



Illinois Department of Insurance

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Governor

ANN GILLESPIE
Director

TO: All Pharmacy Benefit Managers Registered in Illinois and All Illinois Medicaid Managed Care Entities

FROM: Ann Gillespie, Director *ARG*

DATE: May 15, 2026

RE: Company Bulletin 2026-07 – PDAA Applicability to Medicaid Managed Care Plans

The Illinois Department of Insurance (“Department”) is issuing this bulletin to address the Medicaid-related applicability of provisions within Section 513b1 of the Illinois Insurance Code (“Code”) (215 ILCS 5/513b1), especially provisions that fall after subsection (f) and before subsection (g).

Since January 1, 2026, pharmacy benefit managers (“PBMs”) and their affiliates have been required to comply with subsections (f-5) through (f-25) of Section 513b1 of the Code in relation to Medicaid managed care plans. Additionally, as “insurers” or “health insurers” within the meaning of Section 513b1(a-5), Medicaid managed care entities and their affiliates directly have been required to comply with subsections (f-10), (f-20), and (f-25) of Section 513b1.

As added by the Prescription Drug and Affordability Act,¹ these subsections establish the following requirements for the administration of pharmacy benefits under health benefit plans:

(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. This prohibition also applies to an insurer and its affiliates. Existing agreements entered into before the effective date of this amendatory Act of the 104th General Assembly shall supersede this subsection until the termination of the current term of such agreement.”

(f-15): “A pharmacy benefit manager or affiliated rebate aggregator must remit no less than 100% of any amounts paid by a pharmaceutical manufacturer, wholesaler, or other distributor of a drug, including, but not limited to, rebates, group purchasing fees, and other fees, to the health benefit plan sponsor, covered individual, or employer.” The subsection further establishes a PBM reporting requirement to the Department of Insurance and protects confidential information received by the Department.

(f-20): “A pharmacy benefit manager or an affiliate acting on its behalf is prohibited from limiting a covered individual's access to drugs from a pharmacy or pharmacist enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage area by designating the

covered drug as a specialty drug contrary to the definition in this Section. This prohibition also applies to an insurer and its affiliates.”

(f-25) “The contract between the pharmacy benefit manager and the insurer or health benefit plan sponsor must allow and provide for the pharmacy benefit manager's compliance with an audit at least once per calendar year of the rebate and fee records remitted from a pharmacy benefit manager or its affiliated party to a health benefit plan. This audit may be incorporated into the audit under paragraph (5) of subsection (b) of this Section. Contracts with rebate aggregators, pharmacy services administrative organizations, pharmacies, or drug manufacturers must be available for audit by health benefit plan sponsors, insurers, or their designees at least once per plan year. Audits shall be performed by an auditor selected by the health benefit plan sponsor, insurer, or its designee.” The subsection further requires copies of the report to be provided to the PBM and to the Department, affirms the Department’s authority to access books and records regardless of any plan sponsor-initiated audit, and protects confidential information received by the Department.

In general, Section 513b1 of the Code applies with respect to Medicaid managed care plans: “This Section applies to contracts entered into or renewed on or after July 1, 2022. Unless provided otherwise in this Section or in the Illinois Public Aid Code, this Section applies to pharmacy benefit managers that are contracted with a Medicaid managed care entity on or after January 1, 2026...” 215 ILCS 5/513b1(j).

Additionally, the Code states: “The changes made to this Section by Public Act 104-27 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.” 215 ILCS 5/513b1(k). The definition of “health benefit plan” refers to contracts with an “insurer” to pay for the costs of various health benefits, and the definition of “insurer” expressly includes Medicaid managed care organizations and managed care community networks. 215 ILCS 5/513b1(a) and (a-5).

Section 513b1 of the Code contains only one provision with a Medicaid-related exemption:

(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:

...
[list of prohibited contractual provisions]

...
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” (emphasis added).

Because the phrase “this subsection” occurs within subsection (f), the phrase refers to subsection (f). Subsections (f-5) through (f-25) are different from, and not part of, subsection (f). In fact, subsection (f) predates the PDAA and was not substantively modified by it.² Therefore, the “f-dash” subsections are not affected by the above exemption. All “f-dash” subsections of Section 513b1 of the Code have applied with respect to Medicaid managed care plans since they took effect on January 1, 2026.

Questions regarding this company bulletin can be directed to DOI.InfoDesk@illinois.gov.