State PBM Reform Inventory

Updated October 2026

Alabama

Issue	Summary	Citation
Licensing/Registration	PBMs must obtain a license to operate from the Department of Insurance (DOI). Licenses must be renewed annually. DOI may refuse to issue or renew a license if the applicant is found to have violated the insurance laws of this state or any other jurisdiction or has had an insurance certificate or license denied or revoked in any jurisdiction. The initial license application fee is set at $500. DOI calculates the proportionate share of the annual cost of PBM licensee renewal and oversight activities, with a minimum cost of $500 per year.	AL Code §27-45A-4 (2025)
Reporting Requirements	A PBM shall annually prepare a report by June 1 that discloses all of the following to each client: 1) The aggregate amount of all rebates that the PBM received from pharmaceutical manufacturers on behalf of the client. 2) The aggregate amount of the rebates the PBM did not pass through to the client. 3) If the PBM or any consultant providing pharmacy benefit management services engages in spread pricing, the aggregated amount of the differences between the amount paid by the client for prescription drugs and the actual amount paid to the pharmacy or pharmacist for pharmacist services.	AL Code § 27-45A-9 (2025)
PBM Income	N/A	
Pharmacy Contracting Standards	**Patient steering** A PBM may not do any of the following: • Require a covered individual to purchase pharmacist services exclusively through a mail-order pharmacy or PBM affiliate. • Prohibit or limit any covered individual from selecting an in-network pharmacy or pharmacist who agrees to contract terms and conditions. • Impose a monetary advantage or penalty under a health benefit plan that would affect a covered individual's choice of pharmacy among network pharmacies. • Use a covered individual's pharmacy services data collected pursuant to the provision of claims processing services for the purpose of soliciting, marketing, or referring the covered individual to a mail-order pharmacy or PBM affiliate. The PBM may notify covered individuals that a less costly option is available through a mail-order or affiliate pharmacy, provided the notification state that switching to the less costly option is not mandatory.	AL Code § 27-45A-8 (2025); § 27-45A-6 (2025); AL Code § 27-45A-10 (2025)

	• Reimburse an in-network pharmacy or pharmacist in the state an amount less than the amount that the PBM reimburses a similarly situated PBM affiliate for providing the same pharmacist services to covered individuals in the same health benefit plan. These requirements not apply to the administration of prescription drug benefits by a self-funded health benefit plan governed by ERISA.	
Patient Cost-Sharing	**Maximum Cost-Sharing Levels:** Patient cost-sharing at the point of sale may not exceed the lesser of the contracted cost-share amount or the amount an individual would pay for a prescription if that individual were paying without insurance. This does not apply to self-funded health benefit plans governed by ERISA. **Copay Cap:** A health benefit plan that provides coverage for prescription insulin drugs shall cap the total amount of any cost-sharing or co-pay that an insured or beneficiary is required to pay under the plan for a covered prescription insulin drug at an amount not to exceed one hundred dollars ($100) per 30-day supply of the insulin drug, without regard to the policy deductible, regardless of the amount or type of insulin needed to fill the insured's or beneficiary's prescription. On January 1 of each year, the limit on the amount that an insured is required to pay for a 30-day supply of a covered prescription insulin drug shall increase by a percentage equal to the percentage change from the preceding year in the prescription drug component of the Consumer Price Index of the Bureau of Labor Statistics of the United States Department of Labor. This requirement does not apply to a health benefit plan if implementing the cost-sharing or co-pay cap would necessitate increasing the health benefit plan's cost-sharing for other services to comply with federally mandated actuarial values for non-grandfathered individual and small group plans.	AL Code § 27-45A-8 (2025); AL Code § 27-63-1 (2025)

Alaska

Issue	Summary	Citation
Licensing/Registration	PBMs must register with the Department of Insurance as TPAs and renew registration every two years.	AK § 21.27.901; AK § 21.27.905
Reporting Requirements	N/A	
PBM Income	**Spread Pricing:** An insurer providing a health care insurance policy or its PBM may not conduct or participate in spread pricing.	AK § 21.36.520
Pharmacy Contracting	**MAC Pricing:** PBMs must make the methodology and sources used to determine MAC list prices available to network	AK § 21.27.945; AK § 21.27.950; AK § 21.27.945;

	pharmacies at the beginning of a contract and upon renewal. PBMs must provide a process for pharmacies to access applicable drug pricing lists without charge and information about how to appeal. The drug pricing list must be available in a searchable electronic format. PBMs shall review and update applicable information at least once every 7 business days to reflect pricing modifications. In the event of a significant price update or modification—defined as an increase or decrease of 10 % or more in the pharmacy acquisition cost, a change in the methodology used to calculate the MAC, or a change in the value of a variable used to determine the MAC—a PBM shall update the drug pricing list within 1 business day. The pharmacy's dispensing fee shall not be included in the drug's list price. Before placing a specific drug on the drug pricing list, a PBM shall ensure that the drug is therapeutically equivalent and pharmaceutically equivalent to a prescribed product, an interchangeable biological product (if applicable), readily available for purchase from national or regional wholesalers operating in the state, and the drug is not obsolete or temporarily unavailable. **Patient Steering:** An insurer providing a health care insurance policy or its PBM may not: • Reimburse a pharmacy or pharmacist an amount less than an amount paid to an affiliate of the PBM for providing the same pharmacy services, calculated on a per-unit basis using the same generic product identifier or generic code number • Interfere with a covered person's right to choose a pharmacy or provider • Interfere with a covered person's right of access to a clinician-administered drug • Use a covered person's pharmacy services data collected under the provision of claims processing services for the purpose of soliciting, marketing, or referring the person to an affiliate of the PBM	AK § 21.36.520
Patient Cost-Sharing	N/A	

Arizona

Issue	Summary	Citation
Licensing/Registration	PBMs must maintain a certificate of authority to operate, which must be renewed every 2 years.	Ariz. Rev. Stat. 20-3333
Reporting Requirements	N/A	
PBM Income	N/A	
Pharmacy Contracting	**MAC Pricing:** PBMs must:	Ariz. Rev. Stat. § 20-3331

	• Update drug prices on their lists every seven business days to keep pricing current. • Share pricing sources with pharmacies at the start of a contract, during renewals, and at least once a year so pharmacies know how drug prices are determined. • Provide a way for pharmacies to challenge their payment for drugs if they believe they are being underpaid. • Allow a pharmacy services organization to appeal pricing on behalf of pharmacies in its network.	
Patient Cost Sharing	**Copay Adjustment Programs:** Insurers or their PBM shall include any cost sharing amount paid by either the enrollee or another person on behalf of the enrollee for a prescription drug that is either: • Without a generic equivalent, or • With a generic equivalent where the enrollee has obtained access to the drug through prior authorization, step therapy, or the insurer's exceptions and appeals process.	Ariz. Rev. Stat. § 20-1126

Arkansas

Issue	Summary	Citation
Licensing	The PBM must obtain a license from the Insurance Commissioner	Ark. Code Ann. § 23-79-2503
Reporting Requirements	The Insurance Commissioner may examine the books and records of a PBM as necessary to determine: • The aggregate amount of rebates received by a PBM, distributed by a PBM, or passed on to an enrollee of each healthcare payor at the point of sale • The individual and aggregate amount paid by a healthcare payor to the PBM and the amount the PBM paid for pharmacist services itemized by pharmacy, product, and goods and services, including other prescription drug or device services.	Ark. Code Ann. § 23-92-505 (2025)
PBM Income	**Spread Pricing:** PBMs are prohibited from conducting spread pricing in Arkansas. **Rebate Pass-Through:** PBMs shall reduce an enrollee's cost-sharing for a prescription drug by an amount equal to at least 100% of all rebates received, or expected to be received, in connection with the dispensing or administration of the drug.	Ark. Code Ann. § 23-92-505 (2025); Ark. Code. § 23-79-2503 (2026)
Pharmacy Contracting	**Patient Steering:** PBMs may not reimburse a pharmacy or pharmacist in the state an amount less than the amount that the PBM reimburses a PBM affiliate for providing the same pharmacist services. **Minimum Reimbursement:**	Ark. Code Ann. § 23-92-506; Ark. Code Ann. § 17-92-507 (2026)

	PBMs may not pay or reimburse a pharmacy or pharmacist less than the NADAC for a covered drug. If the NADAC is unavailable, the PBM shall use the WAC to calculate the minimum reimbursement.
	
	MAC Pricing:
	A PBM shall:
	• Provide access to its MAC list to each applicable pharmacy.
	• Update its MAC list on a timely basis, but in no event longer than 7 calendar days from an increase of 10% or more in the pharmacy acquisition cost from 60% or more of the pharmaceutical wholesalers doing business in the state or a change in the methodology on which the MAC list is based or in the value of a variable involved in the methodology.
	• Provide a reasonable administrative appeal procedure to allow pharmacies to challenge the MAC list price and reimbursements made under a MAC list for a specific drug or drugs as:
	  ○ Not meeting the requirements of this section; or
	  ○ Being below the pharmacy acquisition cost.	

Patient Cost Sharing	**Copay Adjustment Programs:** When calculating an enrollee's contribution to any applicable cost-sharing requirement, an insurer shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. This requirement does not apply to a brand drug if it is not considered medically necessary and has a therapeutically equivalent generic.	AR Code § 23-92-511 (2025)
Vertical Integration	Bans PBMs from having direct or indirect ownership in a retail or mail-order pharmacy. All existing pharmacy licenses that violate this section will be revoked on and after January 1, 2026. Limited exceptions for rare and orphan drugs as needed. Set to take effect in 2026 but is currently on hold due to a federal court injunction.	AR Code § 17-92-416 (2025) CASE NO. 4:25-CV-00520-BSM

California

Issue	Summary	Citation
Licensing/Registration	Currently, PBMs must register with the Department of Managed Health Care. Starting the earlier of the date the Department of Managed Health Care issues licensure rules or January 1, 2027, PBMs must obtain a license from the department to operate. The department shall develop an application form that contains at least the information required in s. 1385.009 and establish application fees in accordance with s. 1385.0016. A PBM shall reimburse the director for the actual cost of processing their application up to $25,000.	CA HSC § 1385.004 CA HSC § 1385.005 CA HSC § 1385.009 CA HSC § 1385.0016

	A health care service plan that contracts with a PBM for management of any or all of its prescription drug coverage shall require the PBM to register with the Department of Managed Health Care.	
Reporting Requirements	The PBM shall, on a quarterly basis, disclose, upon the request of an insurer, the following information with respect to prescription benefits specific to the insurer: • The aggregate WACs and rebates (including utilization discounts) from a pharmaceutical manufacturer or labeler for each therapeutic category of drugs containing three or more drugs. • Any administrative fees received from the pharmaceutical manufacturer or labeler. • Whether the PBM has a contract, agreement, or other arrangement with a pharmaceutical manufacturer to exclusively dispense or provide a drug to a purchaser's employees, insureds, or enrollees, and the application of all consideration or economic benefits collected or received pursuant to that arrangement. • Prescription drug utilization information for the purchaser's enrollees or insureds that is not specific to any individual enrollee or insured. • The aggregate of payments, or the equivalent economic benefit, made by the PBM to pharmacies owned or controlled by the PBM and to pharmacies not owned or controlled by the PBM. • The aggregate amount of the fees imposed on, or collected from, network pharmacies or other assessments against network pharmacies, and the application of those amounts collected pursuant to the contract with the purchaser. A PBM shall submit to the department annual financial statements within 120 days after the close of the fiscal year. An audit shall be conducted in accordance with generally accepted auditing standards and the rules and regulations of the director. Within 45 days after the close of each quarter of its fiscal year, a PBM shall submit its quarterly unaudited financial statement, prepared in accordance with generally accepted accounting principles and consisting of at least a balance sheet, statement of income, statement of cash flows, statement of changes in equity, and notes to financial statements as of the date and for the period specified by the director. The director may require the submission of these reports on a monthly or other periodic basis.	CA BPC § 4441 CA HSC § 1385.005 CA HSC § 1385.0011
PBM Income	**Spread Pricing:** Starting January 1, 2026, no contract that is established or renewed between a health care service plan and a licensed PBM may authorize spread pricing. If a preexisting contract between a PBM and a payer authorizes spread pricing, a subsequent amendment or	CA HSC § 1385.0031 CA INS § 10123.2045

	renewal of that contract shall not contain that authorization. Spread pricing contract terms shall be void on and after January 1, 2029. **Bona Fide Service Fee:** For contracts issued or renewed after January 1, 2026, a PBM shall not derive income from pharmacy benefit management services provided to a payer except for income derived from a pharmacy benefit management fee for pharmacy benefit management services provided. • The amount of any pharmacy benefit management fee shall be set forth in the agreement between the PBM and the payer. • The PBM shall disclose the amount and types of the pharmacy benefit management fees to the payer. • A pharmacy benefit management fee may not be based on the acquisition or ingredient cost of a drug, the amount of rebates or other price concessions negotiated by the PBM, the amount of cost-sharing collected by the PBM, coverage or formulary placement decisions made by the PBM, or any other methodology determined by the department. **Rebate Pass-Through:** For contracts issued or renewed after January 1, 2026, a PBM shall use a passthrough pricing model. A PBM, group purchasing organization, and affiliated entity shall direct 100 percent of all prescription drug manufacturer rebates received to the payer or program, if the contractual arrangement delegates the negotiation of rebates to the PBM, group purchasing organization, or affiliated entity, for the sole purpose of offsetting defined cost sharing, deductibles, and coinsurance contributions and reducing premiums of plan participants. PBMs may receive performance bonused based on savings to the payer that decrease premiums paid by the plan participant or that result in plan participants paying the lowest level of cost sharing, deductibles, and coinsurance for a drug, as long as the performance bonus is not based or contingent on any of the following: • The acquisition or ingredient cost of a drug. • The amount of savings, rebates, or other fees charged, realized, or collected by, or generated based on the activity of, the PBM or its affiliated entities that is retained by the PBM. • The amount of premiums, deductibles, or other cost-sharing or fees charged, realized, or collected by the PBM or its affiliated entities from patients or other persons on behalf of a patient, except for	CA HSC § 1385.0034 CA HSC § 1385.0029

	performance bonuses that are based or contingent on a decrease in premiums, deductibles, or other cost-sharing. *Note: The spread pricing, bona fide service fee, and rebate pass-through requirements do not apply to PBMs serving Taft-Hartley self-insured prescription drug plans that are governed by ERISA.*	
Pharmacy Contracting	**MAC Pricing:** • PBMs shall make available to a network pharmacy, upon request, the most up-to-date MAC list or lists used by the PBM in a readily accessible, secure, and usable Web-based format or other comparable format. • PBMs shall review and adjust to the MAC of each drug on a MAC list using the most recent data sources available at least once every 7 days. • PBMs shall also establish a clearly defined process for a network pharmacy to appeal the MAC for a drug on a MAC list. • A contracting pharmacy shall be provided no less than 14 business days following receipt of payment for the claim upon which the appeal is based to file an appeal with a PBM. The PBM shall make a final determination regarding a contracting pharmacy's appeal within 7 business days of the PBM's receipt of the appeal. • If an appeal is denied by a PBM, the PBM shall provide to the contracting pharmacy the reason for the denial and the NDC of an equivalent drug that may be purchased by a similarly situated pharmacy at the price that is equal to or less than the MAC of the appealed drug. • If an appeal is upheld by a PBM, the PBM shall adjust the MAC of the appealed drug for the appealing contracting pharmacy and all similarly situated contracting pharmacies in the state within 1 calendar day of the date of determination. The PBM shall permit the appealing pharmacy to reverse and resubmit the claim upon which the appeal was based in order to receive the corrected reimbursement. A drug shall not be included on a MAC list or reimbursed on a MAC basis unless all of the following apply: • The drug is listed as "A" or "B" rated in the most recent version of the FDA's approved drug products with therapeutic equivalent evaluations, also known as the Orange Book, or has an "NA," "NR," or "Z" rating or a similar rating by a nationally recognized pricing reference, such as Medi-Span or First DataBank. • The drug is generally available for purchase in the state from a national or regional wholesaler. • The drug is not obsolete.	CA BPC § 4440 CA HSC § 1385.0026 CA HSC § 1385.0027

	Patient Steering: A PBM may not reimburse a nonaffiliated pharmacy for a pharmacist service at a rate lower than the rate it would reimburse an affiliated pharmacy for the same service. A PBM shall not: • Require a plan participant to use only an affiliated pharmacy if there are nonaffiliated pharmacies in the network. • Financially induce a plan participant to transfer a prescription only to an affiliated pharmacy if there are nonaffiliated pharmacies in the network. • Require a nonaffiliated pharmacy to transfer a prescription to an affiliated pharmacy if there are nonaffiliated pharmacies in the network. This section does not prevent a purchaser or PBM from offering to plan participants financial incentives to use a particular pharmacy, such as lower copays, coinsurance, or any other cost-sharing for a prescription when the prescription is dispensed. • Unreasonably restrict a plan participant from using a particular contracted pharmacy for the purpose of receiving pharmacist services covered by the plan participant's contract or policy. • Communicate to or mislead a plan participant, in any manner, that the plan participant is required to have a prescription dispensed at, or pharmacy services provided by, a particular affiliated pharmacy or pharmacies if there are other non-affiliated pharmacies that have the ability to dispense the medication or provide the services and are also in network. • Deny a nonaffiliated contract pharmacy the opportunity to participate in a PBM network as preferred participation status if the pharmacy is willing to accept the same terms and conditions that the PBM has established for affiliated pharmacies as a condition of preferred network participation status.	
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A health insurance policy issued, amended, or renewed on or after January 1, 2026, that provides prescription drug coverage shall not calculate an insured's cost-sharing at an amount that exceeds: • The actual rate paid by the insurer for the prescription drug; • The net price paid by the PBM or GPO, if available. **Copay Cap:** A large group health care service plan contract or insurance policy that is issued, amended, or renewed on or after January 1, 2026, shall not impose a copayment, coinsurance, deductible, or any other cost-sharing on an insulin prescription drug that exceeds $35 for a 30-day	CA HSC § 1367.2075 CA HSC § 1367.51 CA INS § 10176.61

	supply. At least one insulin for a given drug type in all forms and concentrations shall be on the prescription drug formulary. An individual or small group health care service plan contract or insurance policy that is issued, amended, or renewed on or after January 1, 2027, shall not impose a copayment, coinsurance, deductible, or any other cost-sharing on an insulin prescription drug that exceeds $35 for a 30-day supply. If an individual or small group health care service plan contract maintains a drug formulary grouped into tiers, the cost-sharing cap shall apply only to insulin prescription drugs that are in the two lowest tiers. At least one insulin for a given drug type in all forms and concentrations shall be on each of the two lowest tiers. If there is no Tier 1 or Tier 2 insulin prescription drug that is clinically appropriate for an enrollee, the health care service plan shall limit the cost-sharing for a higher-tier drug to no more than $35 for a 30-day supply for an individual enrollee.	

