons committed to its custody who have alcohol or drug abuse problems, and for making appropriate treatment available to such persons; the Department shall report to the General Assembly on such plan not later than April 1, 1987. The maintenance and implementation of such plan shall be contingent upon the availability of funds.

(b-1) To create and implement, on January 1, 2002, a pilot program to establish the effectiveness of pupillometer technology (the measurement of the pupil's reaction to light) as an alternative to a urine test for purposes of screening and evaluating persons committed to its custody who have alcohol or drug problems. The pilot program shall require the pupillometer technology to be used in at least one Department of Corrections facility. The Director may expand the pilot program to include an additional facility or facilities as he or she deems appropriate. A minimum of 4,000 tests shall be included in the pilot program. The Department must report to the General Assembly on the effectiveness of the program by January 1, 2003.

(b-5) To develop, in consultation with the Illinois State Police, a program for tracking and evaluating each

inmate from commitment through release for recording his or her gang affiliations, activities, or ranks.

(c) To maintain and administer all State correctional institutions and facilities under its control and to establish new ones as needed. Pursuant to its power to establish new institutions and facilities, the Department may, with the written approval of the Governor, authorize the Department of Central Management Services to enter into an agreement of the type described in subsection (d) of Section 405-300 of the Department of Central Management Services Law. The Department shall designate those institutions which shall constitute the State Penitentiary System. The Department of Juvenile Justice shall maintain and administer all State youth centers pursuant to subsection (d) of Section 3-2.5-20.

Pursuant to its power to establish new institutions and facilities, the Department may authorize the Department of Central Management Services to accept bids from counties and municipalities for the construction, remodeling, or conversion of a structure to be leased to the Department of Corrections for the purposes of its serving as a correctional institution or facility. Such construction, remodeling, or conversion may be financed with revenue bonds issued pursuant to the Industrial Building Revenue Bond Act by the municipality or county. The lease specified in a bid shall be for a term of not

less than the time needed to retire any revenue bonds used to finance the project, but not to exceed 40 years. The lease may grant to the State the option to purchase the structure outright.

Upon receipt of the bids, the Department may certify one or more of the bids and shall submit any such bids to the General Assembly for approval. Upon approval of a bid by a constitutional majority of both houses of the General Assembly, pursuant to joint resolution, the Department of Central Management Services may enter into an agreement with the county or municipality pursuant to such bid.

(c-5) To build and maintain regional juvenile detention centers and to charge a per diem to the counties as established by the Department to defray the costs of housing each minor in a center. In this subsection (c-5), "juvenile detention center" means a facility to house minors during pendency of trial who have been transferred from proceedings under the Juvenile Court Act of 1987 to prosecutions under the criminal laws of this State in accordance with Section 5-805 of the Juvenile Court Act of 1987, whether the transfer was by operation of law or permissive under that Section. The Department shall designate the counties to be served by each regional juvenile detention center.

(d) To develop and maintain programs of control, rehabilitation, and employment of committed persons within

its institutions.

(d-5) To provide a pre-release job preparation program for inmates at Illinois adult correctional centers.

(d-10) To provide educational and visitation opportunities to committed persons within its institutions through temporary access to content-controlled tablets that may be provided as a privilege to committed persons to induce or reward compliance.

(e) To establish a system of supervision and guidance of committed persons in the community.

(f) To establish in cooperation with the Department of Transportation to supply a sufficient number of prisoners for use by the Department of Transportation to clean up the trash and garbage along State, county, township, or municipal highways as designated by the Department of Transportation. The Department of Corrections, at the request of the Department of Transportation, shall furnish such prisoners at least annually for a period to be agreed upon between the Director of Corrections and the Secretary of Transportation. The prisoners used on this program shall be selected by the Director of Corrections on whatever basis he deems proper in consideration of their term, behavior and earned eligibility to participate in such program - where they will be outside of the prison facility but still in the custody of the Department of Corrections. Prisoners convicted of first degree murder,

or a Class X felony, or armed violence, or aggravated kidnapping, or criminal sexual assault, aggravated criminal sexual abuse or a subsequent conviction for criminal sexual abuse, or forcible detention, or arson, or a prisoner adjudged a Habitual Criminal shall not be eligible for selection to participate in such program. The prisoners shall remain as prisoners in the custody of the Department of Corrections and such Department shall furnish whatever security is necessary. The Department of Transportation shall furnish trucks and equipment for the highway cleanup program and personnel to supervise and direct the program. Neither the Department of Corrections nor the Department of Transportation shall replace any regular employee with a prisoner.

