Riding the Currents: Navigating 2026 Pharmacy Law and Policy in a Time of Change

Garth K. Reynolds, BSPharm, RPh, MBA, FAPhA
Executive Director
Illinois Pharmacists Association

1

Disclosures and Conflict of Interest

- **Garth Reynolds declares no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings and honoraria.**

2

Disclosure of AI Use

The following AI applications were utilized for image development for this activity.

- ChatGPT 5.5 (July 2026)

3

Pharmacist Objectives

At the conclusion of this program, the pharmacist will be able to:

- Describe significant federal and Illinois pharmacy law and regulatory changes affecting pharmacy practice in 2026.
- Explain the impact of recent legislative and regulatory developments on pharmacy practice, patient care, and reimbursement.
- Identify legal and regulatory requirements related to current pharmacy practice, including changes in scope of practice, compliance expectations, and reimbursement policies.
- Recognize appropriate responses to common pharmacy law and regulatory situations using current legal and professional standards.

4

Technician Objectives

At the conclusion of this program, the pharmacist will be able to:

- Describe federal and Illinois pharmacy law updates that affect technician practice.
- Explain how recent legal and regulatory changes influence pharmacy workflow, patient safety, and technician responsibilities.
- Identify compliance requirements applicable to pharmacy technicians and situations that require pharmacist involvement.
- Recognize resources available to support compliance with current pharmacy laws and regulations.

5

Which of the following best describes the DEA's April 2026 final order on marijuana scheduling?

a) All marijuana, including adult-use, moved to Schedule III
b) Marijuana was fully removed from the CSA
c) DEA rejected HHS's recommendation and left it in Schedule I
d) FDA-approved products and state-licensed medical marijuana moved to Schedule III; adult-use and synthetic THC remain Schedule I

6

Under HB 1443/SB 66's PDAB provisions, what is the practical impact of the Upper Payment Limit on pharmacy reimbursement?

a) A ceiling manufacturers can't exceed, unrelated to pharmacy pay
b) A ceiling PBMs may negotiate below
c) A floor — pharmacies must receive at least the UPL amount, with dispensing fees separate
d) Applies only to dispensing fees

7

Under new Section 1330.120, pharmacists may order/administer tests or therapeutics for which conditions?

a) Flu and COVID-19 only
b) Influenza, SARS-CoV-2, Group A Strep, RSV, adult-stage head louse, and statewide public health emergency conditions
c) Any condition, unrestricted
d) Chronic conditions only, under standing order

8

A patient asks a pharmacy to transfer an unfilled Schedule II prescription to another pharmacy. Under SB 3213, what is the pharmacy's appropriate response?

a) Refuse the transfer — Schedule II prescriptions can never be transferred under Illinois law
b) Transfer is permitted only for Schedules III-V; Schedule II remains categorically non-transferable
c) The patient must get an entirely new prescription rather than requesting a transfer
d) The pharmacy must transfer the prescription, since transfer is now required on patient request for Schedules II-V unless the prescriber has documented a specific clinical reason against it, or federal law prohibits it

9

Riding the Currents

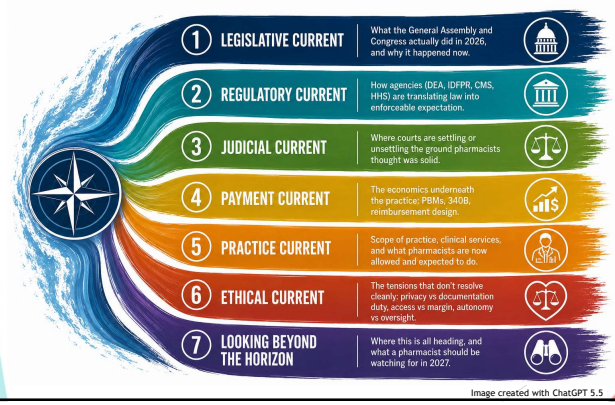


Image created with ChatGPT 5.5

10

Image created with ChatGPT 5.5

11

HB1697 | Prescription Drug Affordability Act

- Establishes extensive requirements on PBM conduct affecting Illinois patients and pharmacies:
  - Restoring Fairness and Stop PBM Abuses
  - Enforcing Transparency and Accountability
  - Supporting Pharmacy Sustainability and Patient Access
- Enforcement and reporting are going to be key as the Act continues to be implemented.
- **We need your assistance:** consider keeping a timestamped log of any suspected anomaly tied to specific PBM conduct.
- This bill did not just happen by chance. It passed because members showed up: testifying, calling, standing up at the Capitol.

https://ilga.gov/legislation/PublicActs/View/104-0027

12

HB2371|Patient Access to Pharmacy Protection Act
HB4327|340B Transparency, Reporting, and Accountability Act

- Sponsors: Rep. Anna Moeller | Sen. David Koehler
- Bars manufacturers from restricting a 340B covered entity's or contract pharmacy's acquisition of 340B drugs, unless federal law prohibits it
- Bars restricting a covered entity's ability to contract with or designate a contract pharmacy
- Each individual restricted transaction is a separate violation
- New reporting duty for covered entities to HFS
- STATUS: Public Act 104-0758 | Effective August 7, 2026

- Sponsors: Rep. Camille Lilly | Sen. David Koehler
- Directs the Department of Insurance to study 340B participation in Illinois; requires insurer/PBM/manufacturer compliance with DOI information requests
- Enforcement amendments to HB 2371 activate only if HB 2371 becomes law
- STATUS: Public Act 104-0769 | Effective August 7, 2026

https://iliga.gov/legislation/PublicActs/View/104-0758
https://iliga.gov/legislation/PublicActs/View/104-0769