Colorado

Issue	Summary	Citation
Licensing/Registration	Starting in 2024, a person shall not establish or operate as a PBM in this state unless the person has registered with the insurance commission. Each carrier must submit to the commissioner a list of all PBMs the carrier contracts with or uses for claims processing services or other prescription drug or device services.	C.R.S. § 10-16-122.1 (2026)
Reporting Requirements	Starting January 1, 2027, a contract between a PBM and a covered person's health benefit plan must include a provision that requires the PBM to disclose prescription drug cost information to the health benefit plan, including claims-level pharmacy data and PBM income derived from prohibited sources that the PBM must pass through to the health benefit plan. The information must be provided within thirty days after the date of the notification to the PBM by the health benefit plan or at regular negotiated reporting intervals necessary for the health benefit plan to determine the PBM's compliance with the contract terms and this section. The PBM shall assess no additional fees with regard to the provision of this information. The contract between the PBM and a covered person's health benefit plan must include a provision authorizing the health benefit plan to annually execute an audit for the purpose of validating compliance with contract terms and this section.	C.R.S. 10-16-122.8
PBM Income	**Bona Fide Service Fee:** Starting January 1, 2027, a PBM may earn income derived from the assessment of a single, flat-dollar	C.R.S. 10-16-122.8

	service fee for the provision of a prescription drug, which service fee is transparently expressed in a written agreement between the PBM and health benefit plan. The single, flat-dollar service fee may vary from client to client of the PBM based on the number of health benefit plan participants, clinical and administrative services provided, value-based payment arrangement, and other considerations. Starting January 1, 2027, a PBM shall not: • Earn any income that is directly or indirectly based on the price or cost of a prescription drug, including income from prescription drug mark-ups, copayments that exceed the cost of prescription drugs, up-charging or spread-pricing, or manufacturer-derived revenues; or • Design a prescription drug formulary to favor a certain branded pharmaceutical or biologic over a therapeutically equivalent generic or biosimilar, unless the branded pharmaceutical or biologic has a lower net acquisition cost and that lower cost is reflected in a lower out-of-pocket expense for consumers.	
Pharmacy Contacting	**MAC Pricing:** • In each contract between a PBM and a pharmacy, the pharmacy shall be given the right to obtain from the PBM, within ten days after any request, a current list of the sources used to determine MAC pricing. The PBM shall update the pricing information at least every 7 days and provide a means by which contracted pharmacies may promptly review pricing updates in a format that is readily available and accessible. • Each contract between a PBM and a pharmacy must include a process to appeal, investigate, and resolve disputes regarding MAC pricing. **Minimum Reimbursement:** Starting January 1, 2027, a PBM shall reimburse an unaffiliated pharmacy or a PBM-affiliated retail, mail order, or specialty pharmacy for the fulfillment of a prescription drug in an amount equal to the NADAC for the dispensed prescription drug ingredients and a reasonable and adequate dispensing fee. If the NADAC is not available at the time a prescription drug is administered or dispensed, a PBM shall not reimburse in an amount that is less than the WAC of the prescription drug.	C.R.S. § 25-37-103.5 C.R.S. 10-16-122.8
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A PBM shall not require a pharmacy to charge or collect a copayment from a covered person that exceeds the total charges submitted by the network pharmacy. **Copay Adjustment Programs:**	C.R.S. § 10-16-122.7 C.R.S. § 10-16-161 C.R.S. 10-16-151

	Effective January 1, 2025, when calculating a covered person's overall contribution to an out-of-pocket maximum or cost-sharing requirement under the covered person's health benefit plan, a carrier or PBM shall include any amount paid by the covered person or on behalf of the covered person if: • The drug does not have a generic equivalent, biosimilar, or interchangeable biosimilar; or • The drug has a generic equivalent, biosimilar, or interchangeable biosimilar, and the covered person is using the brand-name drug after obtaining prior authorization, complying with a step therapy protocol, or receiving approval through the carrier's or PBM's exceptions, appeals, or review process. This requirement does not apply to HSA-eligible high-deductible plans until after a covered person has met their minimum deductible under IRS rules. **Copay Cap:** A carrier that provides coverage for prescription insulin drugs pursuant to the terms of a health coverage plan the carrier offers shall cap the total amount that a covered person is required to pay for all covered prescription insulin drugs at an amount not to exceed $100 for the covered person's entire 30-day supply of insulin, regardless of the amount or type of insulin needed to fill the covered person's prescription or the number of prescriptions. **Contribution Credits/Coupons:** When calculating a covered person's contribution to an out-of-pocket-maximum or cost-sharing requirement under the plan, the plan must account for and credit to the covered person an out-of-pocket expense they incur by purchasing a prescription drug directly from a pharmacy or DTC platform. The carrier shall apply the contribution credit to the out-of-pocket maximum or cost-sharing requirement that is applicable in the plan year in which the out-of-pocket expense was incurred. The covered person must provide proof of payment within 90 days of purchase. The carrier shall not apply the contribution credit if: • For an amount of a covered person's out-of-pocket expense incurred by the direct purchase of a prescription drug that is greater than the amount the covered person would have incurred if they had obtained the same prescription drug in the same plan year from an in-network pharmacy and pursuant to the terms of their plan; • If the covered person does not provide proof of payment; • If the covered person incurred the out-of-pocket expense by purchasing a prescription drug that	C.R.S. 10-16-161

	is not covered under the formulary of the covered person's plan, unless the carrier grants an exception; or • If the covered person does not comply with the carrier's utilization management processes, including prior authorization and step therapy protocols required under the covered person's plan	

Connecticut

Issue	Summary	Citation
Licensing/Registration	PBMs must obtain a certificate of registration from the Insurance Commissioner before operating in the state. PBMs must annually apply for renewal. A PBM operating as a line of business or affiliate of a health insurer, hospital service corporation, medical service corporation, or fraternal benefit society licensed in the state is exempt from this requirement. However, the parent entity must notify the Insurance Commissioner annually that it is affiliated with or operates a PBM.	Conn. Gen. Stat. § 38a-479bbb
Reporting Requirements	PBMs must file a report annually to the Department of Insurance, no later than February 1, containing the following information about pharmacy benefits managed by the PBM in the previous calendar year: • Aggregate dollar amount of all rebates collected from pharmaceutical manufacturers for products that were covered by contracted health plans and are attributable to patient utilization. • Aggregate dollar amount of all rebates that were not received by health carriers that contracted with the PBM The Insurance Commissioner must establish a standardized form for reporting information. The Commissioner shall submit a report by March 1 of each year to the General Assembly aggregating the information submitted by all PBMs. The Commissioner may impose a penalty of up to $7,500 for each violation. Each health carrier must submit the following information to the Insurance Commissioner when the carrier submits a rate filing for a health plan: • For covered outpatient drugs, the 25 most frequently prescribed drugs, the 25 drugs the health plan covered at the greatest cost, and the 25 drugs that experienced the greatest year-over-year increase in cost. • The portion of the premium for such health plan that is attributable to covered outpatient drugs, stratified by brand-name drugs, generic drugs, or specialty drugs. • The year-over-year increase, calculated on a per-member, per-month basis and expressed as a	Conn. Gen. Stat. § 38a-479ppp Conn. Gen. Stat. § 38a-479qqq

	percentage, in the annual total cost of brand-name drugs, generic drugs, and specialty drugs covered by the plan. • A comparison, calculated on a per-member, per-month basis, of the year-over-year increase in the cost of covered outpatient drugs to the increase in the costs of other contributors to the premium costs of the health plan. • The name of each specialty drug covered during the calendar year. • The names of the 25 most frequently prescribed outpatient prescription drugs for which the carrier received manufacturer rebates.	
PBM Income	N/A	
Pharmacy Contracting	N/A	
Patient Cost Sharing	**Copay Adjustment Programs:** When calculating an enrollee's liability for a coinsurance, copay, deductible, or other out-of-pocket expense for a covered benefit, an MCO shall give credit for any discount provided or payment made by a third party. **Maximum Cost-Sharing Levels:** No health carrier or PBM shall require an individual to make a payment at the point of sale for a covered drug that is greater than the lesser of 1) the applicable copayment, 2) the allowable claim amount (i.e. the amount the carrier or PBM has agreed to pay the pharmacy), or 3) the amount an individual would pay without using a health benefit plan or any other source of discounts. **Copay Cap:** Each individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for the treatment of all types of diabetes. No policy shall impose coinsurance, copayments, deductibles and other out-of-pocket expenses on an insured that exceed: • $25 for each 30-day supply of a medically necessary covered insulin drug, • $25 for each 30-day supply of a medically necessary covered noninsulin drug if such noninsulin drug is a glucagon drug. • $100 for a 30-day supply of all medically necessary covered diabetes devices and diabetic ketoacidosis devices for such insured that are in accordance with such insured's diabetes treatment plan.	Conn. Gen. Stat. § 38a-478w Conn. Gen. Stat § 38a-477cc Conn. Gen. Stat. § 38a-492d

Delaware

Issue	Summary	Citation
Licensing/Registration	A PBM must register with the Insurance Commissioner as a PBM before providing pharmacy benefit management services in Delaware to a purchaser.	Del. Code tit. 18 § 3353A-3354A

	Purchasers may not enter into an agreement or contract with a PBM that has not registered with the commission. A PBM applying for registration must file an application form provided by the commission along with a fee of $1,000. A PBM registration expires on May 1 after its effective date. A PBM may renew its registration for an additional 1-year term by filing a registration renewal application and paying a $1,000 renewal fee.	

Reporting Requirements	A PBM shall report to the commission, on a quarterly basis, all of the following for each insurer:
	• An itemization of PBM revenue sources, including professional fees, administrative fees, processing fees, audits, direct and indirect remuneration fees, or any other fees,
	• The aggregate amount of rebates distributed to the appropriate insurer,
	• The aggregate amount of rebates passed on to insureds of each insurer at the point of sale that reduced the insureds' applicable cost-sharing amount,
	• The individual and aggregate amount the insurer paid to the PBM for pharmacy goods or services itemized by:
	  ○ Pharmacy.
	  ○ Product.
	  ○ Goods and services.
	• The individual and aggregate amount a PBM paid for pharmacy goods or services, itemized by all of the following:
	  ○ Pharmacy.
	  ○ Product.
	  ○ Goods and services.
	• A PBM cannot initiate an audit of a pharmacy more often than once every 12 months.
	• The cost of any audit shall be borne by the PBM, who may not impose a fee or charge or pass along costs related to an audit to the pharmacy or pharmacist.
		Del. Code tit. 18 § 3363A
		
		Del. Code tit. 18 § 3304A

PBM Income	**Spread Pricing:** A PBM or a representative of a PBM may not engage in spread pricing. Purchasers may not contract with a PBM that conducts spread pricing.	Del. Code tit. 18 § 3371A-3372A
Pharmacy Contracting	**Minimum Reimbursement:** A PBM or a representative of a PBM may not pay or reimburse a pharmacy or pharmacist for the ingredient drug product component of pharmacist services at a rate less than the NADAC, or if unavailable, the WAC. **MAC Pricing:** A PBM must ensure that a product meets certain requirements before placing it on a MAC list and maintain a process to remove a product from the list if it no longer meets these requirements.	Del. Code tit. 18 § 3372A Del. Code tit. 18 § 3322A-3324A

	A PBM engaging in MAC pricing must make the sources used to determine such prices available to all network providers at the beginning of the network provider contract and upon renewal. MAC price information must be made available to network pharmacy providers in an electronic format. A PBM shall review MAC prices at least every 7 business days and update MAC price information if there are any modifications. A PBM shall use the updated price information to calculate MAC reimbursements on the day following a modification. Dispensing fees may not be included in the MAC price. A PBM must establish a process for a network pharmacy provider to appeal their reimbursement for a drug subject to MAC pricing. Information on how to file an appeal must be provided to network pharmacies at the beginning of their contract and upon renewal; the PBM must also disclose its appeals process on its website. If a PBM denies an appeal, it must provide the reason for the denial and the name and NDC of the national or regional wholesalers operating in Delaware that have the drug in stock at a price below the MAC. A pharmacy may appeal a denial to the Insurance Commission, which will review the PBM's compensation program. If a PBM grants an appeal, it shall update the MAC price information and provide updated reimbursement to the petitioning pharmacy without requiring the pharmacy to reverse and rebill the claim. It shall also notify similarly situated pharmacies and allow them to reverse and rebill claims without requiring a separate appeal. A PBM may not charge a fee related to the re-adjudication of a claim or retaliate against a network pharmacy provider for exercising its right to appeal a reimbursement. This section does not apply to the Medicaid fee-for-service program. **Appeals:** A PBM must establish a process which a contracted pharmacy can appeal the amount reimbursed by the PBM. • If an appeal is denied, the PBM must provide a detailed reason for the denial	
Patient Cost Sharing	**Copay Adjustment Programs:** When calculating an enrollee's contribution to any cost-sharing requirement, a PBM shall include any cost-sharing amounts paid by the enrollee or on the enrollee's behalf by another person. **Copay Cap:** An individual health insurance policy, contract, or certificate that is delivered, issued for delivery, renewed, extended, or modified in this State that provides	Del. Code tit. 18 § 3382 Del. Code tit. 18 § 3344B

	coverage for prescription insulin drugs must do all of the following:
	• Cap the total amount that a covered individual is required to pay for covered prescription insulin drugs at no more than $100 per month for each enrolled individual, regardless of the amount or types of insulin needed to fill the covered individual's prescriptions. The $100 per month cap includes deductible payments and cost-sharing amounts charged once a deductible is met.
	• Include at least 1 formulation of each of the following types of prescription insulin drugs on the lowest tier of the drug formulary developed and maintained by the carrier:
	  ○ Rapid-acting.
	  ○ Short-acting.
	  ○ Intermediate-acting.
	  ○ Long-acting.	

Florida

Issue	Summary	Citation
Licensing/Registration	A PBM must register with the Office of Insurance Regulation to conduct business in Florida. To register or renew a registration, a PBM shall submit a nonrefundable fee of up to $500, a copy of the registrant's corporate charter, and a complete registration form as determined by the department. Registration is valid for 2 years after its date of issue. A person who fails to register while operating as a PBM is subject to a fine of $10,000 for each violation. Starting January 1, 2024, PBMs must also obtain a certificate of authority to act as an administrator under Florida's Insurance Code. PBMs must comply with the requirements under s. 626.8805.	Fla. Stat. § 624.490 Fla. Stat. § 626.8805
Reporting Requirements	Beginning January 1, 2024, PBMs must submit reports annually to OIR to meet the requirements for certified administrator under s. 626.89. Under this section, PBMs must submit: • A full and true statement of its financial condition, transactions, and affairs, • An audited financial statement performed by an independent certified public accountant, • A statement attesting to its compliance with the network requirements of s. 626.8825, and • Any administrative, civil, or criminal complaints, settlements, or discipline of the PBM or any of its affiliates which relate to a violation of the insurance laws, including pharmacy benefit laws in any state. OIR may investigate PBMs. The office shall examine the business and affairs of each registered PBM at least biennially. The biennial examination of each PBM must be a systematic review for the purpose of determining the	Fla. Stat. § 626.89 Fla. Stat. § 626.8828 Fla. Stat. § 626.8814

	PBM's compliance with all provisions of this part and all other laws or rules applicable to PBMs and must include a detailed review of the PBM's compliance with ss. 626.8825 and 626.8827. The first 2-year cycle for conducting biennial reviews begins January 1, 2025. By January 15, 2026, and each January 15 thereafter, the office shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report summarizing the results of the prior year's examinations which includes detailed descriptions of any violations committed by each PBM and detailed reporting of actions taken by the office against each PBM for such violations. PBMs shall identify to OIR any ownership affiliation of any kind with any pharmacy which, either directly or indirectly, through one or more intermediaries: • Has an investment or ownership interest in a PBM holding a certificate of authority issued under this part; • Shares common ownership with a PBM holding a certificate of authority; or • Has an investor or a holder of an ownership interest which is a PBM holding a certificate of authority. • A PBM shall report any change in the above information to OIR in writing within 60 days after the change occurs.	
PBM Income	**Spread Pricing:** All contracts between a PBM and a pharmacy benefits plan or program shall exclude terms that allow for the direct or indirect engagement in the practice of spread pricing unless the PBM passes along the entire amount of such difference to the pharmacy benefits plan or program. **Rebate Pass-Through:** All contracts between a PBM and a pharmacy benefits plan or program shall use a pass-through pricing model that requires the PBM to pass 100 percent of all prescription drug manufacturer rebates received to the pharmacy benefits plan or program, if the contractual arrangement delegates the negotiation of rebates to the PBM, for the sole purpose of offsetting defined cost sharing and reducing premiums of covered persons. Any excess rebate revenue after the PBM and the pharmacy benefits plan or program have taken all actions required under this section must be used for the sole purpose of offsetting copayments and deductibles of covered persons. This requirement does not apply to contracts involving Medicaid managed care plans.	Fla. Stat. § 626.8825

Pharmacy Contracting	**MAC Pricing:** A contract between a health insurer and a PBM must require that the PBM: • Update MAC pricing information at least every 7 calendar days. • Maintain a process that will, in a timely manner, eliminate drugs from MAC lists or modify drug prices to remain consistent with changes in pricing data used in formulating MAC prices and product availability. Pharmacy network contracts must provide a reasonable administrative appeal procedure to allow a pharmacy or pharmacist to challenge the MAC pricing information and the reimbursement made under the MAC as defined in s. 627.64741 for a specific drug as being below the acquisition cost available to the challenging pharmacy or pharmacist. S. 626.8825 establishes standards for MAC appeal procedures. • Every 90 days, a PBM shall report to Office of the Insurance Regulator the total number of appeals received and denied in the preceding 90-day period, with an explanation or reason for each denial, for each specific drug for which an appeal was submitted. **Patient Steering:** Pharmacy networks may not be limited to include only affiliated pharmacies. PBMs are prohibited from offering or implementing pharmacy networks that require or provide a promotional item or an incentive, defined as anything other than a reduced cost-sharing amount or enhanced quantity limit allowed under the benefit design for a covered drug, to a covered person to use an affiliated pharmacy or an affiliated health care provider for the in-person administration of covered prescription drugs; or advertising, marketing, or promoting an affiliated pharmacy to covered persons. For the in-person administration of covered prescription drugs, PBMs may not require a covered person to receive pharmacist services from an affiliated pharmacy or an affiliated health care provider. PBMs may not require a covered person to receive a prescription drug by United States mail, common carrier, local courier, third-party company or delivery service, or pharmacy direct delivery unless the prescription drug cannot be acquired at any retail pharmacy in the PBM's network for the covered person's pharmacy benefits plan or program. PBMs may operate mail-order or delivery programs on an opt-in basis at the sole discretion of a covered person, provided that the covered person is not penalized through the imposition of any additional retail	Fla. Stat. § 627.64741 Fla. Stat. § 626.8825

	cost-sharing obligations or a lower allowed-quantity limit for choosing not to select the mail-order or delivery programs. **Appeals:** The appeal procedure must allow a pharmacy the option to submit a consolidated administrative appeal representing multiple adjudicated claims that share the same drug and day supply and have a date of service occurring within the same calendar month.	
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A PBM may not require a covered individual to pay a cost-sharing obligation that exceeds: • The applicable cost-sharing amount under the applicable pharmacy benefits plan or program; or • The usual and customary price.	Fla. Stat. § 626.8827