(g) To maintain records of persons committed to it and to establish programs of research, statistics, and planning.

(h) To investigate the grievances of any person committed to the Department and to inquire into any alleged misconduct by employees or committed persons; and for these purposes it may issue subpoenas and compel the attendance of witnesses and the production of writings and papers, and may examine under oath any witnesses who may appear before it; to also investigate alleged violations of a parolee's or releasee's conditions of parole or release; and for this purpose it may issue subpoenas and

compel the attendance of witnesses and the production of documents only if there is reason to believe that such procedures would provide evidence that such violations have occurred.

If any person fails to obey a subpoena issued under this subsection, the Director may apply to any circuit court to secure compliance with the subpoena. The failure to comply with the order of the court issued in response thereto shall be punishable as contempt of court.

(i) To appoint and remove the chief administrative officers, and administer programs of training and development of personnel of the Department. Personnel assigned by the Department to be responsible for the custody and control of committed persons or to investigate the alleged misconduct of committed persons or employees or alleged violations of a parolee's or releasee's conditions of parole shall be conservators of the peace for those purposes, and shall have the full power of peace officers outside of the facilities of the Department in the protection, arrest, retaking, and reconfining of committed persons or where the exercise of such power is necessary to the investigation of such misconduct or violations. This subsection shall not apply to persons committed to the Department of Juvenile Justice under the Juvenile Court Act of 1987 on aftercare release.

(j) To cooperate with other departments and agencies

and with local communities for the development of standards and programs for better correctional services in this State.

(k) To administer all moneys and properties of the Department.

(l) To report annually to the Governor on the committed persons, institutions, and programs of the Department.

(l-5) (Blank).

(m) To make all rules and regulations and exercise all powers and duties vested by law in the Department.

(n) To establish rules and regulations for administering a system of sentence credits, established in accordance with Section 3-6-3, subject to review by the Prisoner Review Board.

(o) To administer the distribution of funds from the State Treasury to reimburse counties where State penal institutions are located for the payment of assistant state's attorneys' salaries under Section 4-2001 of the Counties Code.

(p) To exchange information with the Department of Human Services and the Department of Healthcare and Family Services for the purpose of verifying living arrangements and for other purposes directly connected with the administration of this Code and the Illinois Public Aid Code.

(q) To establish a diversion program.

The program shall provide a structured environment for selected technical parole or mandatory supervised release violators and committed persons who have violated the rules governing their conduct while in work release. This program shall not apply to those persons who have committed a new offense while serving on parole or mandatory supervised release or while committed to work release.

Elements of the program shall include, but shall not be limited to, the following:

(1) The staff of a diversion facility shall provide supervision in accordance with required objectives set by the facility.

(2) Participants shall be required to maintain employment.

(3) Each participant shall pay for room and board at the facility on a sliding-scale basis according to the participant's income.

(4) Each participant shall:

(A) provide restitution to victims in accordance with any court order;

(B) provide financial support to his dependents; and

(C) make appropriate payments toward any other court-ordered obligations.

(5) Each participant shall complete community service in addition to employment.

(6) Participants shall take part in such counseling, educational, and other programs as the Department may deem appropriate.

(7) Participants shall submit to drug and alcohol screening.

(8) The Department shall promulgate rules governing the administration of the program.

(r) To enter into intergovernmental cooperation agreements under which persons in the custody of the Department may participate in a county impact incarceration program established under Section 3-6038 or 3-15003.5 of the Counties Code.

(r-5) (Blank).

(r-10) To systematically and routinely identify with respect to each streetgang active within the correctional system: (1) each active gang; (2) every existing inter-gang affiliation or alliance; and (3) the current leaders in each gang. The Department shall promptly segregate leaders from inmates who belong to their gangs and allied gangs. "Segregate" means no physical contact and, to the extent possible under the conditions and space available at the correctional facility, prohibition of visual and sound communication. For the purposes of this paragraph (r-10), "leaders" means persons who:

(i) are members of a criminal streetgang;

(ii) with respect to other individuals within the streetgang, occupy a position of organizer, supervisor, or other position of management or leadership; and

(iii) are actively and personally engaged in directing, ordering, authorizing, or requesting commission of criminal acts by others, which are punishable as a felony, in furtherance of streetgang related activity both within and outside of the Department of Corrections.

