State PBM Reform Inventory

Updated October 2026

Virginia

Issue	Summary	Citation
Licensing/Registration	Unless otherwise covered by a license as a carrier, no person shall provide pharmacy benefits management services or otherwise act as a PBM in the Commonwealth without first obtaining a license in a manner and in a form prescribed by the Commission. Each PBM shall renew its license annually and shall, at the time of renewal, pay a renewal fee in an amount and in a manner prescribed by the Commission.	Va. Code Ann. § 38.2-3466
Reporting Requirements	By March 31 of each year, each carrier on its own or through its contract for pharmacy benefits, shall report the following information to the Commissioner for each health benefit plan: • The aggregate amount of rebates received by the PBM; • The aggregate amount of rebates distributed to the appropriate health benefit plan; • The aggregate amount of rebates passed on to the enrollees of each health benefit plan at the point of sale that reduced the enrollees' applicable deductible, copayment, coinsurance, or other cost-sharing amount; • The aggregate amount of the PBM's retained rebates; • The PBM's aggregate retained rebate percentage; • The aggregate amount of administrative fees received by the PBM; • Upon the request of the Commission, the individual and aggregate amount paid by the health benefit plan to the PBM for services itemized by pharmacy, by product, and by goods and services; and • Upon the request of the Commission, the individual and aggregate amount a PBM paid for services itemized by pharmacy, by product, and by goods and services.	Va. Code Ann. § 38.2-3468
PBM Income	**Spread Pricing:** No carrier, PBM, or representative of a PBM shall conduct spread pricing in the Commonwealth. **Pass Through Pricing:**	Va. Code Ann. § 38.2-3467

	Each carrier through its PBM shall use a pass-through pricing model and, if requested, offer at least one contractual arrangement that limits income from PBM services to only include PBM fees for services provided. The amount of any fee shall be set forth in a contract agreement between the PBM and carrier/health plan. The PBM shall direct 100% of all prescription drug manufacturer rebates to either the carrier or covered individual at the point of sale to reduce cost sharing, deductibles, copayments, etc.	
Pharmacy Contracting	**Patient Steering:** No HMO providing health care plans, or its PBM, shall prohibit any person receiving pharmaceutical benefits, including specialty pharmacy benefits, from selecting the pharmacy of their choice to furnish such benefits. This right extends to any pharmacy that is not a participating provider under any such health care plan and that has previously notified the health maintenance organization or its PBM of its agreement to accept reimbursement for its services at rates applicable to pharmacies that are participating providers, including any copayment consistently imposed by the plan, as payment in full. No HMO or PBM shall impose upon any person receiving pharmaceutical benefits furnished under any such health care plan: • Any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, class or copayment level, whether or not such benefits are furnished by pharmacists who are not participating providers; • Any monetary penalty that would affect or influence any such person's choice of pharmacy; or • Any reduction in allowable reimbursement for pharmacy services related to utilization of pharmacists who are not participating providers. No carrier or PBM shall: • Reimburse a pharmacy or pharmacist an amount less than the amount that the PBM reimburses a PBM affiliate for providing the same pharmacist services, calculated on a per-unit basis using the same generic product identifier or generic code number and reflecting all drug manufacturer's	Va. Code Ann. § 38.2-4312.1; Va. Code Ann. § 38.2-3467; Va. Code Ann. § 38.2-3407.15:3

	rebates, direct and indirect administrative fees, and costs and any remuneration; • Restrict participation of a pharmacy in a pharmacy network for provider accreditation standards or certification requirements if a pharmacist meets such accreditation standards or certification standards; or • Interfere with a covered individual's right to choose a pharmacy or provider, based on the pharmacy or provider's status as a covered entity or contract pharmacy. **MAC Pricing:** Any contract between a carrier or its intermediary and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or obligation to establish a MAC, shall contain specific provisions that require the intermediary or carrier to: • Update, not less frequently than once every 7 days, the MAC list, unless there has been no change to the MAC of any drug on the list since the last update; • Verify, not less frequently than once every 7 days, that the drugs on the MAC list are available to participating pharmacy providers from at least one regional or national pharmacy wholesaler and that the amount for each drug is not obsolete and promptly revise the MAC if necessary to comply with this subsection; and • Provide a process for each participating pharmacy provider to readily access the MAC list specific to that provider. Any contract between a carrier or its intermediary and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or obligation to establish a MAC, shall contain specific provisions that require the intermediary or carrier to provide a process for an appeal, investigation, and resolution of disputes regarding MAC drug pricing that includes: • A time period of 14 days from the date of initial claim adjudication for the participating pharmacy provider to file its dispute request; • A requirement that the dispute request be investigated and resolved within 14 days of its initiation by the participating pharmacy provider;	

	• A telephone number at which the participating pharmacy provider may contact the carrier or its intermediary to speak to a person responsible for processing dispute requests; • A requirement that a carrier or its intermediary, if a dispute request is denied, provide (i) a reason for the denial, and (ii) the NDC of the drug under dispute that the carrier or its intermediary contends may be purchased by the participating pharmacy provider for an amount that is equal to or less than the MAC; and • A requirement that a carrier or its intermediary, if a dispute is successful, update the MAC for the drug under dispute within five days of the determination of the dispute. The termination of a provider contract with a pharmacy that is not a PBM affiliate shall not release a carrier or PBM from any payment obligation to an adjudicated claim unless it is related to insurance fraud.	
Patient Cost-Sharing	**Copay Adjustment Programs:** When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health plan, a carrier shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person. If this requirement would result in a health plan's ineligibility to qualify as an HSA-qualified High-Deductible Health Plan, then These requirements shall not apply with respect to the deductible of HSA-eligible high-deductible health plans until after the enrollee has satisfied the minimum deductible, with the exception of preventive services. **Maximum Cost-Sharing Levels:** No provider contract between a health carrier or its PBM and a pharmacy or its contracting agent shall require an enrollee to make a copayment for a covered prescription drug in an amount that exceeds the lesser of: • The applicable copayment for the prescription drug that would be payable in the absence of this section; or • The cash price the enrollee would pay for the prescription drug if the enrollee purchased the prescription drug without using the enrollee's health plan.	Va. Code Ann. § 38.2-3407.20; Va. Code Ann. § 38.2-3407.15:4; Va. Code Ann. § 38.2-3407.15:5; Va. Code Ann. § 38.2-3467

	Copay Cap: Every health plan offered by a carrier shall set the cost-sharing payment that a covered person is required to pay for a covered prescription insulin drug at an amount that does not exceed $50 per 30-day supply of the prescription insulin drug, regardless of the amount or type of insulin needed to fill the covered person's prescription. The PBM shall direct 100% of all prescription drug manufacturer rebates to; • The carrier or health benefit plan for offsetting cost sharing, deductibles, coinsurance, or premiums • The covered individual at the point of sale to reduce their applicable deductible, copayment, coinsurance or other cost-sharing amount	