13

HB4154 | Pharmacist Application/Exam

- Sponsors: Rep. Natalie Manley | Sen. David Koehler
- Removes the MPJE requirement for pharmacist licensure.
- Pharmacist licensure applicants must complete an ACPE-accredited Illinois pharmacy law program, developed and provided by IPhA
- Renewal now requires two CPE hours to be pharmacy law specifically
  - Applies for 2028 renewals
- Illinois Pharmacist Orientation and Readiness Program (ILPRO) began operation on June 16, 2026.
- STATUS: Public Act 104-0461 | Effective June 1, 2026

https://iliga.gov/legislation/PublicActs/View/104-0461

14

Illinois Pharmacist Readiness and Orientation Program (ILPRO)

- 815 registrations
- 744 completions
- Self-paced, 10-modules
- Covering Illinois pharmacy law, regulatory compliance, and professional responsibility
- Each module includes embedded knowledge checks and concludes with a graded assessment (75% passing threshold)

ILPRO
ILLINOIS PHARMACIST READINESS AND ORIENTATION PROGRAM
A Program of the Illinois Pharmacists Association

15

HB4793 | Pharmacist Dispensing Ability

- Sponsors: Rep. Rick Ryan | Sen. David Koehler
- Pharmacists may add missing ancillary devices or DME to a prescription using professional judgment — no new prescriber contact needed
- Document the change in the patient's record
- STATUS: Public Act 104-0679 | Effective January 1, 2027

https://iliga.gov/legislation/PublicActs/View/104-0679

16

HR746 | HFS Reimbursement Parity

- Sponsor: Rep. Maurice West, II
- Non-binding resolution urging Medicaid managed-care pharmacy reimbursement parity with fee-for-service
- A documented advocacy data point, even though non-binding
- STATUS: Resolution adopted May 28, 2026

https://ilga.gov/Legislation/BillStatus?DocNum=746&GAID=18&DocTypeID=HR&LegId=168137&SessionID=114

17

HB5804 | Medicaid – MCO Rx Payments

- Sponsor: Rep. Dave Vella
- Require Medicaid MCOs to reimburse non-CAP pharmacies at no less than Illinois Medicaid fee-for-service rates.
- Apply the floor to both the professional dispensing fee and drug acquisition cost.
- Cover payments made directly by an MCO or through its contracted PBM.
- Apply the protection to all pharmacy services provided under the Illinois Public Aid Code.
- Status: Filed with the (H) Clerk

18

HB4834 | Controlled Sub-Testosterone

- Sponsors: Rep. Kelly Cassidy | Sen. Sara Feigenholtz
- Removes testosterone, mifepristone, misoprostol, GnRH analogues, and estrogen from PMP tracking
- DHS must purge existing records by January 1, 2027
- **Compliance Note:** make sure that your pharmacy management systems have started editing the PMP submission records.
- STATUS: Public Act 104-0535 | Effective June 29, 2026

https://ilga.gov/legislation/PublicActs/View/104-0535

19

HB5148 | Cont Sub-PMP-Schedule II&IV

- Sponsors: Rep. Janet Yang Rohr | Sen. Julie Morrison
- Requires prescribers to document a PMP-check attempt for initial Schedule II stimulant or opioid and Schedule IV benzodiazepine prescriptions
- STATUS: Public Act 104-0512 | Effective January 1, 2027

https://ilga.gov/legislation/PublicActs/View/104-0512

20

SB3213 | Electronic Prescriptions

- Sponsors: Sen. Steve McClure | Rep. Kelly Cassidy
- Upon a patient's request, a pharmacy must transfer the prescription to another pharmacy, including Schedule II controlled substances, if the prescription has been received but not yet filled. Pharmacies must transfer on patient request unless the prescriber documented a clinical reason against it.
  - (a) the prescriber prohibits transfer in writing on the prescription and documents a clinical reason prohibiting transfer on the prescription; or
  - (b) the transfer is otherwise prohibited by federal law.
- Transfers may occur electronically or by facsimile when permitted by federal law.
- A pharmacy technician may perform the transfer if delegated by a pharmacist.
- Additional reasons why the CS prescription may not be electronic:
  - (4.5) prescriptions issued prior to 1/1/2028 that may need to be filled outside of typical retail pharmacy operating hours;
  - (4.6) prescriptions issued prior to 1/1/2028 that may be difficult to obtain because the prescriber knows of drug shortages or pharmacy inventory limitations;
- STATUS: Public Act 104-0846 | Effective: January 1, 2027

https://ilga.gov/legislation/PublicActs/View/104-0846

21

SB1743 | Clinic Psyc-No Prescrip Opioid

- Sponsors: Sen. Lakesia Collins | Rep. Maurice West, II
- Removes prior age restriction (under 17 y/o and over 64 y/o) on prescribing psychologists' patients
- Expands delegated controlled-substance authority to nonnarcotic, nonopioid Schedule II-V — Schedule II opioid delegation still not allowed
- STATUS: Public Act 104-0622 | Effective July 24, 2026

https://ilga.gov/legislation/PublicActs/View/104-0622

22

HB4982 | Pharmacies-9-8-8 Information
SB3223 | Practice of Pharmacy

- Sponsors: Rep. Jackie Haas | Sen. Erica Harriss
- Every patient-facing pharmacy must post 988 Suicide and Crisis Lifeline signage
  - Additional hotline numbers (411, Poison Control, etc)
- Electronic delivery satisfies this if the patient consented electronically; non-physical-location pharmacies include the notice with dispensed prescriptions
- STATUS: Public Act 104-0691 | Effective January 1, 2027

