Illinois Department of Insurance

JB PRITZKER
Governor

ANN GILLESPIE
Director

TO: All Pharmacy Benefit Managers Registered in Illinois, All Health Insurers Transacting Business in Illinois, and Certain Plan Sponsors Providing Health Benefit Plans in Illinois

FROM: Ann Gillespie, Director AG

DATE: November 26, 2025

RE: Company Bulletin 2025-20 – Clarification of PDAA Applicability and PBM Covered Individual Reports and Fees

Introduction

Under the Prescription Drug Affordability Act ("PDAA"),[1] each pharmacy benefit manager ("PBM") must file with the Illinois Department of Insurance ("Department") annual reports that include the number of covered individuals in health benefit plans they administer as outlined under Sections 513b2(f) and 513b1.1 of the Illinois Insurance Code ("Code") (215 ILCS 5/513b2(f) and 5/513b1.1). The first filing was a limited report due August 1, 2025, and PBMs were required to send a payment to the Department calculated at a rate of $15 per covered individual by September 1, 2025.[2] The PDAA does not require a covered individual or their plan sponsor or insurer to pay the fee.

When analyzing how to comply with the requirements in this first year, PBMs raised questions about whether the PDAA in general, and the reporting and fee requirements in particular, applied in relation to specific types of health-related coverage, plan sponsors, or covered individuals.

On October 30, 2025, the Illinois General Assembly passed HB 767 to clarify how the PDAA is intended to apply.[3] To that end, if a PBM failed to submit a payment in an amount that conformed with the PDAA's intended applicability, HB 767 states that the PBM must file a revised report with a corrected number of covered individuals by December 1, 2025. If the revised report indicates that the PBM previously undercounted the number of covered individuals who were within the intended scope of Section 513b2(f) of the Code, then HB 767 would require the PBM to pay the difference to the Prescription Drug Affordability Fund by January 2, 2026. If the revised report indicates that the PBM overcounted the number of covered individuals, then HB 767 would allow the PBM to receive either a credit toward a future payment or a cash refund, subject to funds availability, if the PBM includes the request with the submission of its revised report.

[1] Public Act 104-0027 (eff. July 1, 2025). https://ilga.gov/Documents/Legislation/PublicActs/104/PDF/104-0027.pdf.
[2] Labor Day occurred on September 1, 2025, so the Department allowed payments to be submitted on September 2.
[3] 104th General Assembly, HB 767. Enrolled bill: https://ilga.gov/Legislation/BillStatus/FullText?LegDocId=196211&DocName=10400HB0767enr&DocNum=767&DocTypeID=HB&LegID=156445&GAID=18&SessionID=114&SpecSess=&Session=.

As of November 26, 2025, HB 767 has not yet been signed into law, so its provisions for revised covered individual reports and fee adjustments are not currently in force. However, the Department is issuing this bulletin to prepare PBMs for implementation and to declare a limited exercise of enforcement discretion on the deadlines for the revised report and related fee adjustments.

Enforcement Discretion on Deadlines

It is possible that HB 767 will not be signed into law until December 1, 2025 or a later date, which would preclude compliance with the legislation's stated deadline for revised reports. The Department recognizes that each PBM will need time to review the legislation's clarifications against the PBM's previous interpretations of applicability to health benefit plans and covered individuals, as well as to identify all health benefit plans that were subject to Article XXXIIB of the Code and all Illinois residents who were covered individuals under those plans as of the date of their initial report or reporting deadline. **Therefore, the Department will not take enforcement action against any PBM for filing an otherwise compliant, revised report after December 1, 2025, as long as the PBM files the report within 30 business days of the date HB 767 is signed into law.**

Relatedly, the Department will not take enforcement action against a PBM that submits payment for any and all difference it owes to the Prescription Drug Affordability Fund within 1 calendar month of this bulletin's deferred enforcement date for filing the revised report.

The Department will publish the deferred enforcement dates on its website on the page named "Company Tax Forms, Deposits, Fees and Online ePay for Taxes and Invoices" once HB 767 is signed into law.

If the revised report indicates that a PBM overcounted the number of covered individuals in its initial report, the Department will enforce HB 767's addition of Section 513b2(f)(2) of the Code except for the phrase "on or before December 1, 2025."

Clarification of Applicability

HB 767 clarifies that, notwithstanding the fact that the PDAA's substantive requirements in Section 513b1 of the Code take effect January 1, 2026, the PDAA's amendments to the definitions in Section 513b1 apply to the covered individual report and fee payments that were due in 2025.

HB 767 also clarifies that the 2025 covered individual report and the related fee are based on the number of Illinois residents who are covered individuals. Beginning in 2026, the annual report in Section 513b1.1 of the Code will be required to include data on both the total number of covered individuals in Illinois-domiciled health benefit plans and the number of Illinois residents who are covered individuals. The annual covered individual fee will continue to be based only on Illinois residents.