"Streetgang", "gang", and "streetgang related" have the meanings ascribed to them in Section 10 of the Illinois Streetgang Terrorism Omnibus Prevention Act.

(s) To operate a super-maximum security institution, in order to manage and supervise inmates who are disruptive or dangerous and provide for the safety and security of the staff and the other inmates.

(t) To monitor any unprivileged conversation or any unprivileged communication, whether in person or by mail, telephone, or other means, between an inmate who, before commitment to the Department, was a member of an organized gang and any other person without the need to show cause or satisfy any other requirement of law before beginning the monitoring, except as constitutionally required. The monitoring may be by video, voice, or other method of

recording or by any other means. As used in this subdivision (1)(t), "organized gang" has the meaning ascribed to it in Section 10 of the Illinois Streetgang Terrorism Omnibus Prevention Act.

As used in this subdivision (1)(t), "unprivileged conversation" or "unprivileged communication" means a conversation or communication that is not protected by any privilege recognized by law or by decision, rule, or order of the Illinois Supreme Court.

(u) To establish a Women's and Children's Pre-release Community Supervision Program for the purpose of providing housing and services to eligible female inmates, as determined by the Department, and their newborn and young children.

(u-5) To issue an order, whenever a person committed to the Department absconds or absents himself or herself, without authority to do so, from any facility or program to which he or she is assigned. The order shall be certified by the Director, the Supervisor of the Apprehension Unit, or any person duly designated by the Director, with the seal of the Department affixed. The order shall be directed to all sheriffs, coroners, and police officers, or to any particular person named in the order. Any order issued pursuant to this subdivision (1)(u-5) shall be sufficient warrant for the officer or person named in the order to arrest and deliver the

committed person to the proper correctional officials and shall be executed the same as criminal process.

(u-6) To appoint a point of contact person who shall receive suggestions, complaints, or other requests to the Department from visitors to Department institutions or facilities and from other members of the public.

(v) To do all other acts necessary to carry out the provisions of this Chapter.

(2) The Department of Corrections shall by January 1, 1998, consider building and operating a correctional facility within 100 miles of a county of over 2,000,000 inhabitants, especially a facility designed to house juvenile participants in the impact incarceration program.

(3) When the Department lets bids for contracts for medical services to be provided to persons committed to Department facilities by a health maintenance organization, medical service corporation, or other health care provider, the bid may only be let to a health care provider that has obtained an irrevocable letter of credit or performance bond issued by a company whose bonds have an investment grade or higher rating by a bond rating organization.

(3.5) If the Department has a contract with a pharmacy benefit manager or a contract with an insurance company, health maintenance organization, limited health service organization, administrative services organization, or any other managed care entity or health insurance issuer where a

pharmacy benefit manager administers the provider's coverage of, payment for, or formulary design for drugs necessary to safeguard the minor's life or health, the contract with the pharmacy benefit manager and the pharmacy benefit manager's activities shall be subject to Article XXXIIB of the Illinois Insurance Code and the authority of the Director of Insurance to enforce such provisions. The provider shall have all the rights of a plan sponsor under those provisions.

(4) When the Department lets bids for contracts for food or commissary services to be provided to Department facilities, the bid may only be let to a food or commissary services provider that has obtained an irrevocable letter of credit or performance bond issued by a company whose bonds have an investment grade or higher rating by a bond rating organization.

(5) On and after the date 6 months after August 16, 2013 (the effective date of Public Act 98-488), as provided in the Executive Order 1 (2012) Implementation Act, all of the powers, duties, rights, and responsibilities related to State healthcare purchasing under this Code that were transferred from the Department of Corrections to the Department of Healthcare and Family Services by Executive Order 3 (2005) are transferred back to the Department of Corrections; however, powers, duties, rights, and responsibilities related to State healthcare purchasing under this Code that were exercised by the Department of Corrections before the effective date of

Executive Order 3 (2005) but that pertain to individuals resident in facilities operated by the Department of Juvenile Justice are transferred to the Department of Juvenile Justice.

