State PBM Reform Inventory

Updated October 2026

Illinois

Issue	Summary	Citation
Licensing/Registration	To conduct business in Illinois, a PBM must register with the Department. Certificates shall be valid for 2 years after its date of issue. To initially register or renew a registration, a PBM shall submit: • A nonrefundable fee not to exceed $500. • A copy of the registrant's corporate charter, articles of incorporation, or other charter document. • A completed registration form adopted by the Director. On or before August 1, 2025, the PBM 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 PBM administers. On or before September 1, 2025, a registered PBM, 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 PBM 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 s. 513b1.1. All amounts collected shall be deposited into the Prescription Drug Affordability Fund.	215 Ill. Comp. Stat. § 5/513b2
Reporting Requirements	Records of rebates and fees remitted from the PBM or rebate aggregator must be disclosed to the Department annually in a format to be specified by the Department.	215 Ill. Comp. Stat. § 5/513b1 (f-15)

	A PBM 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:
	• Data on the health benefit plan including:
	  ○ A list of drugs including corresponding information on therapeutic class, brand name, generic name, or specialty drug name;
	  ○ The total number of covered individuals and number of Illinois residents who are covered individuals;
	  ○ Number of drug-related claims;
	  ○ Dosage units;
	  ○ Dispensing channel used;
	  ○ Average WAC per drug; and
	  ○ Total out-of-pocket spending by deidentified covered
	  ○ individual per drug, per transaction;
	• Amount received by the health benefit plan in rebates, fees, or discounts related to drug utilization or spending;
	• Total gross spending on drugs by the health benefit plan;
	• Total net spending, gross spending less administrative portion of the medical loss ratio, on drugs by the health benefit plan;
	• The amount paid by the health benefit plan to the PBM for reimbursement cost of a drug and service per transaction;
	• The amount a PBM paid for pharmacists' services and drugs rendered related to the health benefit plan per transaction, including, but not limited to, any dispensing fee;
	• The specific rebate amount received by the PBM 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;
	• Any information collected from drug manufacturers pertaining to copayment assistance to the extent such information is collected;
	• Any compensation paid to brokers, consultants, advisors, or any other individual or firm for referrals, consideration, or retention by the health benefit plan;
		215 Ill. Comp. Stat. § 5/513b1 (f-25)
		
		215 Ill. Comp. Stat. § 5/513b1.1

	• 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 • A complete copy of each unredacted contract the PBM has with the health benefit plan sponsor or insurer. Annual reports must be filed with the Department by September 1. Annual reports must be written in plain language and contain only summary health information to ensure plan, coverage, or covered individual information remains private and confidential. Upon request by a covered individual, the annual report must be made available to help covered individuals understand their health benefit plan's prescription drug coverage. Failure to comply with these reporting requirements may result in fines up of to $10,000 per violation per day	
PBM Income	**Spread Pricing:** A PBM or an affiliate acting on its behalf shall not conduct spread pricing. **Rebate Pass-Through:** A PBM 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.	215 Ill. Comp. Stat. § 5/513b1 (f-5)
Pharmacy Contracting	**MAC Pricing:** To place a drug on a MAC list, the PBM must ensure that: • If the drug is a generically equivalent drug, it is listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the FDA'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; • The drug is available for purchase by each pharmacy in the State from national or regional wholesalers operating in Illinois; and	215 Ill. Comp. Stat. § 5/513b1 (b-c) 215 Ill. Comp. Stat. § 5/513b1 (f-10)

	• The drug is not obsolete.
	
	A contract between a health insurer or plan sponsor and a PBM must require that the PBM:
	• Update MAC pricing information at least every 7 calendar days;
	• Maintain a process to eliminate drugs from MAC lists or modify drug prices to remain consistent with changes in pricing data used in formulating MAC prices and product availability in a timely manner;
	• Provide access to its MAC list to each pharmacy or PSAO, subject to the MAC list. Access may include a real-time pharmacy website portal to view the MAC list.
	• Provide a process by which a contracted pharmacy can appeal the provider's reimbursement for a drug subject to MAC pricing. The appeals process must, at a minimum, include the following:
	  ○ A requirement that a contracted pharmacy has 14 calendar days after the applicable fill date to appeal to a MAC if the reimbursement for the drug is less than the net amount that the network provider paid to the supplier of the drug.
	  ○ A requirement that a PBM must respond to a challenge within 14 calendar days of the contracted pharmacy making the claim for which the appeal has been submitted.
	  ○ A telephone number and e-mail address or website to network providers, at which the provider can contact the PBM to process and submit an appeal.
	  ○ A requirement that, if an appeal is denied, the PBM must provide the reason for the denial and the name and the NDC number from national or regional wholesalers.
	  ○ A requirement that, if an appeal is sustained, the PBM 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 MCO or PBM.
	• Allow a plan sponsor or insurer whose coverage is administered by the PBM an annual right to audit compliance with the terms of the contract by the PBM, 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 PBM by a pharmaceutical manufacturer. The cost of the audit shall be borne exclusively by the PBM. • Allow a plan sponsor or insurer whose coverage is administered by the PBM to request that the PBM disclose the actual amounts paid by the PBM to the pharmacy. • Provide notice to the plan sponsor or the insurer party contracting with the PBM of any consideration that the PBM receives from the manufacturer for dispense as written once a generic or biologically similar product becomes available. **Patient Steering:** A PBM or an affiliate acting on its behalf shall not steer a covered individual. This prohibition also applies to an insurer and its affiliates. Steering includes: • Requiring a covered individual to only use a pharmacy, including a mail-order or specialty pharmacy, in which the PBM or its affiliate, or an insurer or its affiliate, maintains an ownership interest or control; • Offering or implementing a plan design that encourages a covered individual to only use a pharmacy in which the PBM 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 PBM or its affiliate or an insurer or its affiliate; and • Reimbursing a pharmacy or pharmacist for a drug and pharmacist service in an amount less than the amount that the PBM or an insurer reimburses itself or an affiliate, including affiliated manufacturers or joint ventures for providing the same drug or service.	
Patient Cost-Sharing	**Maximum Cost Sharing Levels:** A health insurer or PBM 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;	215 Ill. Comp. Stat. § 5/513b1 (e)

	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. **Copay Cap:** An insurer that provides coverage for prescription insulin drugs pursuant to the terms of a health coverage plan the insurer offers shall limit the total amount that an insured is required to pay for a 30-day supply of covered prescription insulin drugs at an amount not to exceed $35, regardless of the quantity or type of covered prescription insulin drug used to fill the insured's prescription. **Copay Adjustment Programs:** A health care plan shall apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by or on behalf of such insured for prescription drugs toward a covered individual's deductible, copay, or cost-sharing responsibility, or out-of-pocket maximum associated with the individual's health insurance. For high-deductible health plans, this requirement applies after a covered individual has met their minimum deductible necessary to remain HSA-eligible	215 Ill. Comp. Stat. § 5/356z.41; 215 Ill. Comp. Stat. § 134/30