HB 767 further revises and expands the PDAA's definitions in Section 513b1(a) and (a-5), explains the method to determine applicability to self-funded nonfederal governmental plans in Section 513b1(m), and explains the method to determine applicability to a plan or covered individual outside Illinois in Section 513b1(n). **A PBM must take these definitions and methods into account when ascertaining whether and how HB 767 would require it to submit a revised covered individual report and fee adjustment for 2025.** This bulletin's lack of mention of any particular definition or method must not be construed as a waiver of the requirement for a PBM to apply the definition or method under the PDAA and HB 767.

A. Revised and Expanded Definitions

HB 767 expressly adopts federal definitions of "employee welfare benefit plan," "plan sponsor," "multiemployer plan," "federal governmental plan," and "nonfederal governmental plan" contained in the Employee Retirement Income Security Act of 1974 ("ERISA") and the Public Health Service Act. The bill also replaces citations to 29 U.S.C. 1144 with 29 U.S.C. 1003. The bill also removes a redundant sentence from the definition of "health benefit plan." Among other things, the changes clarify:

- A plan sponsor is not the same as an insurer. Article XXXIIB of the Code distinguishes when its requirements apply to a PBM in relation to an insurer versus a plan sponsor, or both. Article XXXIIB also places some substantive requirements directly on insurers, but not plan sponsors.
- An ERISA plan does not technically include nonfederal governmental plans or church plans, but the PDAA uses the ERISA terms "plan sponsor" and "employee welfare benefit plan" to include an employer that sponsors nonfederal governmental plans and church plans.
- The definition of "health benefit plan" includes ERISA plans that are not self-funded multiemployer plans.[4] Some, but not all, requirements of Article XXXIIB apply to PBMs in relation to ERISA plans they administer. The covered individual report and fee provisions **do apply** to PBMs in relation to ERISA plans that are not self-funded multiemployer plans.

B. Self-Funded Nonfederal Governmental Plans; Pharmacy Services for Persons in Custody

For self-funded nonfederal governmental plans, HB 767 clarifies that Article XXXIIB of the Code applies "only when a State law organizing the governmental unit incorporates this Article by reference." The same principle applies to any PBM that "administers coverage of, payment for, or formulary design for drugs necessary to safeguard the life or health of any person in custody" of the State or a local government. The PDAA treats the governmental unit as a plan sponsor for purposes of Article XXXIIB of the Code. To date, Article XXXIIB has been incorporated into the following State laws for nonfederal governmental plans and for governmental units holding persons in custody:

- Nonfederal governmental plans covering employees and their dependents:
  - The State Employees Group Insurance Act of 1971 (5 ILCS 375/6.11)
  - The School Code (105 ILCS 5/10-22.3f)

- Pharmacy services for persons in custody:
  - The Juvenile Court Act of 1987 (705 ILCS 405/5-515)
  - The Unified Code of Corrections (730 ILCS 5/3-2-2)
  - The County Jail Act (730 ILCS 125/17)

C. Applicability to plans and individuals outside Illinois

HB 767 clarifies that Sections 121-2.03, 121-2.04, 121-2.05, 121-3(a), (c), and (e), and 352(c) of the Code determine the applicability of Article XXXIIB regardless of whether the health benefit plan is insurance. Thus, Article XXXIIB generally does not apply to ERISA plans or church plans with a domicile or a *bona fide* situs outside Illinois. Please consult the cited statutes for more information.

However, except for the covered individual fee under Section 513b2(f), when Article XXXIIB applies to a health benefit plan, statutory references to a "covered individual" include all individuals covered under the plan regardless of whether they reside in Illinois.

[4] A "multiemployer plan" is different from a "multiple employer welfare arrangement." *Compare* 29 U.S.C. § 1002(37) *with* 29 U.S.C. § 1002(40).

D. Implications for Covered Individual Report and Fee

The reporting and fees required under Section 513b2(f) of the Code relate to Illinois residents who are covered individuals under each health benefit plan the PBM administers. The definition of "health benefit plan" includes:

- Any policy, contract, certificate, or agreement entered into, offered, or issued by an "insurer" as defined in Section 513b1(a-5)
- Any self-funded employee welfare benefit plan, except for a self-funded multiemployer plan that is not a nonfederal government plan.

Taking into consideration all principles previously discussed in this bulletin, under the PDAA as clarified by HB 767, the Section 513b2(f) reporting and fee provisions **do apply** to PBMs in relation to:

- Policies of fully-insured health insurance coverage that are sitused in Illinois
- Except as further provided, self-funded employee welfare benefit plans that are sitused in Illinois. This includes:
    - Self-funded ERISA-covered plans, other than ERISA-covered self-funded multiemployer plans
    - Self-funded "church plans" as defined at 29 U.S.C. § 1002(33), unless the church plan also qualifies as an ERISA-covered self-funded multiemployer plan
    - Self-funded plans established under the State Employees Group Insurance Act of 1971 (5 ILCS 375)
    - Self-funded plans established under the School Code (105 ILCS 5), including any intergovernmental pools in relation to their school district members
- Illinois Medicaid and All-Kids
- Any contracts or arrangements for drugs needed by persons in custody as described in 705 ILCS 405/5-515(b), 730 ILCS 5/3-2-2(3.5), or 730 ILCS 125/17, as amended by the PDAA.