Georgia

Issue	Summary	Citation
Licensing/Registration	PBMs must obtain a license to operate from the Insurance Commission, which must be renewed annually. Fees include $2,000 for an initial application and $1,000 for a renewal application. Applicants must file and maintain a bond worth $100,000 in favor of the Commissioner and maintain liability insurance coverage of at least $250,000. The Insurance Commission may suspend, revoke, or refuse to renew a license under certain circumstances set out in s. 33-64-2. The Commissioner may levy a civil monetary penalty of up to $2,000 per violation and up to $10,000 per willful violation. PBMs do not need a license as an administrator to perform pharmacy benefit management functions.	GA Code § 33-64-2 - 33-64-6 (2025)
Reporting Requirements	A PBM shall report annually to each health plan and the Department of Insurance the aggregate amount of all rebates and other payments that the PBM received from pharmaceutical manufacturers in connection with claims if administered on behalf of the health plan. A PBM shall report in the aggregate to a health plan the difference between the amount the PBM reimbursed a pharmacy and the amount the PBM charged the health plan. By March 1 of each year, a PBM shall provide a letter to the Insurance Commissioner attesting as to whether, in the previous calendar year, it engaged in the practices of steering or imposing point-of-sale fees or retroactive fees. The PBM shall also submit data detailing all prescription drug claims it administered for Georgia insureds on behalf of each health plan client and any other data the Commissioner deems necessary to	GA Code § 33-64-10 (2025) GA Code § 33-64-12 (2025)

	evaluate whether a PBM may be engaged in the practice of steering or imposing point-of-sale fees or retroactive fees. Such data shall be confidential and not subject to Article 4 of Chapter 18 of Title 50, relating to open records; provided, however, that the Commissioner shall prepare an aggregate report reflecting the total number of prescriptions administered by the reporting PBM on behalf of all health plans in the state, along with the total sum due to the state. The Department of Audits and Accounts shall have access to all confidential data collected by the Commissioner for audit purposes.	
PBM Income	**Rebate Pass-Through:** A PBM shall offer a health plan the ability to receive 100% of all rebates it receives from pharmaceutical manufacturers. **Spread Pricing:** A PBM shall offer a health plan the option of charging such health plan the same price for a prescription drug as it pays a pharmacy for the prescription drug. A PBM must charge a health benefit plan administered by or on behalf of the state or a political subdivision of the state, including any county or municipality, the same price for a prescription drug as it pays a pharmacy for the prescription drug.	GA Code § 33-64-10 (2025)
Pharmacy Contracting	**MAC Pricing:** Upon each contract execution or renewal between a PBM and a pharmacy or a pharmacy's contracting agent, a PBM shall: • Identify the sources utilized to determine multi-source generic drug pricing and update such pricing information at least every five business days; and • Maintain a procedure to eliminate products from the multi-source generic list of drugs subject to such pricing or modify multi-source generic drug pricing within five business days when such drugs do not meet the standards and requirements, to remain consistent with pricing changes in the marketplace. A PBM shall reimburse pharmacies for drugs subject to multi-source generic drug pricing based upon pricing information that has been updated within five business days. A PBM may not place a drug on a multi-source generic list unless there are at least two therapeutically equivalent, multi-source generic drugs, or at least one generic drug available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers. All network contracts shall include a process for internal appeals, investigations, and resolution of disputes regarding multi-source generic drug pricing. The process shall include the following:	GA Code § 33-64-9 (2025) GA Code § 33-64-9.1 (2025) GA Code § 26-4-119 (2025) GA Code § 33-64-11 (2025) GA Code § 33-64-12 (2025)

	• The right to appeal shall be limited to 14 calendar days following reimbursement of the initial claim; and • A requirement that the health benefit plan issuer or PBM shall respond to an appeal described in subsection (a) of this Code section no later than 14 calendar days after the date the appeal was received by such health benefit plan issuer or PBM. For appeals that are denied, the PBM shall provide the reason for the denial and identify the NDC of a drug product that may be purchased by contracted pharmacies at a price at or below the MAC. If the appeal is successful, the health benefit plan issuer or PBM shall: • Adjust the MAC price that is the subject of the appeal effective on the day after the date the appeal is decided; • Apply the adjusted MAC price to all similarly situated pharmacists and pharmacies as determined by the health plan issuer or PBM; and • Allow the pharmacist or pharmacy that succeeded in the appeal to reverse and rebill the pharmacy benefits claim giving rise to the appeal. Appeals shall be upheld if: • The pharmacy being reimbursed for the drug subject to the multi-source generic drug pricing in question was not reimbursed as required in subsection (b) of this Code section; or • The drug subject to the multi-source generic drug pricing in question does not meet the requirements set forth in subsection (c) of this Code section. PBMs shall file the methodologies used in connection with determining MAC pricing lists with the Insurance Commission. **Minimum Reimbursement:** A PBM shall use the NADAC as a point of reference for the ingredient drug product component of a pharmacy's reimbursement for drugs appearing on the NADAC list. PBMs are not required to reimburse a pharmacy based on the NADAC price for a covered drug. A PBM shall produce a report every four months, which shall be provided to the Commissioner and published by the PBM on a website available to the public for no less than 24 months, of all drugs appearing on the NADAC list reimbursed at least 10 percent below the NADAC, as well as all drugs reimbursed at least 10 percent above the NADAC. For each drug in the report, a PBM shall include the month the drug was dispensed, the quantity of the drug dispensed, the amount the pharmacy was reimbursed per unit or dosage, whether the dispensing	

	pharmacy was an affiliate, whether the drug was dispensed pursuant to a state or local government health plan, and the average NADAC for the month the drug was dispensed. Such report shall exclude drugs dispensed pursuant to the 340B Drug Discount Program. **Patient Steering:** A PBM shall be prohibited from engaging in patient steering. S. 26-4-119 defines activities that may be considered steering, including offering or implementing plan designs that require patients to utilize affiliated pharmacies or other pharmacies with affiliates, or that increase plan or patient costs, including requiring patients to pay the full cost for a prescription when patients choose not to use affiliated pharmacies or other pharmacies with affiliates. A PBM may not transfer records relative to prescription information containing patient-identifiable and prescriber-identifiable data to an affiliated pharmacy for any commercial purpose. This does not prohibit the exchange of prescription information between a PBM and an affiliated pharmacy for the limited purposes of pharmacy reimbursement, formulary compliance, pharmacy care, or utilization review A PBM that engages in the practices of steering or imposing point-of-sale fees or retroactive fees shall be subject to a surcharge payable to the state of 10 percent on the aggregate dollar amount it reimbursed pharmacies in the previous calendar year for prescription drugs for Georgia insureds.	
Patient Cost Sharing	**Copayment Adjustment Programs:** When calculating an insured's contribution to any out-of-pocket maximum, deductible, or copayment responsibility, a PBM shall include any amount paid by the insured or paid on their behalf through a third-party payment, financial assistance, discount, or product voucher for a prescription drug that does not have a generic equivalent or that has a generic equivalent but was obtained through prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process. **Maximum Cost-Sharing Levels**: A PBM may not charge or collect a copayment from an insured that exceeds the total submitted charges by the network pharmacy or other dispenser practice.	GA Code § 33-64-10 (2025)

Hawaii

Issue	Summary	Citation
Licensing/Registration	PBMs must register with the Department of Commerce and Consumer Affairs (DCCA). Registrations must be renewed annually. Each person seeking to register as a	Haw. Rev. Stat. § 431S-3

	PBM shall file with the commissioner an application on a form prescribed by the commissioner. The application shall include: • The name, address, official position, and professional qualifications of each individual who is responsible for the conduct of the affairs of the PBM, including all members of the board of directors; board of trustees; executive commission; other governing board or committee; principal officers, as applicable; partners or members, as applicable; and any other person who exercises control or influence over the affairs of the PBM; • The name and address of the applicant's agent for service of process in the State; and • A nonrefundable issuance fee of $140. The commissioner may, upon showing of good cause, waive or modify, in whole or part, the fee in this subsection by order.	
Reporting Requirements	No later than March 31 of each calendar year, each prescription drug benefit plan, health benefits plan, and PBM shall file with the insurance commissioner, in such form and detail as the insurance commissioner shall prescribe, a report for the preceding calendar year stating that the PBM or prescription drug benefit plan is in compliance with this chapter. The report shall fully disclose the amount, terms, and conditions relating to copayments, reimbursement options, and other payments associated with a prescription drug benefit plan. The insurance commissioner shall review and examine records supporting the accuracy and completeness of the report and, no later than ninety days after the receipt of the report, shall make available to a purchaser of a prescription drug benefit plan and to any retail community pharmacy participating in a retail pharmacy network under section 431R-2 that provides benefits to beneficiaries of a prescription drug benefit plan a summary of the amount, terms, and conditions relating to copayments, reimbursement options, and other payments associated with a prescription drug benefit plan.	Haw. Rev. Stat. § 431R-4
PBM Income	N/A	
Pharmacy Contracting	**Audits:** • All requests for an audit of a pharmacy shall be made in writing with at least two weeks notice. • Any clerical or recordkeeping error identified during an audit shall not constitute fraud or intentional misrepresentation. • Each PBM shall establish an appeal process where a pharmacy or pharmacist may appeal an unfavorable audit report. • Audit information from one PBM shall not be shared with another PBM unless the audit is to involve fraud or willful misrepresentation.	HRS § 461

Patient Cost Sharing	N/A	

Idaho

Issue	Summary	Citation
Licensing/Registration	A person may not perform any pharmacy benefit management service unless the person is registered as a PBM with the Department of Insurance. PBMs must apply by April 1 of each year using a form prescribed by the director.	Idaho Code Ann. § 41-349 (3)
Reporting Requirements	The PBM shall disclose the following information to each health plan, payer, and pharmacy with which the PBM has a contract to provide pharmacy benefit management services: • The cost, price, and reimbursement of the prescription drug; • Each fee, markup, and discount charged or imposed by the PBM; or • The aggregate amount of all remuneration the PBM receives from a prescription drug manufacturer for a prescription drug, including any rebate, discount, administration fee, and any other payment or credit obtained or agreement for pharmacy benefit management services to a health plan or payer. No later than January 1, 2025, and each year thereafter, each licensed PBM shall report to the director of the Department of Insurance the following information: • The aggregate amount of the difference between the amount the PBM paid each pharmacy on behalf of the health plan for prescription drugs; and • If at any time during the reporting year the PBM moved or reassigned a prescription drug to a formulary tier that has a higher cost, higher copayment, higher coinsurance, higher deductible to a consumer, or lower reimbursement to a pharmacy, an explanation of the reason why the drug was moved or reassigned, including whether the move or reassignment was determined or requested by a prescription drug manufacturer or other entity. • Any PBM that owns, controls, or is affiliated with a pharmacy shall also report any difference in reimbursement rates or practices, direct and indirect remuneration fees or other price concessions, and clawbacks between a pharmacy that is owned, controlled, or affiliated with the PBM and any other pharmacy.	Idaho Code Ann. § 41-349 (6) Idaho Code Ann. § 41-349 (10)
PBM Income	**Spread Pricing:** A PBM shall not charge a pharmacy benefits plan or program a different amount for a prescription drug's ingredient cost or dispensing fee than the amount the PBM reimburses a pharmacy for the prescription drug's	Idaho Code Ann. § 41-349 (4)

	ingredient cost or dispensing fee, where the PBM retains the amount of any such difference. **Rebate Pass-Through:** The PBM shall pass along or return 100% of any manufacturer rebate to a pharmacy benefits plan or program, including any payment, discount, incentive, fee, price concession, or other remuneration.	Idaho Code Ann. § 41-349 (5)

Pharmacy Contracting	**MAC Pricing:**
	A PBM using MAC pricing may place a drug on a MAC list if the PBM does the following:
	• Ensures that the drug:
	  ○ Is listed as A-rated or B-rated in the most recent version of the FDA's approved drug products with therapeutic equivalence evaluations, also known as the "orange book"; or
	  ○ Has an NR or NA rating or a similar rating by a nationally recognized reference; and
	  ○ Is available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;
	• Provides to a network pharmacy, at the time a contract is entered into or renewed with the network pharmacy, the sources used to determine the MAC pricing for the MAC list specific to that provider;
	• Reviews and updates MAC price information at least once every 7 business days to reflect any modification of MAC pricing;
	• Establishes a process for eliminating products from the MAC list or modifying MAC prices in a timely manner to remain consistent with pricing changes and product availability in the marketplace;
	• Establishes a process by which a network pharmacy, or a network pharmacy's contracting agent, may appeal the reimbursement for a generic drug no later than thirty (30) days after such reimbursement is made; and
	• Provides a process for each of its network pharmacies to readily access the MAC list specific to that provider.
	
	Patient Steering:
	Pharmacy networks must meet or exceed Medicare Part D program standards for convenient access to network pharmacies and:
	• Do not limit a network to solely include affiliated pharmacies;
	• Do not require a covered person to receive a prescription drug by United States mail, common carrier, local courier, third-party company or delivery service, or pharmacy direct delivery unless the prescription drug cannot be acquired at any retail pharmacy in the PBM's network for the covered person's pharmacy benefits plan or program. The provisions of this subparagraph do not prohibit a
		Idaho Code Ann. § 41-349 (7)
		
		Idaho Code Ann. § 41-349 (11)

	PBM from operating mail order or delivery programs on an opt-in basis at the sole discretion of a covered person, provided that the covered person is not penalized through the imposition of any additional retail cost-sharing obligations or a lower allowed-quantity limit for choosing not to select the mail order or delivery programs; • For the in-person administration of covered prescription drugs, prohibit requiring a covered person to receive pharmacist services from an affiliated pharmacy or an affiliated health care provider; and • Prohibit offering or implementing pharmacy networks that require or provide a promotional item or an incentive to a covered person to use an affiliated pharmacy or an affiliated health care provider for the in-person administration of covered prescription drugs or advertising, marketing, or promoting an affiliated pharmacy to covered persons. Provided, however, a PBM may include an affiliated pharmacy in communications to covered persons regarding network pharmacies and prices as long as the PBM includes information, such as links to all nonaffiliated network pharmacies, in such communications and that the information provided is accurate and of equal prominence. The provisions of this subparagraph may not be construed to prohibit a PBM from entering into an agreement with an affiliated pharmacy to provide pharmacist services to covered persons.	
Patient Cost Sharing	**Maximum Cost Sharing Levels:** The PBM may not communicate at the point-of-sale, or otherwise require, a cost-sharing obligation for the covered person in an amount that exceeds the lesser of: • The applicable cost-sharing amount under the applicable pharmacy benefits plan or program; or • The amount that will be retained by the pharmacy.	Idaho Code Ann. § 41-349 (13)

Illinois

Issue	Summary	Citation
Licensing/Registration	To conduct business in Illinois, a PBM must register with the Department. Certificates shall be valid for 2 years after its date of issue. To initially register or renew a registration, a PBM shall submit: • A nonrefundable fee not to exceed $500. • A copy of the registrant's corporate charter, articles of incorporation, or other charter document. • A completed registration form adopted by the Director. On or before August 1, 2025, the PBM shall submit a report to the Department that lists the name of each health benefit plan it administers, provides the number of	215 Ill. Comp. Stat. § 5/513b2

	Illinois residents who are covered individuals for each health benefit plan as of the date of submission, and provides the total number of Illinois residents who are covered individuals across all health benefit plans the PBM administers. On or before September 1, 2025, a registered PBM, as a condition of its authority to transact business in this State, must submit to the Department an amount equal to $15 or an alternate amount as determined by the Director by rule per covered individual enrolled by the PBM in this State, as detailed in the report submitted to the Department under this subsection, during the preceding calendar year. On or before September 1, 2026, and each September 1 thereafter, payments submitted under this subsection shall be based on the number of Illinois residents who are covered individuals reported to the Department in s. 513b1.1. All amounts collected shall be deposited into the Prescription Drug Affordability Fund.	

Reporting Requirements	Records of rebates and fees remitted from the PBM or rebate aggregator must be disclosed to the Department annually in a format to be specified by the Department.
	
	A PBM that provides services for a health benefit plan must submit an annual report no later than September 1, to the Department, each health benefit plan sponsor, and each insurer that includes the following:
	• Data on the health benefit plan including:
	  ○ A list of drugs including corresponding information on therapeutic class, brand name, generic name, or specialty drug name;
	  ○ The total number of covered individuals and number of Illinois residents who are covered individuals;
	  ○ Number of drug-related claims;
	  ○ Dosage units;
	  ○ Dispensing channel used;
	  ○ Average WAC per drug; and
	  ○ Total out-of-pocket spending by deidentified covered individual per drug, per transaction;
	• Amount received by the health benefit plan in rebates, fees, or discounts related to drug utilization or spending;
	• Total gross spending on drugs by the health benefit plan;
	• Total net spending, gross spending less administrative portion of the medical loss ratio, on drugs by the health benefit plan;
	• The amount paid by the health benefit plan to the PBM for reimbursement cost of a drug and service per transaction;
	• The amount a PBM paid for pharmacists' services and drugs rendered related to the health benefit plan
		215 Ill. Comp. Stat. § 5/513b1 (f-15)
		
		215 Ill. Comp. Stat. § 5/513b1 (f-25)
		
		215 Ill. Comp. Stat. § 5/513b1.1

	per transaction, including, but not limited to, any dispensing fee; • The specific rebate amount received by the PBM per transaction, the amount of the rebates passed through to the health benefit plan per transaction, and the amount of the rebates passed on to covered individuals at the point of sale that reduced the covered individuals' applicable deductible, copayment, coinsurance, or other cost-sharing amount per transaction; • Any information collected from drug manufacturers pertaining to copayment assistance to the extent such information is collected; • Any compensation paid to brokers, consultants, advisors, or any other individual or firm for referrals, consideration, or retention by the health benefit plan; • Explanation of benefit design parameters encouraging or requiring covered individuals to use affiliated pharmacies, percentage of drugs charged by these pharmacies, and a list of drugs dispensed by affiliated pharmacies with their associated costs; and • A complete copy of each unredacted contract the PBM has with the health benefit plan sponsor or insurer. Annual reports must be filed with the Department by September 1. Annual reports must be written in plain language and contain only summary health information to ensure plan, coverage, or covered individual information remains private and confidential. Upon request by a covered individual, the annual report must be made available to help covered individuals understand their health benefit plan's prescription drug coverage. Failure to comply with these reporting requirements may result in fines up of to $10,000 per violation per day.	
PBM Income	**Spread Pricing:** A PBM or an affiliate acting on its behalf shall not conduct spread pricing. **Rebate Pass-Through:** A PBM 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.	215 Ill. Comp. Stat. § 5/513b1 (f-5)
Pharmacy Contracting	**MAC Pricing:** To place a drug on a MAC list, the PBM must ensure that: • If the drug is a generically equivalent drug, it is listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the FDA's most recent version of the "Orange Book" or have an NR or NA	215 Ill. Comp. Stat. § 5/513b1 (b-c) 215 Ill. Comp. Stat. § 5/513b1 (f-10)

	rating by Medi-Span, Gold Standard, or a similar rating by a nationally recognized reference; • The drug is available for purchase by each pharmacy in the State from national or regional wholesalers operating in Illinois; and • The drug is not obsolete. A contract between a health insurer or plan sponsor and a PBM must require that the PBM: • Update MAC pricing information at least every 7 calendar days; • Maintain a process to eliminate drugs from MAC lists or modify drug prices to remain consistent with changes in pricing data used in formulating MAC prices and product availability in a timely manner; • Provide access to its MAC list to each pharmacy or PSAO, subject to the MAC list. Access may include a real-time pharmacy website portal to view the MAC list. • Provide a process by which a contracted pharmacy can appeal the provider's reimbursement for a drug subject to MAC pricing. The appeals process must, at a minimum, include the following: o A requirement that a contracted pharmacy has 14 calendar days after the applicable fill date to appeal a MAC if the reimbursement for the drug is less than the net amount that the network provider paid to the supplier of the drug. o A requirement that a PBM must respond to a challenge within 14 calendar days of the contracted pharmacy making the claim for which the appeal has been submitted. o A telephone number and e-mail address or website to network providers, at which the provider can contact the PBM to process and submit an appeal. o A requirement that, if an appeal is denied, the PBM must provide the reason for the denial and the name and the NDC number from national or regional wholesalers. o A requirement that, if an appeal is sustained, the PBM must make an adjustment in the drug price effective the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the MCO or PBM. • Allow a plan sponsor or insurer whose coverage is administered by the PBM an annual right to audit compliance with the terms of the contract by the PBM, including, but not limited to, full disclosure of any and all rebate amounts secured, whether product specific or generalized rebates, that were provided to	

	the PBM by a pharmaceutical manufacturer. The cost of the audit shall be borne exclusively by the PBM. • Allow a plan sponsor or insurer whose coverage is administered by the PBM to request that the PBM disclose the actual amounts paid by the PBM to the pharmacy. • Provide notice to the plan sponsor or the insurer party contracting with the PBM of any consideration that the PBM receives from the manufacturer for dispense as written once a generic or biologically similar product becomes available. **Patient Steering:** A PBM or an affiliate acting on its behalf shall not steer a covered individual. This prohibition also applies to an insurer and its affiliates. Steering includes: • Requiring a covered individual to only use a pharmacy, including a mail-order or specialty pharmacy, in which the PBM or its affiliate, or an insurer or its affiliate, maintains an ownership interest or control; • Offering or implementing a plan design that encourages a covered individual to only use a pharmacy in which the PBM or an affiliate, or an insurer or its affiliate, maintains an ownership interest or control, if the plan design increases costs for the covered individual. This includes a plan design that requires a covered individual to pay higher costs or an increased share of costs for a drug or drug-related service if the covered individual uses a pharmacy that is not owned or controlled by the PBM or its affiliate or an insurer or its affiliate; and • Reimbursing a pharmacy or pharmacist for a drug and pharmacist service in an amount less than the amount that the PBM or an insurer reimburses itself or an affiliate, including affiliated manufacturers or joint ventures for providing the same drug or service.	
Patient Cost Sharing	**Maximum Cost Sharing Levels:** A health insurer or PBM shall not require a covered individual to make a payment for a drug at the point of sale in an amount that exceeds the lesser of: 1. The applicable cost-sharing amount; 2. The retail price of the drug in the absence of drug coverage; 3. The discounted price presented by the covered individual through a no-cost drug program or drug manufacturer voucher provided by or for the covered individual at the point of sale; or 4. The discounted price presented by the covered individual through a discounted health care services plan provided by or for the covered individual at the point of sale. **Copay Cap:**	215 Ill. Comp. Stat. § 5/513b1 (e) 215 Ill. Comp. Stat. § 5/356z.41 215 Ill. Comp. Stat. § 134/30