- Sponsors: Sen. Doris Turner | Rep. Mary Gill
- Requires QR-code signage near both the counter and drive-up window
- Informing patients of the ability to sign up for medication recalls via the FDA website
- STATUS: Public Act 104-0530 | Effective January 1, 2027

https://ilga.gov/legislation/PublicActs/View/104-0691
https://ilga.gov/legislation/PublicActs/View/104-0530

23

HB3454 | Epinephrine Delivery Device

- Sponsors: Rep. Joyce Mason | Sen. Suzanne Glowiak Hilton
- Renames "epinephrine auto-injector" to "epinephrine delivery system" across multiple Acts
- **Compliance Reminder**: Prescriptions for undesignated supply can be written in the name of the school (in addition to naloxone, glucagon, oxygen, albuterol inhalers, spacers/chambers)
- STATUS: Public Act 104-0762 | Effective January 1, 2027

https://ilga.gov/legislation/PublicActs/View/104-0762

24

SB3896 | Wholesale Drug Distributors
HB4953 | Drug Distribution Restrictions

- Sponsors: Sen. Suzanne Glowiak Hilton | Rep. Theresa Mah
- Creates an IDFPR license category for "virtual wholesale distributors" that broker drug distribution without physical possession
- Cannot operate from a residence; any entity holding physical custody must independently meet its own requirements
- STATUS: Public Act 104-0745 | Effective July 31, 2026

- Sponsors: Rep. Martha Deuter | Sen. Laura Ellman
- Prescription drugs may be delivered only to a registered business address, license premises, or an authorized health care entity address on file
- Controlled substances must go to a registered place of business or professional practice
- STATUS: Public Act 104-0781 | Effective January 1, 2027

https://ilga.gov/legislation/PublicActs/View/104-0745
https://ilga.gov/legislation/PublicActs/View/104-0781

25

SB3341 | Birth Control-Minors Consent
HB5492 | Prescription Hormone Therapy

- Sponsors: Sen. Graciela Guzmán | Rep. Dagmara Avelar
- Minors may consent to contraceptive services with no other person's consent required
- Request may go to a physician, APRN, physician assistant, or pharmacist
- STATUS: Public Act 104-0570 | Effective January 1, 2027

- Sponsors: Rep. Katie Stuart | Sen. Lakesia Collins
- Insurance must cover up to a 6-month supply of prescription hormone therapy dispensed at once
- Coverage mandate applies to policies issued on or after January 1, 2028
- STATUS: Public Act 104-0537 | Effective January 1, 2027

https://ilga.gov/legislation/PublicActs/View/104-0570
https://ilga.gov/legislation/PublicActs/View/104-0537

26

SB3295 | Ins-Durable Medical Equipment

- Sponsors: Sen. Julie Morrison | Rep. Justin Cochran
- DME insurance parity regardless of prescriber type.
- Coverage mandate applies to 2028 policies.
- STATUS: Public Act 104-0531 | Effective June 26, 2026 (parity requirement applies to 2028 policies)

https://ilga.gov/legislation/PublicActs/View/104-0531

27

HB1443 / SB66 Prescription Drug Affordability Board

- Establishes a PDAB (Health Care Availability and Access Board) empowered to set an Upper Payment Limit (UPL) on high-cost drugs.
- 12 negotiated pharmacy-protective provisions moved IPhA from opposed to neutral
- STATUS: Re-referred to (H) Rules Committee (was on (H) 3rd Reading)


How Illinois built a PDAB that protects pharmacies

A model for affordability without dismantling the supply chain

HB 1443 SB 66 **As Illinois advanced its Prescription Drug Affordability Board (PDAB) legislation, pharmacists helped shape the final product. Targeted amendments — negotiated with legislators and advocates — moved the Illinois Pharmacists Association from opposition to NEUTRAL.**

WHAT THE AMENDMENTS SECURED

PHARMACY AT THE TABLE

- **Recognition as protected stakeholders** within the scope and intent of the PDAB. *§10(a)*
- **A pharmacist on the Board** — at least one member must have direct experience in the practice of pharmacy. *§10(b)(2)*
- **Pharmacy seats on the Stakeholder Council**, with designated representatives from both community practice and pharmacy administration. *§20(b)(7)-(8)*

THOUGHTFUL IMPLEMENTATION BEFORE ANY UPL

- **Mandatory operationalization plan** required before any UPL action. The Board must assess pharmacy participation in urban and rural areas, statewide drug distribution, the access of pharmacies to participate, and access in pharmacy deserts — particularly keystone-designated areas. *§21*

REIMBURSEMENT THAT PHARMACIES CAN SURVIVE

- **UPL is a reimbursement floor** — pharmacies must receive at least the UPL amount from PBMs or health plans. *§30(g-1)*
- **Dispensing fees paid on top of the UPL.** The UPL applies only to ingredient cost; dispensing fees are separate. *§30(e), §30(g-2)*
- **Anti-clawback protections** against PBM fees, adjustments, or clawbacks that push payment below the UPL. *§30(f)*
- **Rebate / chargeback framework** built in to support pricing alignment within the state model. *§30(f)*

SUPPLY CHAIN & OPERATIONAL SAFEGUARDS

- **Pharmacy opt-out protection** — pharmacies may decline to dispense if acquisition cost conditions are not met. *§30(g), §30(g-2)*
- **Wholesaler/distributor obligations** to make the drug available at or below the UPL. *§30(g), §30(g-1)*
- **No new administrative burden** — pharmacies are not responsible for eligibility or enrollment in PDAB-related programs. *§30(g-6)*
- **Explicit separation from 340B**, preventing unintended overlap or interference. *§30(a)*

12
PHARMACY-PROTECTIVE PROVISIONS SECURED IN HB 1443 / SB 66

THE ILLINOIS SHIFT
By securing pharmacy representation, a reimbursement floor, and a mandatory implementation review, advocates moved the Illinois Pharmacists Association from **OPPOSED** to **NEUTRAL** on the PDAB bill.