The Section 513b2(f) reporting and fee requirements **do not apply** to PBMs in relation to:

- Self-funded multiemployer plans that **are** covered by ERISA under 29 U.S.C. § 1003.
- Self-funded plans established under the Counties Code (55 ILCS 5)
- Self-funded plans established under the Illinois Municipal Code (65 ILCS 5)
- Self-funded plans established by any other State or local governmental unit not previously mentioned
- Medicare Advantage, Medicare Part D, a Medicare demonstration program, or any program for dually eligible Medicare-Medicaid beneficiaries under which Medicare pays for most or all of the covered drugs
- Tricare
- Federal Employee Health Benefits Program
- Any group or blanket policy or plan sitused outside Illinois to the extent meets all criteria in 215 ILCS 5/121-2.05.

If a PBM also is a plan sponsor of a health benefit plan, it is only subject to 215 ILCS 5/513b2(f) in its capacity as a PBM.

Instructions for Revised Reports and Fee Adjustments

When HB 767 is signed into law, each PBM registered with or required to report to the Department under Article XXXIIB of the Code as clarified by HB 767 shall submit to the Department, using the Excel spreadsheet named "PBM Covered Individual Reporting Template", the following columns of information as of the date of its initial report or, if the PBM submitted no initial report, the information that should have been submitted as of August 1, 2025:

- **Column A.** The name of every health benefit plan the PBM administered on that date based on the clarified applicability from HB 767, as well as all additional health benefit plans the PBM erroneously included in its initial report. **Do <u>not</u> limit the revised report to only those health benefit plans that have been added or removed versus the initial report. That will cause a miscalculation of the fee adjustment.** If the PBM did not submit an initial report but HB 767 indicates that one or more of the plans it administered on August 1, 2025, was a health benefit plan subject to Article XXXIIB of the Code, the PBM must file the report and include all such plans in this column.

- **Column B.** The total number of covered individuals that the PBM previously reported for each health benefit plan identified in the initial report. For each health benefit plan on the revised report that the PBM erroneously omitted from its initial report, or if the PBM erroneously did not file an initial report, write "N/A" in this column for that plan.

- **Column C.** The total number of Illinois residents who were covered individuals for each health benefit plan that the PBM administered on the date of the initial report, based on the maximum scope of health benefit plans subject to the PDAA as clarified by HB 767. If a health benefit plan was included in the initial report that should not have been included based on HB 767, write "N/A" in this column for that plan. Write "0" if the PBM was contracted to administer the plan, but the plan had no covered individuals on the initial reporting date or deadline.

- **Column D.** An explanation of any changes between the initial and revised reports for each health benefit plan. If the initial report correctly specified the number of Illinois residents who were covered individuals for a particular health benefit plan actually subject to the PDAA, write "No change" in this column. If the initial report incorrectly omitted or included the plan in the initial report because the PBM did not understand that the plan, respectively, was or was not subject to the reporting and fee requirements, identify the type of plan the PBM previously believed to have been subject or not subject to the requirements. For example, if the PBM believed that the reporting and fee requirements did not apply to any ERISA plan whatsoever until January 1, 2026, the PBM could write something to the effect that, in its initial report, it erroneously omitted ERISA plans that were not ERISA-covered multiemployer plans. As another example, if the PBM believed that the reporting and fee requirements applied to municipal employee welfare benefit plans, the PBM could write something to the effect that, in its initial report, it erroneously included such plans. If the PBM did not misinterpret the statute but accidentally included or excluded the wrong health benefit plan, or if the PBM miscounted the number of Illinois residents who were covered individuals under the plan, write "miscount" in this column.

You may download the PBM Covered Individual Reporting Template from the Department's website at the page named "Company Tax Forms, Deposits, Fees and Online ePay for Taxes and Invoices".

Within 1 calendar month of the Department's deferred enforcement date for filing the covered individual report, a PBM must remit to the Department, via the "Pharmacy Benefit Manager Covered Individual Fee Form" downloadable from the same webpage, an amount equal to $15 multiplied by the difference

in covered individuals reported. If HB 767 is signed into law, the Department will publish the resulting fee payment deadline on the webpage near the PBM template and form.

An officer's signature attesting to the reported exposure count is required.

Submit the reporting template as described above to DOI.TaxAudit@illinois.gov.

Submit the fee form and payment as described above payable to the Illinois Department of Insurance, Attn.: Tax Admin. Unit, P.O. Box 7087, Springfield, Illinois 62791.

If HB 767 is signed into law, for requests for credit or a cash refund, please file the Pharmacy Benefit Manager Covered Individual Fee Form. Consult 215 ILCS 5/513b2(h)(3) and 50 Ill. Adm. Code 2500 for more information.

To confirm receipt of payment or ask other questions about this bulletin, contact DOI.TaxAudit@illinois.gov.