	An insurer that provides coverage for prescription insulin drugs pursuant to the terms of a health coverage plan the insurer offers shall limit the total amount that an insured is required to pay for a 30-day supply of covered prescription insulin drugs at an amount not to exceed $35, regardless of the quantity or type of covered prescription insulin drug used to fill the insured's prescription. **Copay Adjustment Programs:** A health care plan shall apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by or on behalf of such insured for prescription drugs toward a covered individual's deductible, copay, or cost-sharing responsibility, or out-of-pocket maximum associated with the individual's health insurance. For high-deductible health plans, this requirement applies after a covered individual has met their minimum deductible necessary to remain HSA-eligible	

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 and 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.	IN Code § 27-1-24.5-21 IN Code § 27-1-24.5-29 IN Code §27-1-24.5

	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.	
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
		IN Code § 27-1-24.5-22
		
		IN Code § 27-1-24.5-23
		
		IN Code § 27-1-24.2

	NDC number of the prescription drug that is available from a national or regional wholesaler operating in Indiana. ○ If an appeal is approved, a requirement 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 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	IN Code § 27-1-24.5-27.5 IN Code § 27-1-24.5-27.7

	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.	

Iowa

Issue	Summary	Citation
Licensing/Registration	A PBM doing business in this state shall obtain a certificate as a TPA under chapter 510, and the provisions relating to a TPA pursuant to chapter 510 shall apply to a PBM.	Iowa Code § 510B.2
Reporting Requirements	Each PBM shall provide a report annually by February 15 to the commissioner that contains all of the following information regarding prescription drug benefits provided to covered persons of each health carrier with whom the pharmacy manager has contracted during the prior calendar year: • The aggregate dollar amount of all rebates received by the PBM. • The aggregate dollar amount of all administrative fees received by the PBM. • The aggregate dollar amount of all health carrier administrative service fees received by the PBM. • The aggregate dollar amount of all rebates received by the PBM that the PBM did not pass through to the health carrier. • The aggregate amount of all administrative fees received by the PBM that the PBM did not pass through to the health carrier. • The aggregate retained rebate percentage. • Across all health carrier clients with whom the pharmacy manager was contracted, the highest and the lowest aggregate retained rebate percentages. A PBM shall submit a quarterly report to the commissioner of all drugs reimbursed at ten percent or more below the NADAC, and all drugs reimbursed at ten percent or more above the NADAC, for each prescription drug appearing on the NADAC list on the day the prescription drug was dispensed. A copy of the report shall be published on the PBM's public website for 24 months after the date the report is submitted to the commission. For each prescription drug included in the report, a PBM shall include all of the following information: • The month the prescription drug was dispensed. • The quantity of the prescription drug dispensed. • The amount the pharmacy was reimbursed.	Iowa Code § 510C.2 Iowa Code § 510B.8B

	• If the dispensing pharmacy was an affiliate of the PBM. • If the prescription drug was dispensed pursuant to a government health plan. • The average national drug acquisition cost for the month the prescription drug was dispensed. • The report shall exclude 340B drugs.	
PBM Income	**Rebate Pass-Through:** All contracts executed, amended, adjusted, or renewed on or after July 1, 2025, that apply to prescription drug benefits on or after January 1, 2026, between a PBM and a third-party payor, or between a person and a third-party payor, shall include all the following requirements: • The PBM shall use pass-through pricing. • Payments received by a PBM for services provided by the PBM to a third-party payor or to a pharmacy shall be used or distributed pursuant to the PBM's contract with the third-party payor or with the pharmacy, or as otherwise required by law.	Iowa Code § 510B.8D
Pharmacy Contracting	**MAC Pricing:** Prior to placement of a particular prescription drug on a MAC list, a PBM shall ensure that all of the following requirements are met: • The particular prescription drug must be listed as therapeutically and pharmaceutically equivalent in the most recent edition of the publication entitled "Approved Drug Products with Therapeutic Equivalence Evaluations", published by the FDA, otherwise known as the Orange Book. • The particular prescription drug must not be obsolete or temporarily unavailable. • The particular prescription drug must be available for purchase, without limitations, by all pharmacies in the state from a national or regional wholesale distributor that is licensed in the state. For each MAC list that a PBM uses in the state, the PBM shall do all of the following: • Provide each pharmacy in a pharmacy network reasonable access to the MAC list to which the pharmacy is subject. • Update the MAC list within seven calendar days from the date of an increase of ten percent or more in the NADAC of a prescription drug on the list. • Update the MAC list within seven calendar days from the date of a change in the methodology, or a change in the value of a variable applied in the methodology, on which the MAC list is based. • Provide a reasonable process for each pharmacy in a pharmacy network to receive prompt notice of all changes to the MAC list to which the pharmacy is subject. **Minimum Reimbursement:**	Iowa Code § 510B.8A Iowa Code § 510B.8B Iowa Code § 510B.8E

	• A PBM shall not reimburse any pharmacy located in the state in an amount less than the amount that the PBM reimburses a PBM affiliate for dispensing the same prescription drug as dispensed by the pharmacy. • A PBM shall not reimburse any retail pharmacy located in the state in an amount less than the most recently published NADAC for a prescription drug on the date that the prescription drug is administered or dispensed. If the most recently published NADAC for the prescription drug is unavailable on the date that the prescription drug is administered or dispensed, a PBM shall not reimburse any retail pharmacy located in the state in an amount less than the WAC for the prescription drug on the date that the prescription drug is administered or dispensed. • In addition to the reimbursement required, a PBM shall reimburse the retail pharmacy or pharmacist a professional dispensing fee of $10.86. A PBM shall provide a reasonable process to allow a pharmacy to appeal any matter. The PBM shall allow a period of no less than 30 business days after the date of a pharmacy's initial submission of a clean claim during which the pharmacy may initiate an appeal. The PBM shall respond to an appeal within 7 business days after the date on which the PBM receives the appeal. • If the PBM grants a pharmacy's appeal related to a reimbursement rate, the PBM shall do all of the following: o Adjust the reimbursement rate of the prescription drug that is the subject of the appeal and provide the NDC number that the adjustment is based on to the appealing pharmacy. o Reverse and resubmit the claim that is the subject of the appeal. o Make the adjustment applicable to each pharmacy that is under common ownership with the pharmacy that submitted the appeal and each pharmacy in the state that demonstrates the inability to purchase the prescription drug for less than the established reimbursement rate. • If the PBM denies a pharmacy's appeal, the PBM shall do all of the following: o Provide the appealing pharmacy the NDC number and the name of a wholesale distributor licensed in the state from which the pharmacy can obtain the prescription drug at or below the reimbursement rate. o If the prescription drug identified by the NDC number provided by the PBM is not available below the pharmacy acquisition cost from the wholesale distributor from whom the	

	pharmacy purchases the majority of its prescription drugs for resale, the PBM shall adjust the reimbursement rate above the appealing pharmacy's pharmacy acquisition cost, and reverse and resubmit each claim affected by the pharmacy's inability to procure the prescription drug at a cost that is equal to or less than the previously appealed reimbursement rate.	
Patient Cost Sharing	**Maximum Cost Sharing Levels:** A covered person shall not be required to make a cost-sharing payment at the point of sale for a prescription drug in an amount that exceeds the total amount that the pharmacy at which the covered person fills the covered person's prescription drug order is reimbursed. A PBM shall not impose different cost-sharing or additional fees on a covered person based on the pharmacy at which the covered person fills a prescription drug order. **Copay Adjustment Programs:** A PBM shall include any amount paid by a covered person, or on behalf of a covered person, when calculating the covered person's total contribution toward the covered person's cost-sharing. Any amount paid by a covered person for a prescription drug shall be applied to any deductible imposed on the covered person by the covered person's health benefit plan in accordance with the health benefit plan's coverage documents. For high-deductible health plans, these requirements only apply once a covered individual has met the minimum cost-sharing required to remain eligible for an HSA.	Iowa Code § 510B.8

Kansas

Issue	Summary	Citation
Licensing/Registration	A person shall not perform, act, or do business in this state as a PBM unless such person has a valid license issued by the Insurance Commissioner. Each person seeking a license to act as a PBM shall file with the commissioner an application for a license upon a form to be furnished by the commissioner. Each PBM license shall expire on March 31 each year and may be renewed annually upon the licensee's request. An applicant for a license or renewal must pay a nonrefundable application fee of $2,500. • This requirement applies to any PBM that provides claims processing services, other prescription drug or device services, or both, to covered persons who are residents of Kansas. • PBMs that hold a certificate of registration as an administrator pursuant to K.S.A. 40-3810 are exempt from this requirement.	K.S.A. 40-3821 K.S.A. 40-3824

	• A license issued in accordance with the PBM licensure act shall be nontransferable.	
Reporting Requirements	N/A	
PBM Income	Each PBM shall annually or more frequently report to the commissioner the following; • Amount of rebates received by PBM • Amount of rebates distributed to each health plan/covered entity • Amount paid to PBM by health plan or covered entity A PBM shall not reimburse a pharmacy/pharmacist/pharmacy technician for a prescription drug or pharmacy service less than the national average drug acquisition cost plus a $10.50 professional dispensing fee.	2026 SB 20
Pharmacy Contracting	**MAC Pricing:** A PBM, including the PBM for the state healthcare benefits program, shall: • Not place a drug on a MAC list unless there are at least two therapeutically equivalent multi-source generic drugs, or at least one generic drug available from at least one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers and the NDC for the drug is not obsolete; • Provide to each network pharmacy at the beginning of the term of a contract and upon request thereafter, the sources utilized to determine the MAC price; • Provide a process for each network pharmacy provider to readily access the maximum allowable price specific to that provider; • Review and update each applicable MAC list every 7 business days and apply the updates to reimbursements not later than 1 business day; • Ensure that dispensing fees are not included in the calculation of MAC; • Establish a reasonable administrative appeal procedure to allow a pharmacy or pharmacy's contracting agent to challenge MAC for a specific drug as: o Not meeting the requirements of this section; o Being below the cost at which the pharmacy may obtain the drug; • Include in any administrative appeals procedure the following: o A dedicated telephone number and email address or website for the purpose of submitting administrative appeals; and o The ability to submit an administrative appeal directly to the PBM regarding the pharmacy benefits plan or program or through a pharmacy service administrative organization;	K.S.A. 40-3830 2026 SB 20

	• Permit a network pharmacy or a network pharmacy's contracting agent to file an administrative appeal not later than 10 business days after the fill date;
	• Require that the PBM only request the following information to determine a MAC administrative appeal:
	  ○ The prescription number;
	  ○ The provider's name;
	  ○ The NDC used during the filing of the claim;
	  ○ The date of the fill;
	  ○ The reimbursement amount; and
	  ○ Such other information related to the appealed claim as required by contract; and
	• Provide a response to the appealing network pharmacy not later than 10 business days after receiving an appeal request containing information sufficient for the PBM to process the appeal as specified by the contract.
	• If the appeal is upheld, the PBM:
	  ○ Shall make the adjustment in the drug price effective not later than 1 business day after the appeal is resolved;
	  ○ Shall make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the plan sponsor or PBM, as appropriate; and
	  ○ Shall permit the appealing pharmacy to reverse and rebill the appealed claim.
	• If the appeal is denied, the PBM shall provide the appealing pharmacy the reason for the denial and the NDC number from a national or regional wholesaler operating in Kansas where the drug is generally available for purchase at a price equal to or less than the MAC, and when applicable, may be substituted lawfully.
	
	Audits:
	• All information collected during a pharmacy audit must be kept confidential.
	• An entity conducting an audit must provide the pharmacy being audited with at least 14 calendar days written notice.	

Patient Cost Sharing	**Maximum Cost-Sharing Levels:** Co-payments applied by a health carrier for a prescription drug may not exceed the total submitted charges by the network pharmacy.	K.S.A. 40-3831

Kentucky

Issue	Summary	Citation
Licensing/Registration	To conduct business in this state, a PBM must first obtain a license from the commissioner. The license shall be in lieu of an administrator's license as required by KRS 304.9-052. A licensed PBM performing utilization review,	KRS 304.9-053

	as defined in KRS 304.17A-600, shall be registered as a private review agent in accordance with KRS 304.17A-607. A person seeking a PBM license shall apply to the commissioner in writing on a form provided by the department. Each application for a license, and subsequent renewal for a license, shall be accompanied by a nonrefundable fee of $1,000, evidence of financial responsibility in an amount of $1,000,000, and any methodologies utilized, or to be utilized, by the PBM in connection with reimbursement. All licenses shall be renewed annually.	
Reporting Requirements	N/A	
PBM Income	**Spread Pricing (Medicaid):** By December 31, 2020, the Department for Medicaid Services shall select a TPA to serve as the PBM for every MCO that contracts with the department to deliver Medicaid services. The department shall prohibit the managed Medicaid program's PBM from conducting spread pricing. **Rebate Pass-Through (Medicaid):** By December 31, 2020, the Department for Medicaid Services shall select a TPA to serve as the PBM for every MCO that contracts with the department to deliver Medicaid services. The department shall require that the managed Medicaid program's PBM utilize pass-through pricing.	KRS 205.5512
Pharmacy Contracting	**MAC Pricing:** The PBM shall ensure that drugs subject to MAC pricing are: • Generally available for purchase by pharmacists and pharmacies in Kentucky from a national or regional wholesaler licensed in Kentucky by the Kentucky Board of Pharmacy; • Not obsolete, temporarily unavailable, or listed on a drug shortage list; and • Drugs that have an "A" or "B" rating in the most recent version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book; or rated "NR" or "NA" or have a similar rating by a nationally recognized reference. The PBM shall: • Identify to contracted pharmacies the sources used by the PBM to calculate the drug product reimbursement paid for covered drugs available under the pharmacy health benefit plan administered by the PBM; and • Establish a process for contracted pharmacies, pharmacy services administration organizations, or group purchasing organizations to appeal and	KRS 304.17A-162 KRS 304.17A-595 KRS 304.17A-597 KRS 205.5512

	resolve disputes regarding the MAC pricing. The process shall include the following provisions: ○ The right to appeal shall be limited to 60 days following the initial claim; ○ The appeal shall be investigated and resolved by the PBM within 10 calendar days; ○ The PBM shall respond to all appeals in a manner approved by the department; ○ If the appeal is denied, the PBM shall provide the reason for the denial and identify the NDC of a drug product and source where it may be purchased from a licensed wholesaler by contracted pharmacies at a price at or below the MAC; and ○ If an appeal is granted, the PBM shall: ▪ Make the change in the MAC to the initial date of service the appealed drug was dispensed; ▪ Adjust the MAC of the drug for the appealing pharmacy and for all other contracted pharmacies in the network of that PBM that filled a prescription for patients covered under the same health benefit plan to the initial date of service the appealed drug was dispensed; ▪ Individually notify all other contracted pharmacies in the network of that PBM that a retroactive MAC adjustment has been made as a result of a granted appeal effective to the initial date of service the appealed drug was dispensed; ▪ Adjust the drug product reimbursement for contracted pharmacies that resubmit claims to reflect the adjusted MAC if applicable to their contract; ▪ Allow the appealing pharmacy and all other contracted pharmacies in the network that filled prescriptions for patients covered under the same health benefit 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; and ▪ Make retroactive price adjustments in the next payment cycle. **Minimum Reimbursement:** Every contract between a pharmacy or pharmacist and an insurer, a PBM, or any other TPA of pharmacy benefits, either directly or through a PSAO or GPO, shall:	

	• Prohibit reducing payment for pharmacy or pharmacist services, directly or indirectly, under a reconciliation process to an effective rate of reimbursement.
	• Prohibit reimbursing the pharmacy or pharmacist for a prescription drug or other service at a net amount that is lower than the amount the insurer, PBM, or other administrator reimburses itself or a pharmacy affiliate.
	
	An insurer, PBM, or other administrator shall provide the following minimum reimbursement for pharmacy services:
	• Ingredient costs: Reimbursement for the cost of the drug or other service at an amount that is not less than:
	  ○ The NADAC for the drug or service at the time the drug or service is administered, dispensed, or provided; or
	  ○ If the NADAC is not available at the time a drug is administered or dispensed, the WAC for the drug at the time the drug is administered or dispensed.
	• The above reimbursement for drug costs shall not apply to pharmacies licensed in the state as “retail chain” until determined by the Insurance Commissioner, no sooner than January 1, 2027.
	• Professional dispensing fee: For plan years after January 1, 2027, reimbursement for a professional dispensing fee shall be not less than the average cost to dispense a prescription drug in an ambulatory pharmacy setting in Kentucky, as determined by the commissioner.
	  ○ The minimum dispensing fee shall not apply to mail-order pharmacies.
	  ○ For health plan years beginning prior to January 1, 2027, and for any future health plan years for which the commissioner has not established the average dispensing cost, the minimum dispensing fee for a pharmacy permitted as "retail independent" on file with the Kentucky Board of Pharmacy, or a pharmacist practicing at such a pharmacy, shall be not less than $10.64.
	