WHY IT MATTERS

UPLS WITHOUT GUARDRAILS PUT PHARMACIES AT RISK
Upper payment limits set by PDABs can — without protective provisions — be used by PBMs to drive reimbursement below acquisition cost, accelerating closures and widening pharmacy deserts.

A FLOOR, NOT A CEILING, FOR PHARMACIES
The Illinois model treats the UPL as the **minimum** a pharmacy must be paid by a PBM or plan — not a target reimbursement to negotiate down from.

PATIENT ACCESS IS PRESERVED
Opt-out rights, wholesaler obligations, and a required operationalization plan ensure that affordability gains aren't paid for by shuttered pharmacies in the communities that need them most.

A MODEL FOR OTHER STATES
Amendments that prioritize **pharmacy representation**, safeguard against **negative reimbursement**, and require **thoughtful implementation** can create environments where drug affordability efforts and pharmacy sustainability are not at odds.

PSM IPhA Illinois Pharmacists Association The Voice for Pharmacy in Illinois

Source: Illinois HB 1443 / SB 66, as amended. Section references provided for each provision.

https://ilga.gov/Legislation/BillStatus?DocNum=1443&GAID=18&DocTypeID=HB&LegId=157490&SessionID=114
https://www.safemedicines.org/wp-content/uploads/2026/06/Illinois_PDAB_Pharmacy_Protections.pdf

28

H.R. 7148 | Consolidated Appropriations Act, 2026

- **Medicare Part D delinking:** Beginning in 2028, PBM compensation generally must be limited to flat, fair-market-value service fees rather than payments tied to drug prices or retained rebates.
- **Rebate pass-through:** PBMs must pass through manufacturer rebates, discounts and other price concessions to Medicare drug plans and commercial plan sponsors.
- **Transparency and accountability:** Expanded reporting and audit requirements cover rebates, drug spending, pharmacy reimbursement, affiliated pharmacies and other PBM compensation.
- **Pharmacy network access:** Beginning in 2029, Part D plans must permit pharmacies meeting reasonable and relevant standard contract terms to participate, with a federal process for reporting violations.

29

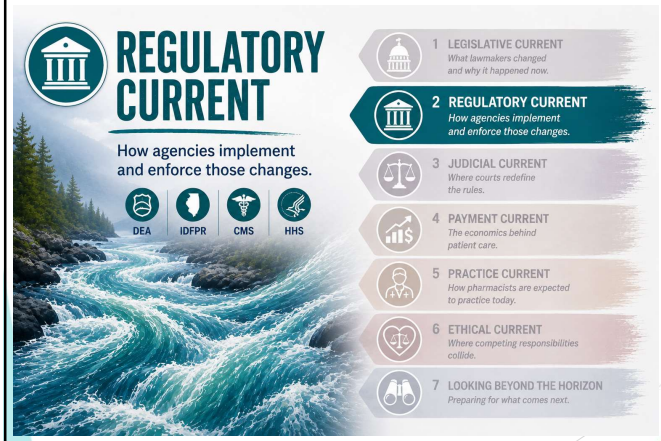


Image created with ChatGPT 5.5

30

Pharmacy Practice Act Rules: Technician, Student Pharmacist, and Renewal Changes

- IDFPR's January 2026 rulemaking is the most consequential state regulatory action this year for technicians and students — covered here across three slides
- **Student pharmacist status is now separate from technician licensure.** Additional IDFPR guidance is expected Fall/Winter 2026
- **Work-experience technician certification now requires a 100-hour didactic minimum** — training programs should be checked against this number
- **CE clarified:** 20 hours in the 24 months preceding license expiration, on a new two-year renewal cycle
- **Restoration:** technicians need a restoration application, the renewal fee, and evidence of meeting renewal requirements. Pharmacies with licenses expired over a year face updated restoration provisions

https://ilga.gov/agencies/JCAR/EntirePart?titlepart=06801330

31

Pharmacy Practice Act Rules: Professional Standards and New Testing Authority

- A new catch-all disciplinary provision allows IDFPR action for breaches of patient responsibility, aligning pharmacists with how other health professions are already regulated ***(Standard of Care)***.
- Mandatory testing training for every technician has been removed. Task-specific training is now the pharmacist's discretion.
- **NEW Section 1330.120** authorizes pharmacists to order and administer tests or therapeutics for influenza, SARS-CoV-2, Group A Streptococcus, RSV, adult-stage head louse, and any condition identified during a statewide public health emergency.
- Training is the responsibility of the pharmacist, student, or technician if it would be warranted for their continued professional development and standard of care.
- These tasks can be delegated to technicians or student pharmacists.

