State PBM Reform Inventory

Updated October 2026

Indiana

Issue	Summary	Citation
Licensing/Registration	A person shall, before establishing or operating as a PBM, apply to and obtain a license from the Insurance Commissioner.	IN Code § 27-1-24.5-18
Reporting Requirements	Beginning June 1, 2021, and annually thereafter, a PBM shall submit a report containing data from the immediately preceding calendar year to the commissioner. The commissioner shall determine what must be included in the report and consider the following information to be included in the report: • The aggregate amount of all rebates that the PBM received from all pharmaceutical manufacturers. • The aggregate amount of administrative fees that the PBM received from all pharmaceutical manufacturers. • The aggregate amount of retained rebates that the PBM received from all pharmaceutical manufacturers did not pass through to insurers with which the PBM contracted. • The highest, lowest, and mean aggregate retained rebate. At least every 6 months, a PBM shall provide a report to the department. The report must include the: • Overall aggregate amount charged to a health plan for all pharmaceutical claims processed by the PBM; and • Overall aggregate amount paid to pharmacies for claims processed by the PBM. Upon request, the department shall make a report received under s. 27-1-24.5-29 available to the members of the general assembly An insurer, a PBM, and any other administrator of pharmacy benefits shall file an annual report with the commissioner in a manner and form prescribed by the commissioner. The annual report must describe the networks of the insurer, PBM, or other administrator used to provide pharmacy or pharmacist services under a health plan.	IN Code § 27-1-24.5-21; IN Code § 27-1-24.5-29; IN Code §27-1-24.5

PBM Income	**Rebate Pass-Through:** An insurer shall pass through to a plan sponsor 100% of all rebates related to the dispensing or administration of prescription drugs to the plan sponsor's covered individuals. At the time of contracting, an insurer shall only offer to plan sponsors the following plans: • A plan that applies 100% of the rebates to reduce premiums for all covered individuals equally. • A plan that calculates defined cost sharing for covered individuals of the plan sponsor at the point of sale based on a price that is reduced by an amount equal to at least 85% of all of the rebates received or estimated to be received by the insurer concerning the dispensing or administration of the prescription drug. In the individual market, a covered individual's defined cost-sharing for a prescription drug must be: • Calculated at the point of sale; and • Based on a price that is reduced by an amount equal to at least 85% of all rebates in connection with the dispensing or administration of the prescription drug.	IN Code § 27-1-50-8; IN Code § 27-1-49-7

Pharmacy Contracting	**MAC Pricing:**
	A PBM shall:
	• Identify the sources used by the PBM to calculate the drug product reimbursement paid for covered drugs available under the pharmacy health plan administered by the PBM to each network pharmacy or their PSAO.
	• Establish an appeal process for contracted pharmacies, PSAOs, or group purchasing organizations to appeal and resolve disputes concerning the MAC pricing. The appeals process must comply with the following standards:
	  ○ The right to appeal a claim up to 60 days following the initial filing of the claim.
	  ○ The investigation and resolution of a filed appeal by the PBM in a time frame determined by the commissioner.
	  ○ If an appeal is denied, a requirement that the PBM do the following:
	  ▪ Provide the reason for the denial.
	  ▪ Provide the appealing contracted pharmacy, PSAO, or group purchasing organization with the NDC
		IN Code § 27-1-24.5-22;
		
		IN Code § 27-1-24.5-23;
		
		IN Code § 27-1-24.2

	number of the prescription drug that is available from a national or regional wholesaler operating in Indiana. ○ If an appeal is approved, a requirement is that the PBM do the following: ▪ Change the MAC of the drug for the pharmacy that filed the appeal as of the initial date of service that the appealed drug was dispensed. ▪ Adjust the MAC of the drug for the appealing pharmacy and for all other contracted pharmacies in the same network of the PBM that filled a prescription for patients covered under the same health plan beginning on the initial date of service the appealed drug was dispensed. ▪ Notify each pharmacy in the PBM's network that the MAC for the drug has been adjusted as a result of an approved appeal. ▪ Adjust the drug product reimbursement for contracted pharmacies that resubmit claims to reflect the adjusted MAC, if applicable. ▪ Allow the appealing pharmacy and all other contracted pharmacies in the network that filled the prescriptions for patients covered under the same health plan to reverse and resubmit claims and receive payment based on the adjusted MAC from the initial date of service the appealed drug was dispensed. ▪ Make retroactive price adjustments in the next payment cycle unless otherwise agreed to by the pharmacy. • Update and make available to pharmacies the MAC list at least every 7 days. The timeframe may be different if agreed upon between the PBM and contracted pharmacies. For every drug for which the PBM establishes a MAC to determine the drug product reimbursement, the PBM shall make available to a contracted PSAO to make available to the pharmacies, or to a pharmacy if the PBM contracts directly with a pharmacy: • Information identifying the national drug pricing compendia or sources used to obtain the drug price	

	data. • The comprehensive list of drugs subject to MAC and the actual MAC for each drug. **Minimum Reimbursement:** An insurer, PBM, or other administrator may not reimburse a pharmacy or pharmacist for a prescription drug or other service at a net amount that is less than the greater of the following: • The amount the insurer, PBM, or other administrator reimburses itself or a pharmacy affiliate for the same prescription drug by NDC number or service, or • The following amount, as applicable: ○ If the prescription drug or service is administered, dispensed, or provided at a pharmacy that is a licensed premises (as defined in IC 7.1-1-3-20), the actual acquisition cost for the prescription drug or service plus a fair and reasonable dispensing fee ○ If the prescription drug or service is administered, dispensed, or provided at a pharmacy not described in item (I), the NADAC for the prescription drug or service, as determined by the federal Centers for Medicare and Medicaid Services at the time the prescription drug or service is administered, dispensed, or provided plus a professional dispensing fee equal to the Medicaid fee for service dispensing fee under 405 IAC 5-24-6.	
Patient Cost-Sharing	**Maximum Cost Sharing Levels:** A PBM may not require a pharmacy or pharmacist to collect a higher copayment for a prescription drug from a customer than the PBM allows the pharmacy or pharmacist to retain. Starting January 1, 2026, a pharmacy benefit manager shall apply the annual limitation on cost sharing set forth in the federal Patient Protection and Affordable Care Act under 42 U.S.C. 18022(c)(1) to prescription drugs that: • Are covered under a health plan administered by the pharmacy benefit manager; • Are life-saving or intended to manage chronic pain; and • Do not have an approved generic version. **Copay Adjustment Programs:** Starting January 1, 2026, when calculating a covered individual's contribution to an applicable cost-sharing requirement, a	IN Code § 27-1-24.5-27.5; IN Code § 27-1-24.5-27.7

	pharmacy benefit manager must include any cost-sharing amounts paid by the covered individual or on behalf of the covered individual by another person. For high-deductible health plans, this requirement shall apply to items or services that are preventive care without a deductible, and all services once an individual meets the minimum deductible to remain HSA-eligible. A pharmacy benefit manager may not directly or indirectly set, alter, implement, or condition the terms of health plan coverage, including the benefit design, based in part or entirely on information about the availability or amount of financial or product assistance available for a prescription drug.	