	Patient Steering:
	An insurer, PBM, or other administrator shall not:
	• Require or incentivize an insured to receive pharmacy or pharmacist services from a pharmacy affiliate. Conduct prohibited under this subparagraph includes but is not limited to:
	  ○ Requiring or incentivizing an insured to obtain a specialty drug from a pharmacy affiliate;	

	○ Charging less cost sharing to insureds that use pharmacy affiliates than what is charged to insureds that use nonaffiliated pharmacies; and ○ Providing any incentives for insureds that use pharmacy affiliates that are not provided for insureds that use nonaffiliated pharmacies. • Require or incentivize an insured to use a mail-order pharmacy. • Impose limits, including quantity limits or refill frequency limits, on an insured's access to medication from a pharmacy that are more restrictive than those existing for a pharmacy affiliate. **Patient Steering (Medicaid):** By December 31, 2020, the Department for Medicaid Services shall select a TPA to serve as the PBM for every MCO that contracts with the department to deliver Medicaid services. The department shall prohibit the managed Medicaid program's PBM from requiring or incentivizing a Medicaid recipient to use a pharmacy owned by or otherwise associated with the state PBM. The department shall also prohibit the state's PBM from requiring a Medicaid recipient to obtain a specialty drug from a specialty pharmacy owned by or otherwise associated with the state PBM.	
Patient Cost Sharing	**Copay Cap:** All health benefit plans issued or renewed on or after January 1, 2022, shall provide coverage for equipment, supplies, outpatient self-management training and education, including medical nutrition therapy, and all medications necessary for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes if prescribed by a health care provider legally authorized to prescribe the items. Cost sharing for a covered prescription insulin drug shall not exceed thirty dollars ($30) per thirty (30) day supply of each prescription insulin drug, regardless of the amount or type of insulin needed to meet the covered person's insulin needs. **Maximum Cost-Sharing Levels:** An insurer issuing or renewing a health plan on or after January 1, 2022, or a PBM, shall not require an insured purchasing a prescription drug to pay a cost-sharing amount greater than the amount the insured would pay for the drug if they were to purchase the drug without coverage. **Copay Adjustment Programs:** An insurer issuing or renewing a health plan on or after January 1, 2022, or a PBM, shall not exclude any cost-sharing amounts paid by an insured or on behalf of an	KRS 304.17A-148 KRS 304.17A-164

	insured by another person for a prescription drug when calculating an insured's contribution to any applicable cost-sharing requirement. These requirements shall not apply to a prescription drug for which there is a generic alternative, unless the insured has obtained access to the brand prescription drug through prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process. These requirements also do not apply to any fully insured health benefit plan or self-insured government employee health plan.	

Louisiana

Issue	Summary	Citation
Licensing/Registration	A PBM shall be deemed to be a TPA for purposes of s. 22:1651. Every PBM shall be required to be licensed by the commissioner of insurance, except PBMs that have their principal place of business in another state and are not soliciting business as an administrator in Louisiana.	La. Stat. Ann. § 22:1657
Reporting Requirements	For each of a PBM's contractual or other relationships with a health benefit plan or health insurance issuer, the PBM shall provide the department with the health benefit plan's formulary and provide timely notification of formulary changes and product exclusions. The information provided pursuant to this Subsection shall be made available in a centralized location on the department's website in a format that allows for consumer access, including links to PBM websites. **Medicaid:** The Louisiana Department of Health shall submit quarterly reports to the Senate and House committees on health and welfare encompassing the following data regarding the Medicaid MCOs' PBMs: • The name of each PBM, identified as contracted or owned by the Medicaid MCO. • Whether the PBM is a subsidiary of the parent company of the Medicaid MCO. • The total dollar amount paid to the PBM by the Medicaid MCO as a transaction fee for each processed claim. • The total dollar amount of the Medicaid drug rebates and manufacturer discounts collected and retained by the Medicaid MCO and PBM. • The total dollar amount of the Medicaid drug rebates and manufacturer discounts collected by the Medicaid MCO and PBM and remitted to the Louisiana Department of Health. • The total dollar amount retained by the PBM through spread pricing. For purposes of this Subparagraph, "spread pricing" means the actual amount paid as reimbursement to a pharmacist as compared to the amount the PBM charged to and was reimbursed by	La. Stat. Ann. § 22:1657 La. Stat. Ann. § 40:1253.2 La 2026 Act No. 914

	the Medicaid MCO to identify the excess amount paid to the PBM above what was paid to the pharmacist. • Identification of any other monies retained by the PBM not otherwise provided for in this Subsection that are not reimbursed to pharmacists.	
PBM Income	**Spread Pricing:** No PBM shall engage in spread pricing or effective rate pricing. **Rebate Pass-Through (Medicaid):** • Any contract for PBM services shall be limited to a transaction fee only, based on a set rate established by the Department of Health to be paid to the PBM for each Medicaid pharmacy claim processed. • No PBM may retain any portion of state supplemental rebates or credits submitted to the state by any pharmaceutical manufacturer. **Rebate Pass-Through:** A PBM may negotiate but shall not retain rebates and fees. All rebates shall be passed through to clients. **Spread Pricing (Medicaid):** • No PBM may retain any portion of any amount charged or claimed by a PBM to an MCO that is more than the amount paid to the pharmacy that filled the prescription. PBMs may earn income only from; • A flat dollar service fee charged on a per-person/per-month/per-prescription/per-event basis. This shall cover all administrative, clinical, print, electronic and related costs. • A flat dollar performance bonus payment paid by a client health benefit plan. Pharmacy benefit management fee covers the cost of providing one or more PBM services and does not exceed the value of the services actually performed. A PBM shall not; • Engage in any activity which increases the cost of prescription drugs to health plans or enrollees • Restrict or impair access to prescription drugs except as required by the design of the health plan • Obtain a rebate, incentive, discount on a name brand drug in exchange for not placing another name brand drug, biosimilar, generic, or other drug in the same class on the PBM formulary, unless the discount is returned to the health insurance issuer or plan sponsor. • Design a formulary to favor a branded pharmaceutical or biologic over a therapeutically equivalent generic or biosimilar unless the branded	La. Stat. Ann. § 22:1867 La. Stat. Ann. § 39:1648 La 2026 Act No. 914

	drug has a lower NAC and that is reflected in lower out-of-pocket expenses or premiums for enrollees. • Use its formulary to effectively ban the use of certain pharmacies. • Base fees on the acquisition cost or price metric of a drug, amount of savings or rebates, the amount of premiums, deductibles, or cost-sharing from patients. • Earn income based on prescription drug list prices, acquisition cost, or other prescription drug pricing metrics.	

Pharmacy Contracting	**MAC Pricing:**
	Before a PBM places or continues a particular NDC or MAC List, the following requirements shall be met:
	• The prescription drug to which the NDC is assigned shall be listed as "A" or "B" rated in the most recent version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, or have an "NR" or "NA" rating or a similar rating by a nationally recognized reference.
	• The prescription drug to which the NDC is assigned shall be available for purchase by pharmacies in the state from national or regional wholesalers.
	• The prescription drug to which the NDC is assigned shall not be considered obsolete, temporarily unavailable, or listed on a drug shortage list.
	• For every drug for which the PBM establishes a MAC to determine the drug product reimbursement, the PBM shall make available to all pharmacies both of the following:
	  ○ Information identifying the national drug pricing compendia or sources used to obtain the drug price data.
	  ○ The comprehensive list of drugs subject to MAC by plan and the actual MAC by plan for each drug.
	
	A PBM shall do all of the following:
	• Provide access to its MAC List to each pharmacy subject to the list.
	• Update its MAC List on a timely basis, but in no event longer than seven calendar days from a change in the methodology on which the MAC List is based or in the value of a variable involved in the methodology.
	• Provide a process for each pharmacy subject to the list to review an update to the MAC List.
	
	Utilization Management:
	A commercial insurer shall not require prior authorization for the dispensing or reimbursement of a generic non-opioid medication if the WAC is no more than $250 per prescription.
	
	Patient Steering:
		La. Stat. Ann. § 22:1864
		
		La. Stat. Ann. § 40:2870
		
		La. 2026 Act No. 913
		
		La 2026 Act No. 914
		
		La. 2026 Act No. 706

	A PBM in Louisiana shall not directly or indirectly engage in patient steering to a pharmacy in which the PBM maintains an ownership interest or control. Patient steering includes but is not limited to any communication by a PBM through data mining or other similar process of any patient information generated or obtained throughout the prescription filling process at any pharmacy, including contacting the patient verbally or in writing to directly or indirectly influence the patient or provide the patient with the option to use an alternate pharmacy that is a preferred carve-out or is in a strategic relationship with the PBM or in which the PBM maintains an ownership interest or control or contracts with to process prescriptions on its behalf. A PBM is prohibited from retaliation or attempts to influence the patient to use the alternate pharmacy. A PBM may not penalize or provide an inducement to the beneficiary for the purpose of getting the beneficiary to use specific retail, mail-order pharmacy, or another network pharmacy provider in which a PBM has an ownership or controlling interest or that has an ownership or controlling interest in a PBM. This provision does not apply to employers, unions, associations, or other persons who employ, own, operate, control, or contract directly with a pharmacy or pharmacist for the purpose of managing or controlling prescription costs paid for the benefit of an employee or member or those covered by the employee or member's plan, or when the persons contract with a PBM to steer employees or members to pharmacists or pharmacies which the person owns, operates, or controls. A PBM, affiliate, or subsidiary shall not directly or indirectly prohibit or restrict a pharmacy or pharmacist from offering services or products to increase transparency, access, and affordability or prescription drugs for patients. **Reimbursement:** A PBM must adopt a reimbursement formula using NADAC as the prescription drug pricing benchmark and a professional dispensing fee established by the Louisiana Department of Health for the Louisiana Medicaid program. The professional dispensing fee shall reflect the actual cost of professional services provided. **Audits:** Audits may only be completed once annually, at maximum. The audit shall be limited to claims submitted within the last twelve months prior to the audit date. **Appeal Process:** A PBM must adopt an appeal process for pharmacists to challenge claim payment errors. If a claim payment error occurred, the PBM shall make an additional payment.	

	The administrative appeal shall allow a pharmacy or pharmacist the option to submit a consolidated appeal representing multiple substantially similar claims. The PBM is prohibited from amending or changing the amount a consumer must pay for an out-of-pocket cost share or expense.
	
	Pharmacy benefit management service includes;
	• Negotiating the price of prescription drugs, rebates, discounts, or other price concessions
	• Managing any aspect of a prescription drug benefit
	• Performing any administrative, managerial, clinical, pricing, financial, data administration, reporting, billing services
	
	Formulary Adjustments:
	Other than at the time of coverage renewal, while an insured is taking a prescription drug, a PBM shall not
	• Remove the prescription drug from its list of covered drugs unless;
	  ○ The FDA issues a statement regarding the safety of the drug
	  ○ The manufacturer discontinues the drug
	  ○ The drug becomes available OTC
	• Reclassify the drug to a more restrictive tier
	• Increase the amount paid for a copayment, coinsurance, or deductible	

Patient Cost Sharing	**Copay Accumulator Programs:** When calculating an enrollee's contribution to any applicable cost-sharing requirement, a health insurance issuer shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. For high-deductible health plans, these requirements shall only apply after a covered individual meets their minimum cost-sharing necessary to remain HSA-eligible. **Copay Cap:** A health coverage plan shall include at least one insulin from each therapeutic class in the plan's formulary. A health coverage plan shall not impose a cost-sharing provision for insulin in the health coverage plan's formulary if the total amount the enrollee is required to pay exceeds $75 dollars per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the enrollee's prescription. The copay cap shall increase annually by the percentage change from the preceding year in the prescription drug component of the Consumer Price Index.	La. Stat. Ann. § 22:976.1 La. RS § 22:1034.1

Maine

Issue	Summary	Citation

Licensing/Registration	A person may not act as a PBM in Maine without first obtaining a license from the superintendent and paying the licensing fee required under section 601, subsection 28-A. Licenses shall be valid for 3 years. The superintendent may issue a PBM license subject to restrictions or limitations, including the type of services that may be supplied or the activities in which the PBM may engage.	Me. Rev. Stat. Ann. tit. 24-A § 4348
Reporting Requirements	Beginning December 31, 2026, and annually by December 31 thereafter, a carrier, or a PBM under contract with a carrier, operating in the State shall certify to the superintendent that it has complied with the requirements of s. 4350-F, related to spread pricing. On or before February 15 of each year, Maine's Health Data Organization shall produce a list of drug product families for which it intends to request pricing component data from manufacturers, wholesale drug distributors, and PBMs. The organization shall consider drug product families that include prescription drugs: • With substantial drug price changes, and • The 25 costliest drugs, the 25 most frequently prescribed drugs in the State, and the 25 drugs with the highest year-over-year cost increases. Not sooner than 30 days after publicly posting the list of drug product families, the organization shall send a request for information from manufacturers, wholesale drug distributors, and PBMs. Within 60 days from the date of a request from the organization relating to a specific prescription drug, a manufacturer, wholesale drug distributor or PBM shall notify the organization of pricing component data per pricing unit of the prescription drug.	Me. Rev. Stat. Ann. tit. 24-A § 4350-F Me. Rev. Stat. Ann. tit. 22 § 8732
PBM Income	**Spread Pricing:** A carrier or PBM may not, either directly or through an intermediary, agent or affiliate, engage in, facilitate, or enter into a contract with another person involving spread pricing in this State. This section does not apply to MaineCare (Medicaid).	Me. Rev. Stat. Ann. tit. 24-A § 4350-F
Pharmacy Contracting	**MAC Pricing:** • Single MAC list. A carrier, or a PBM under contract with a carrier, shall use a single MAC list to establish the maximum amount to be paid by a health plan to a pharmacy provider for a generic drug or a brand-name drug that has at least one generic alternative available. A carrier, or a PBM under contract with a carrier, shall use the same MAC list for each pharmacy provider. • Listing of prescription drug. A MAC may be set for a prescription drug, or a prescription drug may be allowed to continue on a MAC list, only if that prescription drug:	Me. Rev. Stat. Ann. tit. 24-A § 4350

	○ Is rated as "A" or "B" in the most recent version of the United States Food and Drug Administration's "Approved Drug Products with Therapeutic Equivalence Evaluations," also known as "the Orange Book," or an equivalent rating from a successor publication, or is rated as "NR" or "NA" or a similar rating by a nationally recognized pricing reference; and ○ Is not obsolete and is generally available for purchase in this State from a national or regional wholesale distributor by pharmacies having a contract with the PBM. • Changes to MAC list. A carrier, or a PBM under contract with a carrier, shall establish a process for removing a prescription drug from a MAC list or modifying a MAC for a prescription drug in a timely manner to remain consistent with changes to such costs and the availability of the drug in the national marketplace. • Disclosure. With regard to a pharmacy with which the carrier, or the PBM under contract with a carrier, has entered into a contract, a carrier, or a PBM under contract with a carrier, shall: ○ Upon request, disclose the sources used to establish the MACs; ○ Provide a process for a pharmacy to readily obtain the maximum allowable payment available to that pharmacy under a MAC list; and ○ At least once every 7 business days, review and update MAC list information to reflect any modification of the maximum allowable payment available to a pharmacy under a MAC list used by the carrier or the PBM under contract with a carrier. • Appeal procedure. A carrier, or a PBM under contract with a carrier, shall provide a reasonable administrative appeal procedure, including a right to appeal that is limited to 14 days following the initial claim, to allow pharmacies with which the carrier or PBM has a contract to challenge MACs for a specified drug. • Resolution of appeals. A carrier, or a PBM under contract with a carrier, shall respond to, investigate and resolve an appeal within 14 days after the receipt of the appeal. The carrier or PBM shall respond to an appeal as follows: ○ If the appeal is upheld, the carrier or PBM shall make the appropriate adjustment in the MAC and permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question; or ○ If the appeal is denied, the carrier or PBM shall provide the challenging pharmacy or pharmacist the NDC from national or regional	

	wholesalers of a comparable prescription drug that may be purchased at or below the MAC. • AWP; use of a prescription drug not on MAC list. A carrier, or a PBM under contract with a carrier, shall use the AWP to establish the maximum payment for a brand-name drug for which a generic equivalent is not available or a prescription drug not included on a MAC list. In order to use the AWP of a brand-name drug or prescription drug not included on a MAC list, a carrier, or a PBM under contract with a carrier, must use only one national drug pricing source during a calendar year, except that a carrier, or a PBM under contract with a carrier, may use a different national drug pricing source if the original pricing source is no longer available. A carrier, or a PBM under contract with a carrier, shall use the same national drug pricing source for each pharmacy provider and identify on its publicly accessible website the name of the national drug pricing source used to determine the AWP of a prescription drug not included on the MAC list.	
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A carrier or PBM may not require a covered person to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of: • The applicable cost-sharing amount for the prescription drug; • The amount a covered person would pay for the prescription drug if the covered person purchased the prescription drug without using a health plan or any other source of prescription drug benefits or discounts; and • The total amount the pharmacy will be reimbursed for the prescription drug from the PBM or carrier, including the cost-sharing amount paid by a covered person. **Copay Adjustment Programs:** When calculating a covered person's contribution to any applicable cost-sharing or other out-of-pocket expense under a covered prescription drug benefit, a carrier or PBM shall give credit for any waiver or discount of, or payment made by a third party for, the amount of, or any portion of the amount of, the applicable cost-sharing or other out-of-pocket expense for the covered prescription drug that is either: • Without a generic equivalent; or • With a generic equivalent when the covered person has obtained access to the covered prescription drug through prior authorization, a step therapy override exception or other exception or appeal process. A third party that pays as financial assistance any amount, or portion of the amount, of any applicable cost-	Me. Rev. Stat. Ann. tit. 24-A §4349 Me. Rev. Stat. Ann. tit. 24-A §4317-C

	sharing or other out-of-pocket expense on behalf of a covered person for a covered prescription drug: • Shall notify the covered person prior to or within 7 days of the acceptance of the financial assistance of the total amount of assistance available and the duration for which it is available; and • May not condition the assistance on enrollment in a specific health plan or type of health plan, except as permitted under federal law. For high-deductible health plans, this requirement shall only apply after a covered individual meets the minimum cost-sharing amount needed to remain HSA-eligible. **Copay Cap:** A carrier that provides coverage for prescription insulin drugs may not impose any deductible, copayment, coinsurance or other cost-sharing requirement on an enrollee for that coverage that results in out-of-pocket costs to the enrollee that exceed $35 per prescription for a 30-day supply of covered prescription insulin drugs, regardless of the amount of insulin needed to fill the enrollee's insulin prescriptions.	