https://ilga.gov/agencies/JCAR/EntirePart?titlepart=06801330

32

Pharmacy Practice Act Rules: Operational and Structural Updates

- Recordkeeping: invoices are now required for every pharmacy-to-pharmacy drug transfer.
- Telepharmacy: onsite pharmacist coverage at remote sites must now be logged, and an audio/visual consultation is required for every new prescription
- LTC After-hour cabinets/emergency kits: "practitioner order" instead of physician order
- Pharmacy remodel: Division approval is now required *before* starting a pharmacy remodel, not after
- "New prescription" is now "new drug" in the counseling requirement
  - Clarify from renewal of prescription and a new prescription
- Pharmacist-in-Charge (PIC) responsibilities: PICs now share responsibility with the license holder for controlled substance inventory
- New sections cover outpatient clinic pharmacy, offsite institutional pharmacy (including Ambulatory Surgical Treatment Centers, or ASTCs), and centralized prescription filling

https://ilga.gov/agencies/JCAR/EntirePart?titlepart=06801330

33

Cannabis Rescheduling: Medical Marijuana Moves to Schedule III

- **April 23, 2026:** DEA moved two specific categories of cannabis from Schedule I to Schedule III
  - FDA-approved marijuana drug products
  - Cannabis obtained under a qualifying state medical cannabis license.
- This followed a 2023 HHS scientific review recommending Schedule III and a 2024 Department of Justice (DOJ) proposed rule
- **What stayed Schedule I:** adult-use/recreational cannabis, synthetic THC, and hemp (as federally defined)
- **What this unlocks:** expanded DEA-registered research access, an expedited DEA registration pathway for state-licensed medical operators, and relief from tax burden for those operators
- **What's still unresolved:** FDA has issued no guidance on whether this changes anything for cannabis-derived foods or dietary supplements

34

Cannabis Rescheduling: The Adult-Use Hearing and What Comes Next

- DEA opened a second, broader hearing simultaneously with the April order — this one on whether adult-use cannabis should move to Schedule III as well
- **Hearing ran June 29–July 15, 2026**
  - Only parties opposed to rescheduling testified
  - since DEA itself is the rule's proponent
- **Post-hearing briefs are due August 17, 2026.** No deadline for DEA's final decision
- **Bottom line:** Could be a massive opportunity for pharmacy.

35

DEA and FDA: Smaller Topics

- **HALT Fentanyl Act:** fentanyl-related substances are now permanently Schedule I as a class — no more temporary extensions
- **Telemedicine controlled-substance prescribing:** extended again — the "Fourth Temporary Extension," running through December 31, 2026.
- **DSCSA enforcement:** small dispensers have until November 27, 2026 to fully comply with the Drug Supply Chain Security Act (DSCSA). FDA has stated enforcement is active now.
- **Compounding oversight:** FDA is tightening enforcement on compounded GLP-1 products as commercial supply stabilizes — shortage-based allowances are being treated as temporary

36

CMS (IL) and the 340B Cost Claim Memorandum

- Illinois CMS estimated that the existing 340B Program costs Illinois employers approximately $224 million annually.
- The agency projected that the proposed contract-pharmacy legislation could add another $89 million, including $12.4 million for the State Employees Group Insurance Program.
- These estimates and their assumptions remain disputed.

37

Federal Vaccine Policy: The August 2026 Executive Order

- August 10, 2026: the President signed "Delivering Gold Standard Childhood Vaccine Recommendations for Americans"
- It narrows the universal childhood immunization recommendation from 18 diseases to 11, moves others to high-risk-only status, and shifts flu/COVID-19 to shared clinical decision-making
- It directs HHS toward administering vaccines as separate, single-disease shots
  - Starting with splitting the combined MMR vaccine
- It directs DOJ to support legal challenges to state laws that conflict with parental authority and religious exemption claims
- Affordable Care Act (ACA) coverage mandates tie to the *formally published* schedule of the Advisory Committee on Immunization Practices (ACIP) not to the executive order directly.

38

39

340B Contract Pharmacy Litigation: The National Landscape

- The core legal question: can a manufacturer unilaterally restrict a 340B contract pharmacy arrangement?
- Sanofi-Aventis U.S. LLC v. HHS (3rd Cir., 2023) and a parallel D.C. Circuit ruling already answered this at the federal level: the 340B statute does not require unlimited contract pharmacy delivery, and HRSA's enforcement authority was found unlawful
- Federal enforcement is now largely closed off — the fight has moved to state law. AstraZeneca alone has sued at least 19 states over their 340B statutes; Louisiana's law was upheld by the 5th Circuit in February 2026, and AstraZeneca has petitioned for rehearing
- Illinois just became the newest front

40

HB 2371 Under Fire: AstraZeneca, AbbVie, and Novartis Sue Illinois

- AbbVie and Novartis sued first; AstraZeneca joined August 14, 2026, filing AstraZeneca Pharmaceuticals LP v. Raoul in federal court
- AstraZeneca is the third major manufacturer to challenge HB 2371's contract pharmacy restrictions
- The per-transaction penalty is directly at issue: manufacturers face up to $1,000 per affected drug transaction
- Mirrors AstraZeneca's pattern elsewhere: in Washington, AbbVie, Novartis, AstraZeneca, and PhRMA sued within days of a similar law being signed; a judge denied their injunction bid in June 2026, and all three have appealed
- No ruling yet on the Illinois case