(6) The Department of Corrections shall provide lactation or nursing mothers rooms for personnel of the Department. The rooms shall be provided in each facility of the Department that employs nursing mothers. Each individual lactation room must:

(i) contain doors that lock;

(ii) have an "Occupied" sign for each door;

(iii) contain electrical outlets for plugging in breast pumps;

(iv) have sufficient lighting and ventilation;

(v) contain comfortable chairs;

(vi) contain a countertop or table for all necessary supplies for lactation;

(vii) contain a wastebasket and chemical cleaners to wash one's hands and to clean the surfaces of the countertop or table;

(viii) have a functional sink;

(ix) have a minimum of one refrigerator for storage of the breast milk; and

(x) receive routine daily maintenance.

(Source: P.A. 102-350, eff. 8-13-21; 102-535, eff. 1-1-22; 102-538, eff. 8-20-21; 102-813, eff. 5-13-22; 102-1030, eff. 5-27-22; 103-834, eff. 1-1-25.)

Section 35. The County Jail Act is amended by changing Section 17 as follows:

(730 ILCS 125/17) (from Ch. 75, par. 117)

Sec. 17. Bedding, clothing, fuel, and medical aid; reimbursement for medical expenses. The Warden of the jail shall furnish necessary bedding, clothing, fuel, and medical services for all committed persons under his charge, and keep an accurate account of the same. When services that result in qualified medical expenses are required by any person held in custody, the county, private hospital, physician or any public agency which provides such services shall be entitled to obtain reimbursement from the county for the cost of such services. The county board of a county may adopt an ordinance or resolution providing for reimbursement for the cost of those services at the Department of Healthcare and Family Services' rates for medical assistance. To the extent that such person is reasonably able to pay for such care, including reimbursement from any insurance program or from other medical benefit programs available to such person, he or she shall reimburse the county or arresting authority. If such person has already been determined eligible for medical assistance under the Illinois Public Aid Code at the time the person is detained, the cost of such services, to the extent such cost exceeds $500, shall be reimbursed by the Department of

Healthcare and Family Services under that Code. A reimbursement under any public or private program authorized by this Section shall be paid to the county or arresting authority to the same extent as would have been obtained had the services been rendered in a non-custodial environment.

The sheriff or his or her designee may cause an application for medical assistance under the Illinois Public Aid Code to be completed for an arrestee who is a hospital inpatient. If such arrestee is determined eligible, he or she shall receive medical assistance under the Code for hospital inpatient services only. An arresting authority shall be responsible for any qualified medical expenses relating to the arrestee until such time as the arrestee is placed in the custody of the sheriff. However, the arresting authority shall not be so responsible if the arrest was made pursuant to a request by the sheriff. When medical expenses are required by any person held in custody, the county shall be entitled to obtain reimbursement from the County Jail Medical Costs Fund to the extent moneys are available from the Fund. To the extent that the person is reasonably able to pay for that care, including reimbursement from any insurance program or from other medical benefit programs available to the person, he or she shall reimburse the county.

For the purposes of this Section, "arresting authority" means a unit of local government, other than a county, which employs peace officers and whose peace officers have made the

arrest of a person. For the purposes of this Section, "qualified medical expenses" include medical and hospital services but do not include (i) expenses incurred for medical care or treatment provided to a person on account of a self-inflicted injury incurred prior to or in the course of an arrest, (ii) expenses incurred for medical care or treatment provided to a person on account of a health condition of that person which existed prior to the time of his or her arrest, or (iii) expenses for hospital inpatient services for arrestees enrolled for medical assistance under the Illinois Public Aid Code.

If a jail or a unit of local government operating the jail has a contract with a pharmacy benefit manager or a contract with an insurance company, health maintenance organization, limited health service organization, administrative services organization, or any other managed care organization or health insurance issuer where a pharmacy benefit manager administers coverage of, payment for, or formulary design for drugs necessary to safeguard the life or health of any person in custody, that contract and the pharmacy benefit manager's activities shall be subject to Article XXXIIB of the Illinois Insurance Code and the authority of the Director of Insurance to enforce such provisions. The jail or unit of local government shall have all the rights of a plan sponsor under those provisions.

(Source: P.A. 103-745, eff. 1-1-25.)

Section 99. Effective date. This Act takes effect on January 1, 2026, except that this Section and the changes to Section 513b3 of the Illinois Insurance Code take effect upon becoming law.".