Maryland

Issue	Summary	Citation
Licensing/Registration	A PBM shall register with the Insurance Administration as a PBM before providing pharmacy benefits management services to purchasers. An applicant shall file with the commissioner an application on the form that the commissioner provides and pay a registration fee set by the commissioner (currently $5,000). A PBM registration expires on the second September 30 after it is approved. A carrier may not enter into an agreement with a PBM that has not registered with the Commissioner.	Md. Code Ins. Law § 15–1604 Md. Code Ins. Law §15–1605 Md. Code Ins. Law §15–1606
Reporting Requirements	A PBM shall maintain adequate books and records about each purchaser for which the PBM provides pharmacy benefits management services for the duration of the agreement between the PBM and the purchaser; and for 3 years after the PBM ceases to provide pharmacy benefits management services for the purchaser. Whenever the Commissioner considers it advisable, the Commissioner may examine the affairs, transactions, accounts, and records of a registered PBM. Before entering into a contract with a purchaser, a PBM shall inform the purchaser that the PBM may: • Solicit and receive manufacturer payments; • Pass through or retain the manufacturer payments depending on the contract terms with a purchaser;	Md. Code Ins. Law §15–1608 Md. Code Ins. Law §15–1609 Md. Code Ins. Law §15–1623 Md. Code Ins. Law §15–1624

	• Sell aggregate utilization information; and • Share aggregate utilization information with other entities. Before entering into a contract with a purchaser, a PBM shall offer to provide the purchaser a report that contains the: • Net revenue of the PBM from sales of prescription drugs to purchasers made through the PBM's network of contractually affiliated retail pharmacies or through the PBM's mail order pharmacies, with respect to the PBM's entire client base of purchasers; and • The amount of all manufacturer payments earned by the PBM. If a purchaser has a rebate sharing contract, a PBM shall offer to provide the purchaser a report for each fiscal quarter and each fiscal year that contains the amount of the: • Net revenue of the PBM from sales of prescription drugs to purchasers made through the PBM's network of contractually affiliated retail pharmacies or through the PBM's mail order pharmacies, with respect to the PBM's entire client base of purchasers; • Total prescription drug expenditures applicable to the purchaser; • Total manufacturer payments earned by the PBM during the applicable reporting period; and • Total rebates applicable to the purchaser during the applicable reporting period. If the exact amount of each item is not known by the PBM at the time of its report, the PBM shall offer to provide its current best estimate of the amount of each item. The PBM shall provide an updated report containing the exact amount of each item immediately after it becomes available.	
PBM Income	N/A	
Pharmacy Contracting	**Patient Steering:** A PBM may not require that a beneficiary use a specific pharmacy or entity to fill a prescription if: • The PBM or a corporate affiliate of the PBM has an ownership interest in the pharmacy or entity; or • The pharmacy or entity has an ownership interest in the PBM or a corporate affiliate of the PBM. Non-oncology specialty drugs are exempt from the patient steering provision. **Minimum Reimbursement:** A PBM may not reimburse a pharmacy or pharmacist for a pharmaceutical product or pharmacist service in an amount less than the amount that the PBM reimburses	Md. Code Ins. Law §15–1611.1 Md. Code Ins. Law §15–1612 Md. Code Ins. Law §15–1628.1

	itself or an affiliate for providing the same product or service. This requirement does not apply to reimbursements paid to mail-order pharmacies, chain pharmacies with more than 15 stores, or claims for non-oncology specialty drugs. **MAC Pricing:** In each participating pharmacy contract, the PBM shall include the sources used to determine MAC pricing. A PBM shall update its pricing information at least every 7 days, establish a reasonable process by which a contracted pharmacy has access to the current and applicable MAC price lists in an electronic format, and use the updated pricing information in calculating the payments made to all contracted pharmacies. Before placing a prescription drug on a MAC list, a PBM shall ensure that: • The drug is listed as "A" or "B" rated in the most recent version of the U.S. Food and Drug Administration's approved drug products with therapeutic equivalence evaluations, also known as the Orange Book, or has an "NR" or "NA" rating or similar rating by a nationally recognized reference; • If a drug is manufactured by more than one manufacturer, the drug is generally available for purchase by contracted pharmacies, including contracted retail pharmacies, in the State from a wholesale distributor with a permit in the State; or • If a drug is manufactured by only one manufacturer, the drug is generally available for purchase by contracted pharmacies, including contracted retail pharmacies, in the State from at least two wholesale distributors with a permit in the State; and • The drug is not obsolete, temporarily unavailable, or listed on a drug shortage list as currently in shortage. A PBM shall maintain a procedure to eliminate products from the list of drugs subject to MAC pricing as necessary. A product on the MAC list shall be eliminated from the list by the PBM within 7 days after the PBM knows of a change in the availability of the product. For disputes regarding MAC pricing, each participating pharmacy contract must include a process to appeal, investigate, and resolve disputes regarding MAC pricing that includes: • A requirement that an appeal be filed by the contract pharmacy no later than 21 days after the date of the initial adjudicated claim; • A requirement that, within 21 days after the date the appeal is filed, the PBM investigate and resolve the	

	appeal and report to the contracted pharmacy on the PBM's determination on the appeal; • A requirement that a PBM make available on its website information about the appeal process; • A requirement that a PBM provide a reason for any appeal denial as well as the NDC of a drug and the name of the wholesale distributor from which the drug was available on the date the claim was adjudicated at a price at or below the MAC determined by the PBM; and • If an appeal is upheld, a requirement that the PBM adjust the MAC for the drug as of the date of the original claim for payment and allow the appealing pharmacy and similarly situated pharmacies in the state to reverse and rebill the claim.	
Patient Cost Sharing	**Copay Adjustment Programs:** Starting January 1, 2026, when calculating an enrollee's contribution to a cost-sharing requirement, carriers must include any discount, financial assistance payment, product voucher, or other out-of-pocket expense made by or on behalf of the enrollee for covered prescription drugs that do not have a generic equivalent, or have a generic equivalent and the enrollee obtained coverage through prior authorization, a step therapy protocol, or the exception or appeal process. If an enrollee is covered under a high-deductible health plan, the requirements for calculating the enrollee's contribution to cost-sharing do not apply to the deductible requirement. **Copay Cap:** These requirements apply to insurers and nonprofit health service plans, HMOs, and PBMs contracted with these entities. An entity subject to this section shall limit the amount a covered individual is required to pay in copayments or coinsurance for a covered prescription insulin drug to not more than $30 for a 30-day supply, regardless of the amount or type of insulin needed to fill the covered individual's prescription.	Md. Code Ins. Law § 15-118.1 Md. Code Ins. § 15-822.1

Massachusetts

Issue	Summary	Citation
Licensing/Registration	PBMs must obtain a license from the Division of Insurance. A license may be granted only when the division is satisfied that the entity possesses the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered. A PBM license shall be valid for a period of 3 years and shall be renewable for additional 3-year periods. The commissioner shall charge application and renewal fees of $25,000.	M.G.L. c. 176Y § 2
Reporting Requirements	The Center for Health Information and Analysis (CHAI) shall promulgate regulations necessary to ensure the	M.G.L. c. 12C § 10A

	uniform reporting of information from PBMs to enable the center to analyze: • Year-over-year changes in WAC; • Year-over-year trends in formulary, MAC lists and cost-sharing design, including the establishment and management of specialty product lists; • Aggregate information regarding discounts, utilization limits, rebates, administrative fees charged to pharmaceutical manufacturing companies and other financial incentives or concessions related to pharmaceutical products or formulary programs; • Trends in estimated aggregate drug rebates and other aggregate drug price reductions, if any, provided by a PBM to a carrier client or health plan sponsor or passed through from a PBM to a carrier client or health plan sponsor in connection with utilization of drugs in the commonwealth offered through the PBM and a measure of lives covered by each carrier client or health plan sponsor in the commonwealth; and • Any other information deemed reasonably necessary by the center by regulation. CHAI shall require the submission of available data and other information from PBMs including, but not limited to: • The aggregate amount of all rebates that the PBM received from all pharmaceutical manufacturing companies and for all carrier clients or health plan sponsors; • The administrative fees that the PBM received from all carrier clients or health plan sponsors in the aggregate and for each carrier client or health plan sponsor individually; • The aggregate amount of rebates a PBM: (A) retains based on its contractual arrangement with each carrier client or health plan sponsor individually; and (B) passes through to each carrier client or health plan sponsor individually; • The aggregate amount of all retained rebates that the PBM received from all pharmaceutical manufacturing companies and did not pass through to each PBM's carrier client or health plan sponsor individually; • The percentage of contracts that a PBM holds where the PBM: (A) retains all rebates; (B) passes all rebates through to the carrier client or health plan sponsor; and (C) shares rebates with the carrier client or health plan sponsor; and • Information related to the PBM practices of spread pricing, administrative fees, claw-backs, and formulary placement. A licensed PBM shall submit data and reporting information to CHAI.	M.G.L. c. 176Y § 2 M.G.L. c. 176Y § 3

	The commissioner may examine the affairs of a PBM when the commissioner deems it prudent, but not less frequently than once every 3 years. The focus of the examination shall be to ensure that a PBM can meet its responsibilities under contracts with carriers. The examination shall be conducted according to the procedures set forth in paragraph (6) of section 4 of chapter 175. If the examination report reveals that the PBM is operating in violation of this section or any regulation or prior order of the commissioner, the commissioner may order the PBM to take any action the commissioner considers necessary and appropriate to cure such violation. Any carrier, including a PBM, that provides administrative services to 1 or more self-insured groups shall submit to the division a report including the following information by April 1: • The number of the carrier's self-insured customers; • The aggregate number of members, as defined in section 1 of chapter 176J, in all of the carrier's self-insured customers; • The aggregate number of lives covered in all of the carrier's self-insured customers; • The percentage of the carrier's self-insured customers that include each of the benefits mandated for health benefit plans under chapters 175, 176A, 176B and 176G; and • Any other information deemed necessary by the commissioner.	
PBM Income	N/A	
Pharmacy Contracting	N/A	
Patient Cost Sharing	**Copay Cap:** Any policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth and which is considered creditable coverage under section 1 of chapter 111M shall identify 1 generic drug and 1 brand name drug used to treat each of the following chronic conditions: (i) diabetes; (ii) asthma; and (iii) the 2 most prevalent heart conditions among its enrollees. The carrier shall identify insulin as the drug used to treat diabetes. In determining the 1 generic drug and 1 brand name drug used to treat each chronic condition, the carrier shall consider whether the drug is: • of clear benefit and strongly supported by clinical evidence; • likely to: (A) reduce hospitalizations or emergency department visits; (B) reduce future exacerbations of illness progression; or (C) improve quality of life; • cost effective for the carrier and its enrollees;	M.G.L. c. 175 § 47CCC M.G.L. c. 118E § 10Z M.G.L. c. 94C § 21C

	• at low risk for overutilization, abuse, addiction, diversion or fraud; and • one of the most widely utilized as a treatment for the chronic condition. Applicable carriers shall provide coverage for the brand-name drugs and generic drugs identified via the process described above. Coverage for the identified generic drugs shall not be subject to cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible; provided, however, that cost-sharing shall be required if the applicable plan is governed by the Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing under this section. Coverage for identified brand-name drugs shall not be subject to any deductible or co-insurance, and any co-payment shall not exceed $25 per 30-day supply. Coverage for 1 brand-name insulin drug per dosage and type, including rapid-acting, short-acting, intermediate-acting, long-acting, ultra long-acting, and premixed under this section shall not be subject to any deductible or co-insurance, and any co-payment shall not exceed $25 per 30-day supply. The carrier may make changes in its selection of drugs pursuant to this section not more than annually. The carrier shall make public the identified drugs for each applicable chronic condition. Similar requirements apply to MassHealth (Medicaid), plans sold on the individual marketplace, and state employee benefit plans. **Maximum Cost-Sharing Levels:** At the point of sale, a pharmacy shall charge an individual for a prescription drug the lesser of: (i) the applicable cost-sharing amount; or (ii) the pharmacy retail price. A health benefit plan or carrier shall not require an insured to make a cost-sharing payment for a prescription drug in an amount greater than that charged by a pharmacy complying with this section.	

Michigan

Issue	Summary	Citation
Licensing/Registration	A PBM that provides services to residents of this state shall apply for, obtain, and maintain a license to operate as a PBM from the director. A license under this act is renewable biennially and is nontransferable.	MCL § 550.821
Reporting Requirements	By April 1, 2025, and each April 1 after that date, a PBM shall file a transparency report with the director that contains the following information: • The aggregate WACs from a manufacturer or wholesale distributor for each therapeutic category of drugs for the PBM's Michigan plan sponsors, net of	MCL § 550.833

	rebates and other fees and payments, direct or indirect, from all sources.
	• The aggregate amount of rebates that the PBM received from all manufacturers for the PBM's Michigan plan sponsors. The aggregate amount of rebates must include any utilization discounts the PBM receives from a manufacturer or wholesale distributor.
	• The aggregate amount of all fees that the PBM received.
	• The aggregate amount of rebates that the PBM received from all manufacturers that were not passed through to Michigan health plans or insurers.
	• The aggregate amount of fees that the PBM received from all manufacturers that were not passed through to Michigan health plans, carriers, or insurers.
	• The aggregate retained rebate percentage from business conducted in this state.
	• All of the following information attributable to patient use of prescription drugs covered by Michigan health plans:
	  ○ The aggregate amount of rebates and fees that the PBM received from manufacturers.
	  ○ The aggregate amount of rebates and fees that the PBM received from manufacturers that were either of the following:
	  ▪ Passed through to Michigan health plans or enrollees at the point of sale of a prescription drug.
	  ▪ Retained by the PBM.
	
	These reporting requirements do not apply to a contract between a PBM and the Medicaid program.	

PBM Income	**Spread Pricing:** A PBM shall not conduct spread pricing in this state. However, if a contract between a plan sponsor and a health plan is in effect on the effective date of this act and the contract conflicts with this subsection, for that contract, this subsection applies to the PBM beginning on the date the contract is amended, extended, or renewed, or before January 1, 2028, whichever is earlier.	MCL § 550.827
Pharmacy Contracting	**MAC Pricing:** For each drug that a PBM establishes a MAC, the PBM shall do all of the following: • Provide each pharmacy subject to a MAC list with access to the MAC list and the source used to determine the MAC for each drug. • Update its MAC list at least once every 7 calendar days. • Provide a process for each pharmacy subject to the MAC list to receive prompt notification of an update to the MAC list. • Establish and maintain a reasonable administrative appeals process to allow a pharmacy subject to the MAC list or an agent of a pharmacy subject to the	MCL § 550.837

	MAC list to challenge the adjudication of a pharmacy's claim. • Investigate and resolve an appeal under this subsection within 14 calendar days after the PBM receives the appeal. An appeal under this subsection must be submitted to the PBM not later than 45 calendar days after the date the pharmacy's claim for reimbursement has been adjudicated. • Respond in writing to any appealing pharmacy or an appealing pharmacy's agent not later than 30 calendar days after receipt of an appeal if the pharmacy filed the appeal more than 10 calendar days after the date the pharmacy's claim for reimbursement is adjudicated. • If an appeal is denied, provide the appealing pharmacy or the appealing pharmacy's agent the NDC number available for purchase in this state at or below the appealed MAC. • If an appeal is granted, permit the pharmacy to reverse and rebill the claim and all claims for the drug. Before a PBM places or continues a drug on a MAC list, all of the following conditions must be met: • The drug is available for purchase by pharmacies in this state from wholesale distributors operating in this state. • The drug is not obsolete. • The drug is a multiple source drug.	
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A carrier, health plan, or PBM shall not require a covered person or enrollee to make a payment for a prescription drug at the point of sale in an amount greater than the lesser of the following: • The applicable copayment, coinsurance, and deductible. • The final reimbursement amount to the network pharmacy.	MCL § 550.831

Minnesota

Issue	Summary	Citation
Licensing/Registration	No person shall perform, act, or do business in this state as a PBM unless the person has a valid license issued under this chapter by the Commissioner of Commerce. A PBM seeking a license shall apply using a form prescribed by the commissioner and pay a nonrefundable fee of $8,500. A license issued under this chapter is valid for one year. To renew a license, an applicant must submit a completed renewal application on a form prescribed by the commissioner, the network adequacy report required under section 62W.05, and a renewal fee of $8,500.	MRS § 62W.03

Reporting Requirements	Beginning in the second quarter after the effective date of a contract between a PBM and a plan sponsor, the PBM must disclose, upon the request of the plan sponsor, the following information:
	• The aggregate WACs from a drug manufacturer or wholesale drug distributor for each therapeutic category of prescription drugs;
	• The aggregate WACs from a drug manufacturer or wholesale drug distributor for each therapeutic category of prescription drugs available to the plan sponsor's enrollees;
	• The aggregate amount of rebates received by the PBM by therapeutic category of prescription drugs. The aggregate amount of rebates must include any utilization discounts the PBM receives from a drug manufacturer or wholesale drug distributor;
	• Any other fees received from a drug manufacturer or wholesale drug distributor;
	• Whether the PBM has a contract, agreement, or other arrangement with a drug manufacturer to exclusively dispense or provide a drug to a plan sponsor's enrollees, and the application of all consideration or economic benefits collected or received pursuant to the arrangement;
	• Prescription drug utilization information for the plan sponsor's enrollees;
	• De-identified claims level information in electronic format that allows the plan sponsor to sort and analyze the following information for each claim:
	  ○ Whether the claim required prior authorization;
	  ○ The amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive charges;
	  ○ Any spread between the net amount paid to the pharmacy and the amount charged to the plan sponsor;
	  ○ Whether the pharmacy is, or is not, under common control or ownership with the PBM;
	  ○ Whether the pharmacy is, or is not, a preferred pharmacy under the plan;
	  ○ Whether the pharmacy is, or is not, a mail order pharmacy; and
	  ○ Whether enrollees are required by the plan to use the pharmacy;
	• The aggregate amount of payments made by the PBM to pharmacies owned or controlled by the PBM on behalf of the sponsor's plan;
	• The aggregate amount of payments made by the PBM to pharmacies not owned or controlled by the PBM on behalf of the sponsor's plan; and
	• The aggregate amount of the fees imposed on, or collected from, network pharmacies or other
		MRS § 62W.06
		
		MRS § 62W.07

	assessments against network pharmacies, including point-of-sale fees and retroactive charges, and the application of those amounts collected pursuant to the contract with the plan sponsor. Each year, the PBM must submit to the commissioner a transparency report containing data from the prior calendar year as it pertains to plan sponsors doing business in Minnesota. The report must contain the following information: • The aggregate WACs from a drug manufacturer or wholesale drug distributor for each therapeutic category of prescription drugs for all of the PBM's plan sponsor clients, and these costs net of all rebates and other fees and payments, direct or indirect, from all sources; • The aggregate amount of all rebates that the PBM received from all drug manufacturers for all of the PBM's plan sponsor clients. The aggregate amount of rebates must include any utilization discounts the PBM receives from a drug manufacturer or wholesale drug distributor; • The aggregate of all fees from all sources, direct or indirect, that the PBM received for all of the PBM's plan sponsor clients; • The aggregate retained rebates and other fees that the PBM received from all sources, direct or indirect, that were not passed through to plan sponsors; • The aggregate retained rebate and fees percentage; • The highest, lowest, and mean aggregate retained rebate and fees percentage for all of the PBM's plan sponsor clients; and • De-identified claims-level information in electronic format that allows the commissioner to sort and analyze the following information for each claim: o The drug and quantity for each prescription; o Whether the claim required prior authorization; o Patient cost-sharing paid on each prescription; o The amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive charges; o Any spread between the net amount paid to the pharmacy and the amount charged to the plan sponsor; o Identity of the pharmacy for each prescription; o Whether the pharmacy is, or is not, under common control or ownership with the PBM; o Whether the pharmacy is, or is not, a preferred pharmacy under the plan; o Whether the pharmacy is, or is not, a mail order pharmacy; and	