41

PCMA v. Illinois: The Challenge to HB 1697

- June 16, 2026: PCMA sued the Illinois Department of Insurance in the U.S. District Court for the Central District of Illinois
- Legal theory: ERISA preemption — HB 1697 "relates to" self-funded employer health plans in a way federal law overrides
- Two provisions challenged: the annual detailed reporting requirement (first report due September 1, 2026) and the anti-steering rule
- PCMA filed this the same week it sued Tennessee over a PBM-pharmacy divestiture law
- Leans on Pharmaceutical Care Management Association v. Mulready (10th Cir., 2023; cert. denied by SCOTUS June 2025) as precedent
- No ruling yet

42

PBM Litigation Trends Nationally

- FTC v. Caremark, Express Scripts, and OptumRx: federal antitrust case alleging anticompetitive rebating practices that inflated insulin list prices
- Express Scripts settled February 4, 2026; Caremark settled mid-2026 — both require transparency changes, with the Express Scripts settlement alone projected to cut patient insulin costs by up to $7 billion over 10 years
- Structural remedies tested directly in court: Express Scripts and PCMA sued in June 2026 to block Tennessee's PBM-pharmacy divestiture law

43

Arkansas Rule 128: A New ERISA Roadmap?

- Arkansas Rule 128 requires plans and payors to report pharmacy compensation data for review of whether reimbursement is “fair and reasonable.”
- If compensation is inadequate, the Insurance Commissioner may require an additional dispensing fee to support pharmacy network adequacy.
- The court held that ERISA did not preempt the rule because it applies to ERISA and non-ERISA plans and regulates pharmacy costs without dictating benefit design.
- Building on *Rutledge v. PCMA*, the decision offers states a potential framework for extending pharmacy reimbursement protections to self-funded plans.

44

Illinois's Medical Aid in Dying Law: Conscience, Referral, and the Courts

- Deb's Law (SB 1950) was signed December 12, 2025, effective September 12, 2026 — terminally ill Illinois adults (prognosis ≤6 months) may request medication to end their life
- No provider is required to participate — but an objecting provider must refer the patient to one who is "able and willing"
- August 11, 2026: four physicians, a Catholic bishop, and a Lutheran nursing facility sued in federal court to block the referral and documentation requirements on First and Fourteenth Amendment grounds
- August 24, 2026: Illinois agreed not to enforce the referral requirement against these specific plaintiffs while the case proceeds
- Direct relevance to pharmacists: this is the same conscientious-objection-versus-access tension

45

46

How PBMs Actually Make Money

- Four levers: manufacturer rebates, spread pricing, clawback fees, and formulary placement fees
- Vertical integration — one company owning the PBM, the insurer, and the pharmacy
- Transparency alone does not fix this: disclosure doesn't touch the underlying business model creating the misaligned incentive.

47

Spread Pricing and Clawback Fees: Still Live Issues in 2026

- Spread pricing: a PBM charges the payer more than it reimburses the pharmacy, and keeps the difference
- Clawback fees continue eroding margin after the point of sale
- Pharmacy margin remains under real pressure from this in 2026, despite reform progress

48

340B: Why the Margin Fight Is an Access Fight

- 340B savings are not extra revenue — it is a margin lifeline for covered entities and their contract pharmacy partners
- A manufacturer restriction on a contract pharmacy arrangement is a reimbursement dispute and threatens whether that access point survives at all

49

APhA House of Delegates: Structural Reform Over Behavioral Guardrails

- In the APhA HOD the Illinois delegation pushed the House of Delegates toward structural remedies into policy — divestiture, prohibition of certain PBM-pharmacy ownership arrangements versus just disclosure w/only guardrails
- Illinois delegation forced a special HOD session to combat movement outside of the House policy process that would have established a weaker PBM policy voice.

50

2026 Addressing Structural Conflicts of Interest, Patient Safety, and Market Distortions by Pharmacy Benefit Managers

- APhA supports structural, financial, and operational safeguards, including separation requirements where necessary, to address conflicts of interest between pharmacy benefit managers, insurers, pharmacies, and affiliated entities in the pharmaceutical supply chain.
- APhA supports policies that prohibit pharmacy benefit managers, insurers, pharmacies, and affiliated entities in the pharmaceutical supply chain from using ownership relationships or vertically integrated market power to engage in patient steering, self-preferencing, discriminatory reimbursement, anticompetitive network design, or other practices that restrict patient choice, undermine pharmacy access, increase patient and total cost of care, or restrict access to clinically appropriate medications or interfere with pharmacist clinical judgement.
- APhA supports enforceable structural remedies when vertically integrated ownership arrangements create conflicts of interest that harm patients, pharmacies, competition, or the delivery of clinically appropriate care.
- APhA supports state and federal oversight, transparency, and enforcement authority to prevent anticompetitive and discriminatory business practices by vertically integrated pharmacy benefit managers, insurers, and affiliated entities.

51

Image created with ChatGPT 5.5

52

CPESN USA/I-CPEN and the Clinically Integrated Pharmacy Network Model

- I-CPEN — the Illinois Community Pharmacy Enhanced Network — is Illinois's participant in the national CPESN USA model
- Payers increasingly want to contract with networks that can demonstrate clinical outcomes, not individual pharmacies negotiating alone
- Interested in learning more about becoming part of the network and the next phase of the solution and next level of care delivery – Ask for more info

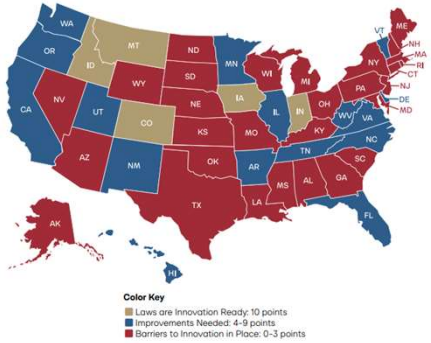
53

Clinical Service Tiering: What "Ready" Actually Looks Like

- Three tiers: foundational services, intermediate clinical services, advanced/complex care management
- Each tier requires specific documentation and workflow infrastructure before a pharmacy can credibly bill or contract for it
- Common mistake: pursuing advanced-tier billing before foundational-tier documentation is airtight. Payers and networks test the foundation first (and not being credentialed and understand the longer road for medical billing)

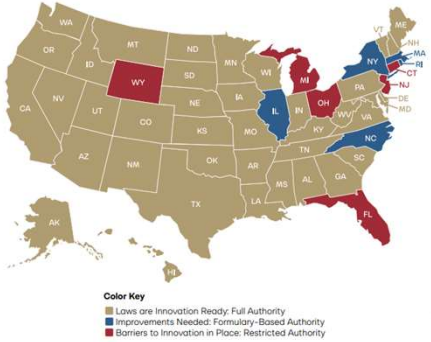
54

FIGURE 2: OVERALL SCORES OF PHARMACIST FULL PRACTICE AUTHORITY ACROSS THE STATES

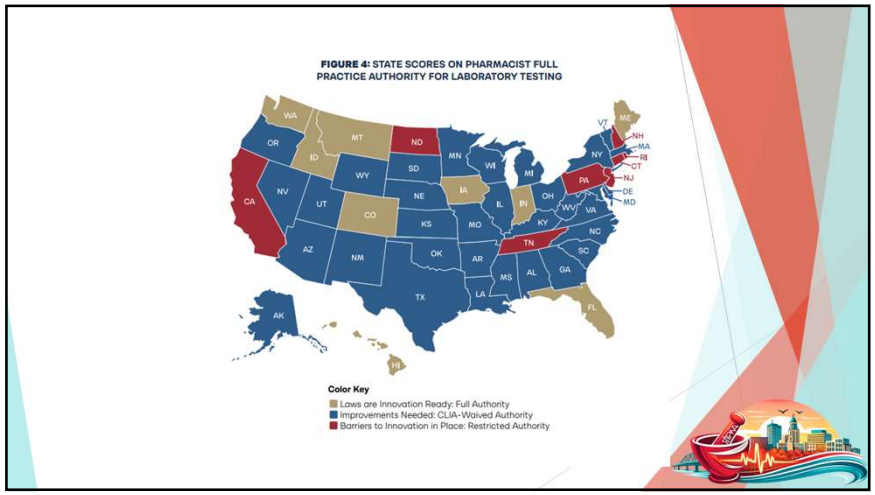


55

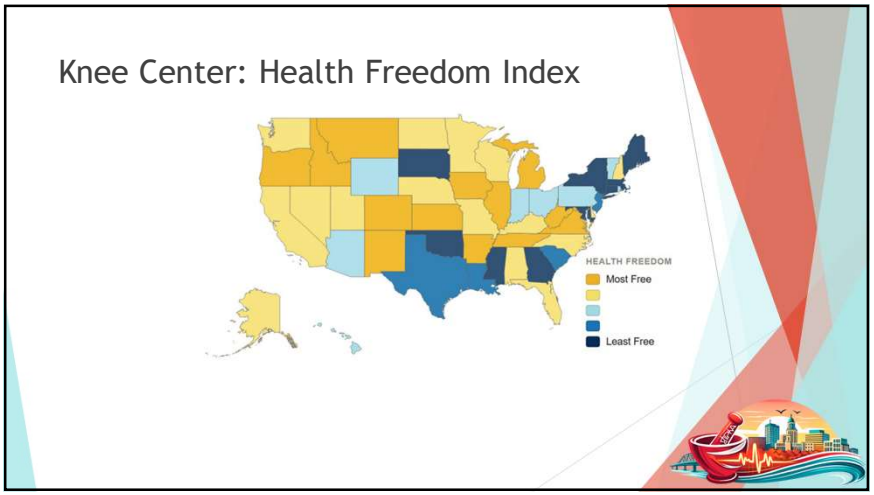
FIGURE 3: STATE SCORES ON PHARMACIST FULL PRACTICE AUTHORITY FOR DRUG ADMINISTRATION



56



57



58

Rural Health Transformation: Where Is Pharmacy?

- **A $50 billion federal opportunity**
- Created by Public Law 119-21 to distribute $10 billion annually from 2026 through 2030.
- Supports rural care redesign, workforce development, technology, chronic disease prevention and sustainable access.
- Illinois received $193.4 million for 2026, with future allocations determined annually by CMS.
- **The pharmacy opportunity**
  - Community pharmacies could serve as rural healthcare access points for:
  - Chronic disease management and medication optimization
  - Vaccination, testing and preventive care
  - Maternal health, behavioral health and substance-use services
  - Telehealth access, remote monitoring and care coordination
  - Rural workforce development and value-based care models
- **Why not pharmacy in Illinois?**
  - Illinois is participating, but pharmacy is not identified as a distinct strategic initiative in the state's published plan.

59

60

Ethical Dilemma: Conscientious Objection and the Duty to Refer

- Illinois law permits a pharmacist to decline to dispense for reasons of conscience, but generally requires the pharmacy to ensure the patient can still get the medication without unreasonable delay — through referral, transfer, or another staff member
- Both sides are legitimate. A pharmacist has a real interest in not being compelled to act against sincere professional or personal conviction. A patient has an equally real interest in timely, non-judgmental access — often to time-sensitive therapies (emergency contraception, PrEP, gender-affirming care)
- No universal resolution exists across states or professional bodies — reasonable people land in different places on where the line sits
- Discussion: if a staff pharmacist declines to dispense for reasons of conscience, what does your pharmacy's referral process actually look like today — and would it hold up if a patient complained it caused an unreasonable delay?

61

Ethical Dilemma: Access vs. Margin

- The 340B and PBM fights are framed publicly as cost and access disputes. At the counter, it is a tension between financial survival and patient service
- When margin is thin, which service gets protected first, and on what basis? There is no universal answer — it depends on community, patient population, and practice setting
- Discussion: if margin pressure forced a pharmacy to discontinue one clinical service (or medication to have on hand) omorrow, how should that decision be made — and who should have a voice in it?

62

What Would You Do? The Patient Who Asks You to Break the Rule

- Scenario: a regular patient asks for an early refill, citing an unplanned trip, with no documentation and a slightly irregular fill pattern
- The tension: clinical judgment vs. policy consistency vs. defensibility — there is no single correct answer
- What matters: what would be documented either way, and what is the actual exposure under each choice?

63

Ethical Dilemma: AI, Automation, and Pharmacist Judgment

- AI-assisted tools are increasingly used in prescription verification, red-flag screening, and clinical decision support
- The tension: genuine efficiency gains against the risk of over-relying on automated screening in a way that erodes independent pharmacist judgment
- The accountability question: if an AI tool flags or clears something, who is responsible for the final decision? The pharmacist.
  - DEA and state board standards evaluate the pharmacist's judgment, not the software's output, regardless of tool sophistication
- Expect regulatory guidance on AI-assisted verification to lag well behind adoption

64

65

National Trends You Should Be Watching

- PBM reform momentum is having an impact, but enforcement is key
  - 141 bills on pharmacist scope of practice and reimbursement were introduced across 41 states in just the first half of 2026, with 37 enacted and 12 final rules issued
- 340B litigation has gone fully national and expands
- Pharmacy access is deteriorating nationally: roughly 48 million Americans live in a pharmacy desert; more than 7,000 U.S. pharmacies have closed since 2019; dense urban markets may absorb closures, but rural communities lose access entirely
- States engaged in the policy shift from brightline to standard of care model Pharmacy Practice Acts
  - Full Practice Authority
  - Less guardrails, more professional autonomy

66

Top Topic Areas for 2027

- **Standard of Care model:** will pharmacy successfully transition from prescriptive rules to professional judgment, or will implementation and practitioner-readiness barriers slow progress?
- **Payment and PBM structure:** will PBM litigation succeed in blocking structural reform, or will it hold?
- **340B and state preemption:** will more states follow Illinois into direct manufacturer litigation, and how will the courts rule?
- **Prescription Drug Affordability Boards:** will state-based PDAB actually reach an Upper Payment Limit determination and lower patient costs
- **Scope of practice and provider status:** does momentum continue, or stall against continued implementation barriers
- **Pharmacy access and health equity:** does the pharmacy desert trend stabilize, or continue accelerating?
- **Federal scheduling:** how does cannabis rescheduling impact patient access and pharmacists' opportunities
- **Public health policy:** what is the continued result of vaccine policy incursions
- **AI:** how quickly does AI move from pilot to standard practice, and what accountability framework follows it?

67

Where Do You Think the Current Is Taking Us?

- Which of the seven currents is most likely to see the most significant change in pharmacy practice over the next 12 months?
- Legislative / Regulatory / Judicial / Payment / Practice / Ethical
- What areas have we not discussed or considered?

68

Questions???

77

Resources and References

- Illinois General Assembly, Bill Status and full text — ilga.gov (104th General Assembly)
- Illinois Pharmacists Association, actionTRACK Legislative Report (Hannah News Service, Inc.), August 24, 2026
- IDFPR, Illinois Pharmacy Practice Act Administrative Rules, 68 Ill. Adm. Code 1330 (January 2026 amendments)
- U.S. DEA, Marijuana Rescheduling Regulatory Actions docket — dea.gov
- The White House, "Delivering Gold Standard Childhood Vaccine Recommendations for Americans," Executive Order, August 10, 2026
- FTC press releases on the Express Scripts (February 2026) and Caremark (July 2026) insulin-rebating settlements — ftc.gov
- NASPA, "2026 Mid-Year Legislative and Regulatory Update"
- NCPA and USC Pharmacy Access Initiative, pharmacy shortage area data
- IPhA and PSM, "How Illinois Built a PDAB That Protects Pharmacies"
- Court filings: AstraZeneca Pharmaceuticals LP v. Raoul and PCMA v. Illinois Department of Insurance (2026)

78

Speaker Contact Information

Garth K. Reynolds, BSPharm, RPh, MBA, FAPhA
Executive Director
greynolds@ipha.org

Illinois Pharmacists Association
204 West Cook Street
Springfield, Illinois 62704
P: 217/522-7300 | F: 217/522-7349
www.ipha.org

Like us on Facebook, Instagram, LinkedIn
Follow us on Twitter
@ILPharmacists | @ILCPEN | @IPhAFoundation

Subscribe on Youtube

Listen to Illinois PharmTalk Podcast

79

Your CE Claim Code for {Program Title}

IPhA will insert claim code on final slide deck

80