	○ Whether enrollees are required by the plan to use the pharmacy. A PBM that has an ownership interest either directly or indirectly, or through an affiliate or subsidiary, in a pharmacy must disclose to a plan sponsor that contracts with the PBM any difference between the amount paid to that pharmacy and the amount charged to the plan sponsor.	
PBM Income	N/A	
Pharmacy Contracting	**Patient Steering:** A PBM or health carrier is prohibited from penalizing, requiring, or providing financial incentives, including variations in premiums, deductibles, co-payments, or coinsurance, to an enrollee as an incentive to use a retail pharmacy, mail order pharmacy, specialty pharmacy, or other network pharmacy provider in which a PBM has an ownership interest or in which the pharmacy provider has an ownership interest in the PBM. This requirement does not apply if the PBM or health carrier offers an enrollee the same financial incentives for using a network retail pharmacy, mail order pharmacy, specialty pharmacy, or other network pharmacy in which the PBM has no ownership interest and the network pharmacy has agreed to accept the same pricing terms, conditions, and requirements related to the cost of the prescription drug and the cost of dispensing the prescription drug that are in the agreement with a network pharmacy in which the PBM has an ownership interest. In addition, a PBM or health carrier is prohibited from imposing limits, including quantity limits or refill frequency limits, on an enrollee's access to medication that differ based solely on whether the health carrier or PBM has an ownership interest in a pharmacy or the pharmacy has an ownership interest in the PBM. **MAC Pricing:** With respect to each contract and contract renewal between a PBM and a pharmacy, the PBM must: • Provide to the pharmacy, at the beginning of each contract and contract renewal, the sources utilized to determine the MAC pricing of the PBM; • Update any MAC price list at least every 7 business days, noting any price changes from the previous list, and provide a means by which network pharmacies may promptly review current prices in an electronic, print, or telephonic format within 1 business day at no cost to the pharmacy; • Maintain a procedure to eliminate products from the list of drugs subject to MAC pricing in a timely manner in order to remain consistent with changes in the marketplace; • Ensure that the MAC prices are not set below sources utilized by the PBM; and	MRS § 62W.07 MRS § 62W.08

	• Upon request of a network pharmacy, disclose the sources utilized for setting MAC price rates on each MAC price list included under the contract and identify each MAC price list that applies to the network pharmacy. A PBM must make the list of the MACs available to a contracted pharmacy in a format that is readily accessible and usable to the network pharmacy. A PBM must not place a prescription drug on a MAC list unless the drug is available for purchase by pharmacies in this state from a national or regional drug wholesaler and is not obsolete. Each contract between a PBM and a pharmacy must include a process to appeal, investigate, and resolve disputes regarding MAC pricing that includes: • A 15-business-day limit on the right to appeal following the initial claim; • A requirement that the appeal be investigated and resolved within seven business days after the appeal is received; and • A requirement that a PBM provide a reason for any appeal denial and identify the NDC of a drug that may be purchased by the pharmacy at a price at or below the MAC price as determined by the PBM. If an appeal is upheld, the PBM must make an adjustment to the MAC price no later than 1 business day after the date of determination. The PBM must make the price adjustment applicable to all similarly situated network pharmacy providers as defined by the plan sponsor.	
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** No PBM or health carrier shall require an enrollee to make a payment at the point of sale for a covered prescription drug in an amount greater than the lesser of: • The applicable co-payment for the prescription drug; • The allowable claim amount for the prescription drug; or • The amount an enrollee would pay for the prescription drug if the enrollee purchased the prescription drug without using a health plan or any other source of prescription drug benefits or discounts. **Copay Cap:** A health plan must limit the amount of any enrollee cost-sharing for prescription drugs prescribed to treat a chronic disease to no more than: (1) $25 per one-month supply for each prescription drug, regardless of the amount or type of medication required to fill the prescription; and (2) $50 per month in total for all related medical supplies. The cost-sharing limit for related medical supplies does not increase with the number of chronic diseases for which an enrollee is treated. Coverage under this section shall not be subject to any deductible.	MRS § 62W.12 MRS § 62Q.481

	The chronic diseases covered under this provision include diabetes, asthma, and allergies requiring an epinephrine auto-injector.	

Mississippi

Issue	Summary	Citation
Licensing/Registration	Before beginning to do business as a PBM, a PBM shall obtain a license to do business from the Board of Pharmacy. To obtain a license, the applicant shall apply to the board on a form to be prescribed by the board. Each PBM providing pharmacy management benefit plans in this state shall file a statement with the board annually by March 1 or within 60 days of the end of its fiscal year if not a calendar year, which shall contain: • A financial statement of the organization, including its balance sheet and income statement for the preceding year; and • Any other information relating to the operations of the PBM required by the board. If the PBM is audited annually by an independent certified public accountant, a copy of the certified audit report shall be filed annually with the board by June 30 or within 30 days of the report being final.	Miss. Code Ann. § 73-21-157
Reporting Requirements	N/A	
PBM Income	N/A	
Pharmacy Contracting	**MAC Pricing:** MAC Drugs. Before a PBM places or continues a particular drug on a MAC list, the drug: • If the drug is a generic equivalent drug product as defined in 73-21-73, shall be listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the United States Food and Drug Administration's most recent version of the "Orange Book" or "Green Book" or have an NR or NA rating by Medi-Span, Gold Standard, or a similar rating by a nationally recognized reference approved by the board; • Shall be available for purchase by each pharmacy in the state from national or regional wholesalers operating in Mississippi; and • Shall not be obsolete. MAC List Information. A PBM shall: • Provide access to its MAC list to each pharmacy subject to the MAC list; • Update its MAC list on a timely basis, but in no event longer than 3 calendar days; and	Miss. Code Ann. § 73-21-156

	• Provide a process for each pharmacy subject to the MAC list to receive prompt notification of an update to the MAC list.
	
	MAC Appeals. A PBM shall:
	• Provide a reasonable administrative appeal procedure to allow pharmacies to challenge a MAC list and reimbursements made under a MAC list for a specific drug or drugs as:
	  ○ Not meeting the requirements to be on a MAC list; or
	  ○ Being below the pharmacy acquisition cost.
	• The PBM shall allow a period of 30 business days to file an administrative appeal.
	• The PBM shall respond to an administrative challenge within 30 business days of receipt of the challenge and:
	  ○ If the appeal is upheld:
	  ▪ Make the change in the MAC list payment to at least the pharmacy acquisition cost;
	  ▪ Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question;
	  ▪ Provide the NDC that the increase or change is based on to the pharmacy or pharmacist; and
	  ▪ Make the price change effective for each similarly situated pharmacy as defined by the payor subject to the MAC list; or
	  ○ If the appeal is denied, provide the challenging pharmacy or pharmacist the NDC and the name of the national or regional pharmaceutical wholesalers operating in Mississippi that have the drug currently in stock at a price below the MAC as listed on the MAC list; or
	  ○ If the NDC provided by the PBM is not available below the pharmacy acquisition cost from the pharmaceutical wholesaler from whom the pharmacy or pharmacist purchases the majority of prescription drugs for resale, then the PBM shall adjust the MAC as listed on the MAC list above the challenging pharmacy's pharmacy acquisition cost and permit the pharmacy to reverse and rebill each claim affected by the inability to procure the drug at a cost that is equal to or less than the previously challenged MAC.	

Patient Cost Sharing	N/A	

Missouri

Issue	Summary	Citation

Licensing/Registration	No entity subject to the jurisdiction of this state shall act as a PBM without a license issued by the Department of Commerce & Insurance. The department shall establish by rule the application process and license fee for PBMs. Currently, the application fee is set at $1,000.	Mo. Rev. Stat. § 376.393
Reporting Requirements	N/A	
PBM Income	N/A	
Pharmacy Contracting	**MAC Pricing:** Upon each contract execution or renewal between a PBM and a pharmacy or between a PBM and a pharmacy's contracting representative or agent, such as a PSAO, a PBM shall, with respect to such contract or renewal: • Include in such contract or renewal the sources utilized to determine MAC and update such pricing information at least every 7 days; and • Maintain a procedure to eliminate products from the MAC list of drugs subject to such pricing or modify MAC pricing at least every 7 days. • A PBM shall not place a drug on a MAC list unless there are at least two therapeutically equivalent multisource generic drugs, or at least one generic drug available from at least one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers. • All contracts between a PBM and a contracted pharmacy or between a PBM and a pharmacy's contracting representative or agent, such as a PSAO, shall include a process to internally appeal, investigate, and resolve disputes regarding MAC pricing. The process shall include the following: ○ The right to appeal shall be limited to 14 calendar days following the reimbursement of the initial claim; and ○ A requirement that the PBM shall respond to an appeal described in this subsection no later than 14 calendar days after the date the appeal was received by such PBM. • For appeals that are denied, the PBM shall provide the reason for the denial and identify the NDC of a drug product that may be purchased by contracted pharmacies at a price at or below the MAC and, when applicable, may be substituted lawfully. • If the appeal is successful, the PBM shall: ○ Adjust the MAC price that is the subject of the appeal effective on the day after the date the appeal is decided; ○ Apply the adjusted MAC price to all similarly situated pharmacies as determined by the PBM; and ○ Allow the pharmacy that succeeded in the appeal to reverse and rebill the pharmacy benefits claim giving rise to the appeal.	Mo. Rev. Stat. § 376.388
Patient Cost Sharing	**Maximum Cost-Sharing Levels:**	Mo. Rev. Stat. § 376.387

	No PBM shall include a provision in a contract with a pharmacy or pharmacist that requires a covered person to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of: • The copayment amount as required under the health benefit plan; or • The amount an individual would pay for a prescription if that individual paid with cash.	

Montana

Issue	Summary	Citation
Licensing/Registration	A person may not perform an act or do business in this state as a PBM without a valid license issued under this part by the Insurance Commissioner. A PBM shall apply to the commissioner on a form prescribed by the commissioner and pay a nonrefundable fee of $1,000 for an initial application and $500 for a renewal. By statute, an applicant must provide: • A copy of the most recent fiscal year-end audited financial statement; • A list of all health carrier, plan sponsor, and workers' compensation insurance carrier clients in Montana; • A description of the projected number of enrollees and injured workers to be administered by the PBM in this state on an annual basis for each health carrier client, plan sponsor client, and workers' compensation insurance carrier client; • A copy of the policies and procedures that demonstrate the PBM has established processes to comply with the requirements related to MAC lists. • A description of the PBM's network service areas and pharmacy accessibility in this state; • Disclosure of any ownership interest, either directly or indirectly or through an affiliate, holding company, or subsidiary in a pharmacy or mail-order pharmacy that is part of the PBM's network; and • Disclosure of any ownership interest, either directly or indirectly or through an affiliate, holding company, or subsidiary by a health carrier or workers' compensation insurance carrier in the PBM or by the PBM in a health carrier or workers' compensation insurance carrier.	Mont. Code Ann. § 33-2-2403
Reporting Requirements	Beginning in the second quarter after the effective date of a contract between a PBM and a health carrier, plan sponsor, or workers' compensation insurance carrier, the PBM shall disclose, within 45 days of a request, the following information regarding prescription drug benefits specific to the health carrier, plan sponsor, or workers' compensation insurance carrier: • The aggregate WACs from a manufacturer or wholesale distributor for each therapeutic category of prescription drugs;	Mont. Code Ann. § 33-2-2406 Mont. Code Ann. § 33-2-2407

	• The aggregate WACs from a manufacturer or wholesale distributor for each therapeutic category of prescription drugs available to enrollees of the health carrier or plan sponsor or injured workers of the workers' compensation insurance carrier;
	• The aggregate amount of rebates received by the PBM by therapeutic category of prescription drugs;
	• Any other fees received from a manufacturer or wholesale distributor and the reason for the fees;
	• Whether the PBM has a contract, agreement, or other arrangement with a manufacturer to exclusively dispense or provide a drug to enrollees of the health carrier or plan sponsor or injured workers of the workers' compensation carrier, and the application of all consideration or economic benefits collected or received pursuant to the arrangement;
	• Prescription drug utilization information for enrollees of the health carrier or plan sponsor or injured workers of the workers' compensation carrier, including but not limited to:
	  ○ The top 10 prescription drugs by average total spending for each enrollee or injured worker;
	  ○ The top 10 prescription drugs by average out-of-pocket spending for each enrollee or injured worker;
	  ○ The top 10 therapeutic classes of prescription drugs by total spending and volume;
	  ○ The total number of pharmacy transactions; and
	  ○ The total number of rejected pharmacy transactions, including a breakdown of the number rejected for the following reasons:
	  ▪ Nonformulary status;
	  ▪ Prior authorization requirements; and
	  ▪ Step therapy requirements;
	• De-identified claims-level information in electronic format that allows the health carrier, plan sponsor, or workers' compensation insurance carrier to sort and analyze the following information for each claim:
	  ○ Whether the claim required prior authorization;
	  ○ The amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive charges;
	  ○ Any spread between the net amount paid to the pharmacy and the amount charged to the health carrier, plan sponsor, or workers' compensation insurance carrier;
	  ○ Whether the pharmacy is or is not:
	  ▪ Under common control or ownership with the PBM;	

	▪ A preferred pharmacy for the health benefit plan or workers' compensation insurance carrier; or ▪ a mail-order pharmacy; and ○ Whether enrollees or injured workers are required by the health benefit plan or workers' compensation insurance carrier to use the pharmacy; • The aggregate amount of payments made by the PBM on behalf of the health carrier, plan sponsor, or workers' compensation insurance carrier to: ○ Pharmacies owned or controlled by the PBM; and ○ Pharmacies not owned or controlled by the PBM; and • The aggregate amount of the fees imposed on or collected from network pharmacies or other assessments against network pharmacies, including point-of-sale fees and retroactive charges, and the amount of fees passed on to the health carrier, plan sponsor, or workers' compensation insurance carrier pursuant to the contract with the health carrier, plan sponsor, or workers' compensation insurance carrier. By July 1 each year, each PBM shall report to the commissioner on a form prescribed by the commissioner the following information regarding prescription drug benefits provided to enrollees of each health carrier, plan sponsor, and injured workers of workers' compensation insurance carriers in the state with which the PBM has contracted during the previous calendar year: • The aggregate prescription drug spending for all of the PBM's health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state; • The aggregate prescription drug spending net of all rebates and other fees and payments, direct or indirect, from all sources; • The aggregate dollar amount of all rebates that the PBM received from all manufacturers; • The aggregate dollar amount of all fees from all sources, direct or indirect, that the PBM received and the reason for the fees; • The aggregate dollar amount of all retained rebates and fees that were not passed through to clients; • The aggregate retained rebate and fees percentage; • The highest, lowest, and mean aggregate retained rebate and fees percentage for all of the PBM's health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state; • De-identified claims-level information in electronic format that allows the commissioner to sort and analyze the following information for each claim: ○ The drug and quantity for each prescription; ○ Whether the claim required prior authorization;	

	○ Patient cost-sharing paid on each prescription; ○ The amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy by the PBM, including point-of-sale and retroactive charges; ○ Any spread between the net amount paid to the pharmacy and the amount charged to the health carrier, plan sponsor, or workers' compensation insurance carrier client; ○ The pharmacy used for each prescription; ○ Whether the pharmacy is or is not: ▪ Under common control or ownership with the PBM; ▪ A preferred pharmacy under the health benefit plan; or ▪ A mail-order pharmacy; and ○ Whether enrollees or injured workers are required by the health benefit plan or workers' compensation insurance carrier to use the pharmacy; and • The aggregate amount of rebates passed on by the PBM to the enrollees of each health carrier and plan sponsor client in this state at the point of sale that reduced the enrollee's applicable deductible, copayment, coinsurance, or other cost-sharing amount.	
PBM Income	N/A	
Pharmacy Contracting	**MAC Pricing:** Before a PBM places or continues a drug on a MAC list, the drug: • Must be listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations or have an "NR" or "NA" rating by a nationally recognized reference; • Must be available for purchase by pharmacies in this state from national or regional wholesalers; and • May not be obsolete, temporarily unavailable, or listed on a drug shortage list. *Note: the phrase "temporarily unavailable, or listed on a drug shortage list" expires on June 30, 2029.* At the time of entering into a contract with a pharmacy or a PSAO and subsequently upon request, a plan sponsor, health insurance issuer, or PBM shall provide the pharmacy or PSAO with the sources used to determine the pricing for the MAC list or the reference used for reference pricing. • If using a MAC list, the plan sponsor, health insurance issuer, or PBM shall: ○ Review and update the price information for each drug on the MAC list at least once every	Mont. Code Ann. § 33-22-171 Mont. Code Ann. § 33-22-172 Mont. Code Ann. § 33-22-173 Mont. Code Ann. § 33-22-177

	10 calendar days to reflect any modification of pricing, ensuring that MAC increases are processed and updated on the same schedule as decreases; ○ Establish a process for eliminating products from the MAC list or modifying the prices in the MAC list in a timely manner to remain consistent with pricing changes and product availability in the marketplace; and ○ Provide a process for each pharmacy to readily access the MAC list specific to the pharmacy in a searchable and usable format. • If using reference pricing, a plan sponsor, health insurance issuer, or PBM shall: ○ Review and update not less than every 10 business days the price information for each drug, product, supply, or service for which reference pricing is used, updating reference pricing on the same date of the change in the referenced source; and ○ Provide a process for each pharmacy to readily access the reference pricing specific to the plan sponsor or the health insurance issuer's plan. • In contracting with a pharmacy or a PSAO, a plan sponsor or PBM shall: ○ Provide a procedure by which a pharmacy or a PSAO may appeal the price of a drug or drugs on the MAC list; ○ Provide a telephone number at which a network pharmacy may contact the PBM to discuss the status of the pharmacy's appeal; and ○ Respond to an appeal no later than 10 calendar days after the date the appeal is made. • If the final determination is a denial of the pharmacy's or the PSAO's appeal, the PBM shall state the reason for the denial and provide the NDC of an equivalent drug that is available for purchase by pharmacies in this state from national or regional wholesalers at a price that is equal to or less than the MAC for that drug. • If a pharmacy's or a PSAO's appeal is determined to be valid by the PBM, the PBM shall: ○ Make an adjustment in the drug price effective on the date the appeal is resolved; ○ Make the adjustment applicable to all similarly situated network pharmacy providers as determined by the plan sponsor or the PBM, as appropriate; and ○ Permit the appealing pharmacy to reverse and rebill the claim in question, using the dates of the original claim or claims.	

	• A PBM shall make price adjustments to all similarly situated pharmacies within 3 days.
	• A pharmacy or a PSAO shall file its appeal within 10 calendar days from the time of denial by the PBM.
	
	Minimum Reimbursement:
	A plan sponsor, PBM, or third-party payer shall ensure that reimbursement to independent pharmacies for each drug dispensed is not less than the NADAC plus a professional dispensing fee. The NADAC price must be the price published in effect for the day the drug claim was billed by the pharmacy.
	• If a particular drug does not have a published national average drug acquisition price, the reimbursement to independent pharmacies must be:
	  ○ For generic drugs, 100% of published WACs plus a professional dispensing fee; and
	  ○ For brand-name drugs, 100% of WACs plus a professional dispensing fee.
	• The minimum professional dispensing fee for independent pharmacies is $15, subject to an annual increase. On January 1 of each year, a plan sponsor, PBM, or third-party payer shall increase the amount of the minimum professional dispensing fee for independent pharmacies for inflation. Inflation is measured by the annual percentage increase, if any, in the Consumer Price Index, U.S. city average, all urban consumers, for all items.
	
	Note: The NADAC reimbursement requirement in s. 22-172 expires on June 30, 2029.
	
	Patient Steering:
	A PBM may not:
	• Reimburse a network pharmacy an amount less than the contract price between the PBM and the insurer, third-party payer, or the pharmacy services management organization the PBM has contracted with; or
	• Require or coerce a patient to use a pharmacy that is owned by or affiliated with the PBM.
	
	Note: the patient steering provisions in s. 22-177 expire on June 30, 2029.	

Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A plan sponsor, health insurance issuer, or PBM may not require a pharmacist to charge or collect a copayment from a covered person that exceeds the total charges submitted by the network pharmacy. A PBM or third-party payer may not charge a patient a copayment that exceeds the cost of the prescription drug. If a patient pays a copayment, the dispensing provider or pharmacy may retain the adjudicated reimbursement and	Mont. Code Ann. § 33-22-172 Mont. Code Ann. § 33-22-176 Mont. Code Ann. § 33-22-312

	the PBM or third-party payer may not alter the adjudicated reimbursement. **Copay Cap:** Each individual policy of disability insurance or certificate issued that contains coverage for prescription drugs must limit the insured's required copayment or other cost-sharing requirement to $35 for up to a 30-day supply of insulin, regardless of the amount or type of insulin prescribed. • The limitation in this section applies to insulin covered by the insurer's formulary. • Coverage of insulin prescribed for an insured is not subject to a deductible. Cost-sharing amounts paid by the insured for insulin must be counted toward the insured's deductible. • This section does not apply to disability income, hospital indemnity, Medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies.	

Nebraska

Issue	Summary	Citation
Licensing/Registration	A person shall not establish or operate as a PBM in this state for a health benefit plan without first obtaining a license from the Director of Insurance. A person applying for a PBM license shall apply for licensure in the form and manner prescribed by the director, and shall pay a nonrefundable fee of $500. PBM licenses must be renewed annually, with a $250 renewal fee.	NRS § 44-4605
Reporting Requirements	N/A	
PBM Income	**Spread Pricing:** A contract between a PBM and a health benefit plan that is issued on or after January 1, 2026, shall not contain spread pricing unless such contract is an extension of a contract entered into prior to January 1, 2026, which included spread pricing. Beginning January 1, 2029, no contract between a PBM and a health benefit plan shall include spread pricing.	NRS § 44-4617
Pharmacy Contracting	**MAC Pricing:** With respect to each contract and contract renewal between a PBM and a pharmacy, the PBM shall: • Update any MAC price list at least every 7 business days, noting any price change from the previous list, and provide a means by which a network pharmacy may promptly review a current price in an electronic, print, or telephonic format within 1 business day of any such change at no cost to the pharmacy;	NRS § 44-4608 NRS § 44-4614

	• Maintain a procedure to eliminate a product from the MAC price list in a timely manner to remain consistent with any change in the marketplace; and • Make the MAC price list available to each contracted pharmacy in a format that is readily accessible and usable to the contracted pharmacy. A PBM shall not place a prescription drug on a MAC price list unless the drug is available for purchase by pharmacies in this state from a national or regional drug wholesaler and is not obsolete. Each contract between a PBM and a pharmacy shall include a process to appeal, investigate, and resolve disputes regarding any MAC price. The process shall include: • A 15-business-day limit on the right to appeal following submission of an initial claim by a pharmacy; • A requirement that any appeal be investigated and resolved within 7 business days after the appeal is received by the PBM; and • A requirement that the PBM provide a reason for any denial of an appeal and identify the NDC for the drug that may be purchased by the pharmacy at a price at or below the price on the MAC price list as determined by the PBM. • If an appeal is determined to be valid by the PBM, the PBM shall: o Make an adjustment in the drug price no later than 1 day after the appeal is resolved; and o Permit the appealing pharmacy to reverse and rebill the claim in question, using the date of the original claim. **Patient Steering:** A health benefit plan, health carrier, or PBM shall not: • Require a covered person to obtain pharmacist services exclusively through the mail-order pharmacy or PBM affiliate; • Prohibit or limit a covered person from selecting a network pharmacist or network pharmacy of the covered person's choice; • Transfer a covered person's prescriptions from a network pharmacy to another pharmacy unless requested by the covered person; • Use financial incentives, including, but not limited to, adjustments in cost-sharing obligations of a covered person, to the exclusive benefit of the PBM affiliate pharmacy; or • Auto-enroll a covered person in mail-order pharmacist services, except in the case of a maintenance medication after the first 90 days where the covered person may opt-out.	
Patient Cost Sharing	**Maximum Cost-Sharing Levels:**	NRS § 44-4606

	A PBM shall not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of the covered person's cost-sharing amount under the terms of the health benefit plan or the amount the covered person would pay for the drug if the covered person were paying the cash price. Any amount paid shall be attributable to any deductible or out-of-pocket maximum under the covered person's health benefit plan. **Copay Cap:** Starting January 1, 2024, plans shall limit the total amount that a covered individual is required to pay for each covered prescription insulin drug on the policy's, contract's, or plan's lowest brand or generic tier to a maximum of thirty-five dollars per thirty-day supply of insulin, regardless of the amount needed. If, due to a national shortage of an insulin drug, a covered individual cannot access a covered prescription insulin drug on the lowest brand or generic tier of the policy, contract, or plan, the policy, contract, or plan shall ensure access to an insulin drug at a maximum of thirty-five dollars per thirty-day supply, until such time that the national shortage ends to prevent disruptions in patient access to insulin. This requirement applies to self-funded health plans governed by ERISA unless preempted by federal law.	NRS § 44-790.01

Nevada

Issue	Summary	Citation
Licensing/Registration	In Nevada, PBMs are required to register as TPAs. Requirements to obtain a certificate of registration as an administrator can be found under s. 683A.08522.	NRS § 679B.133

Reporting Requirements	On or before February 1 of each year, the Department of Business and Industry shall compile:
	• A list of prescription drugs that the Department determines to be essential for treating diabetes in this State and the WAC of each such drug on the list. The list must include, without limitation, all forms of insulin and biguanides marketed for sale in this State.
	• A list of the drugs described above that have been subject to an increase in the WAC of a percentage equal to or greater than:
	  ○ The percentage increase in the Consumer Price Index, Medical Care Component during the immediately preceding calendar year; or
	  ○ Twice the percentage increase in the Consumer Price Index, Medical Care Component during the immediately preceding 2 calendar years.
	• A list of prescription drugs with a WAC exceeding $40 for a course of therapy that have been subject to an
		NRS § 679B.630
		
		NRS § 679B.645

	increase in the WAC of a percentage equal to or greater than: ○ Ten percent during the immediately preceding calendar year; or ○ Twenty percent during the immediately preceding 2 calendar years. On or before April 1 of each year, a PBM shall submit a report to the Department of Business and Industry containing: • The current WAC of each drug included on either or both of the most current lists compiled by the Department pursuant to paragraphs (a) and (c) of subsection 1 of NRS 439B.630 and the minimum and maximum WAC of each such drug during the immediately preceding year; • The total number of units of each drug included on either or both of the most current lists compiled by the Department for which the PBM negotiated directly with the manufacturer for purchases of the drug for use in in this State during the immediately preceding calendar year; • The number of units of each drug included on either or both of the most current lists compiled by the Department for which the PBM negotiated directly with the manufacturer during the immediately preceding calendar year for purchases of the drug for use in this State by: ○ Recipients of Medicare; ○ Recipients of Medicaid; ○ Persons covered by other governmental third parties; ○ Persons covered by commercial insurers; and ○ Persons covered by other third parties not described above. • The aggregate amount of the rebates that the PBM negotiated with manufacturers during the immediately preceding calendar year for purchases of prescription drugs included on the most current lists compiled by the Department, in total for each of those lists and for each drug included on such a list; • The aggregate amount of the rebates that were retained by the PBM, in total for each of the most current lists compiled by the Department and for each drug included on such a list; • The aggregate amount of the rebates that were negotiated for purchases of prescription drugs for use by persons in each category in total for each of the most current lists compiled by the Department and for each drug included on such a list; • The amount of discounts, dispensing fees or other fees that the PBM negotiated with pharmacies, prescription drug networks or PSAOs during the immediately preceding calendar year for purchases of prescription drugs included on the most current lists	

	compiled by the Department in total for each list and for each drug included on such a list; • The amount of discounts, dispensing fees or other fees which were negotiated for purchases of prescription drugs for use by persons in each category in total for each of the most current lists compiled by the Department and for each drug included on such a list; and • Any other information prescribed by regulation of the Department.	
PBM Income	**Spread Pricing (Medicaid):** The Nevada Department of Health and Human Services is required to contract with a single PBM to administer pharmacy benefit management services for the state's Medicaid and CHIP programs. Starting January 1, 2030, the department's contract with the state PBM may not permit spread pricing.	NRS 38 § 422.406
Pharmacy Contracting	**Minimum Reimbursement (Medicaid):** The Nevada Department of Health and Human Services is directed to establish a pricing benchmark, the Nevada Average Acquisition Cost, to measure the average acquisition cost of prescription drugs purchased by pharmacies and Medicaid providers in the state. Starting January 1, 2030, the state PBM shall use a reimbursement methodology adopted by the department that is based on a pharmacy's acquisition cost plus a professional dispensing fee that may vary by pharmacy type.	NRS 38 § 422.4053
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A PBM shall not charge a copayment or coinsurance for a prescription drug in an amount that is greater than the total amount paid to a pharmacy that is in the network of providers. **Copay Cap:** Starting October 1, 2025, an insurer or health benefit plan shall not impose a deductible, copayment, coinsurance, or other cost-sharing obligation for a covered prescription insulin drug that exceeds $35 for a 30-day supply. This requirement does not apply to Medicaid or state employee benefit plans.	NRS § 683A.179 NRS § 683A.177-179

New Hampshire

Issue	Summary	Citation
Licensing/Registration	A person or organization shall not establish or operate as a PBM in this state for health benefit plans without registering with the Insurance Commissioner. A PBM must file an application or renewal form established by the commissioner, as well as a nonrefundable fee of not more than $500 annually.	N.H. Rev. Stat. Ann. § 402-N:2
Reporting Requirements	Each PBM shall submit an annual or quarterly report to the commissioner containing a list of health benefit plans it administered and the rebates it collected from pharmaceutical manufacturers that were attributable to	N.H. Rev. Stat. Ann. § 402-N:6

	patient utilization in the state of New Hampshire during the prior calendar year. The report submitted to the commissioner shall include the following information: • The aggregate number of rebates and total value received by the PBM; The aggregate number of rebates and total value distributed to the appropriate health care insurer; • The aggregate number of rebates and total value passed on to an insured of each health care insurer at the point of sale that reduced the insured's applicable deductible, copayment, coinsurance, or other cost-sharing amount; • The individual and aggregate amount paid by the health care insurer to the PBM for pharmacist services itemized by pharmacy, by product (at the unique NDC level), and by goods and services; and • The individual and aggregate amount a PBM paid for pharmacist services itemized by pharmacy, by product, and by goods and services. Beginning March 1, 2025, and annually thereafter, an insurer shall file with the commissioner a report in the manner and form determined by the commissioner demonstrating the manner in which the insurer and/or its contracted entity for pharmacy benefit services has complied with the rebate pass-through requirements. The report shall include at least the following: • An attestation that all discounts and rebates received by health insurers were used to reduce costs for policyholders; • If a portion of rebates were remitted to the insurer, an explanation of how rebates were used to reduce policyholder premiums; • A description of how rebates were remitted in the individual, small, and large group market; and • A description of the methodology employed to calculate the estimated rebate amount. *Note: All above reporting requirements do not apply to contracts with Medicaid, Medicaid MCOs, Ryan White HIV/AIDS Program administered by the department of health and human services, or self-funded plans such as the state employee health benefit plan.*	N.H. Rev Stat § 415-A:7
PBM Income	**Rebate Pass-Through:** All rebates remitted by or on behalf of a pharmaceutical manufacturer, developer or labeler, directly or indirectly, to an insurer, or to a PBM under contract with an insurer, related to its prescription drug benefits shall be remitted in the following ways: • At least 50% of all rebates shall be emitted directly to the covered person at the point of sale to reduce the out-of-pocket cost to the covered person associated with a particular or specific prescription drug; and	N.H. Rev Stat § 415-A:7

	• The remainder of the rebates shall be remitted to the insurer and shall be applied by the insurer to offset the premium for covered persons.	

Pharmacy Contracting	**MAC Pricing:**
	All contracts between a carrier or PBM and a contracted pharmacy shall include:
	• The sources used by the PBM to calculate the drug product reimbursement paid for covered drugs available under the pharmacy health benefit plan administered by the carrier or PBM.
	• A process to appeal, investigate, and resolve disputes regarding the MAC pricing. The process shall include the following provisions:
	  ○ A provision granting the contracted pharmacy or pharmacist at least 30 business days following the initial claim to file an appeal;
	  ○ A provision requiring the carrier or PBM to investigate and resolve the appeal within 30 business days;
	  ○ A provision requiring that, if the appeal is denied, the carrier or PBM shall:
	  ▪ Provide the reason for the denial; and
	  ▪ Identify the NDC of a drug product that may be purchased by contracted pharmacies at a price at or below the MAC; and
	  ○ A provision requiring that, if an appeal is granted, the carrier or PBM shall, within 30 business days after granting the appeal:
	  ▪ Make the change in the MAC; and
	  ▪ Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question.
	• For every drug for which the PBM establishes a MAC to determine the drug product reimbursement, the PBM shall:
	  ○ Include in the contract with the pharmacy information identifying the national drug pricing compendia or sources used to obtain the drug price data.
	  ○ Make available to a contracted pharmacy the actual MAC for each drug.
	  ○ Review and make necessary adjustments to the MAC for every drug for which the price has changed at least every 14 days.
		N.H. Rev. Stat. § 402-N:3

Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A PBM or insurer shall require a contracted pharmacy to charge an enrollee or insured person the pharmacy's usual and customary price of filling the prescription or the contracted copayment, whichever is less. **Copay Cap:** Each insurer that provides coverage for prescription insulin drugs shall cap the total amount that a covered person is required to pay for each covered insulin drug	N.H. Rev. Stat. § 402-N:4 N.H. Rev. Stat. § 415:6-e

	prescription at an amount not to exceed $30 for each 30-day supply of each insulin prescription. The maximum $30 copayment for each 30-day supply of each covered insulin drug prescription shall apply when an original prescription is dispensed as well as when refills of the prescription are dispensed, including early refills. Coverage for prescription insulin drugs shall not be subject to any deductible.	

New Jersey

Issue	Summary	Citation
Licensing/Registration	PBMs must obtain a license from the Department of Banking and Insurance before operating in the state. A license shall be valid for 3 years and may be renewed for an additional 3-year period. Initial licensing fees and renewal fees are both set at $10,000. The department shall set minimum standards for granting or renewing a PBM license, and shall address: • Conflicts of interest between PBMs and health benefits plans; • Deceptive practices in connection with the performance of pharmacy benefits management services; • Anti-competitive practices in connection with the performance of pharmacy benefits management services; • Unfair claims practices in connection with the performance of pharmacy benefits management services; • Pricing models used by PBMs both for their services and for the payment of services to the PBM; • Standards and practices used in the creation of pharmacy networks and contracting with network pharmacies and other providers, including promotion and use of independent and community pharmacies and patient access and minimizing excessive concentration and vertical integration of markets; and • Protection of consumers. PBMs must also register as TPAs in New Jersey and comply with reporting requirements in ss. 11:23-2.1 to 11:23-2.6.	NJ Rev Stat § 17B:27F-1.1 N.J.A.C. 11:23-2.1-2.6
Reporting Requirements	Starting March 1, 2025, and each year thereafter, a carrier shall file with the department a report explaining how it has complied with the requirements regarding uses of manufacturer compensation. The report shall be written in a manner and determined by the department. By June 1 of each year, PBMs must file with the department a report containing: • The PBM's gross and net revenue in the state; • The total amount of rebates received by the PBM and the amount of rebates passed through to health plans or third parties;	NJ Rev Stat § 17B:27F-3.2

	• The total amount the PBM charged health plans for claims processed by the PBM and the total amount the PBM paid to pharmacies; • The total amount collected by the PBM from pharmacies for overpayments; • The total amount of audit fees, recoupments, and withholds collected by the PBM from pharmacies as a result of audits; • The total amount of per-claim, PMPM, and other administrative fees charged by the PBM to health plans; and • The total amount of administrative fees paid by manufacturers to the PBM.	
PBM Income	**Rebate Pass-Through:** Compensation remitted by or on behalf of a pharmaceutical manufacturer, developer or labeler, directly or indirectly, to a carrier or to a PBM under contract with a carrier related to prescription drug benefits shall be: • Remitted directly to the covered person at the point of sale to reduce the out-of-pocket cost to the covered person associated with a particular prescription drug; or • Remitted to, and retained by, the carrier. Compensation remitted to the carrier shall be applied by the carrier to offset the premium for covered persons. "compensation" means any direct or indirect financial benefit, including, but not limited to, rebates, discounts, credits, fees, grants, chargebacks or other payments or benefits of any kind, that is attributed to, directly or indirectly, the utilization of a health benefits plan or enrollment in a health benefits plan, regardless of how the benefits are otherwise characterized by a PBM and relevant third parties.	NJ Rev Stat § 17B:27F-3.2
Pharmacy Contracting	**MAC Pricing:** Upon execution or renewal of each contract, a PBM shall, with respect to contracts between a PBM and a contracted pharmacy: • Include in the contract the sources utilized to determine multiple source generic drug pricing, including, if applicable, the MAC or any successive pricing formula, of the PBM; • Update that pricing information every 7 calendar days; and • Establish a reasonable process by which contracted pharmacies have a method to access relevant MAC pricing lists and any successive pricing formulas in a timely manner. A PBM shall maintain a procedure to eliminate drugs from the list of drugs subject to multiple source generic drug pricing or modify MAC rates in a timely fashion, but in no event any later than 15 days from the date of any change.	N.J.A.C. 11:4-62.3 N.J.A.C. 11:4-62.4 NJ Rev Stat § 17B:27F-3

	To place a particular prescription drug on a multiple-source generic list, the PBM shall, at a minimum, ensure that: • The drug is listed as therapeutically and pharmaceutically equivalent or "A," "B," "NR," or "NA" rated in the Food and Drug Administration's most recent version of the Approved Drug Products with Therapeutic Equivalence Evaluations, commonly known as the "Orange Book"; and • The drug is available for purchase without limitations by all pharmacies in the State from national or regional wholesalers and is not obsolete or temporarily unavailable. Carriers and PBMs under a contract with a carrier, must use a single MAC list, to establish the maximum amount to be paid by a health benefits plan to a pharmacy provider for a generic drug or a brand-name drug that has at least one generic equivalent available. The same MAC list must be used for each pharmacy provider. For brand-name drugs without a generic equivalent, or a prescription drug not included on a MAC list, carriers or PBMs must use the AWP to establish the maximum payment. All contracts between a PBM and a contracted pharmacy shall include a process to appeal, investigate, and resolve disputes regarding multiple source generic drug pricing. The contract provision establishing the process shall include the following: • The right to appeal shall be limited to 14 calendar days following the initial claim; • The appeal shall be investigated and resolved by the PBM through an internal process within 14 calendar days of receipt of the appeal by the PBM; and • A telephone number at which a pharmacy may contact the PBM and speak with an individual who is involved in the appeals process. • If the appeal is denied, the PBM shall provide the reason for the denial and identify the NDC of a drug product that is available for purchase by contracted pharmacies in this State from wholesalers at a price which is equal to or less than the MAC for the appealed drug as determined by the PBM; and • If the appeal is approved, the PBM shall make the price correction, permit the reporting pharmacy to reverse and rebill the appealed claim, and make the price correction effective for all similarly situated pharmacies from the date of the approved appeal.	
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A carrier or PBM shall not require a covered person to make a payment at the point of sale for a covered prescription drug in an amount greater than the lesser of:	NJ Rev Stat § 17B:27F-3.1

	• The applicable cost-sharing amount for the prescription drug; or • The amount a covered person would pay for the prescription medication if the covered person purchased the prescription medication without using a health benefits plan. **Copay Adjustment Programs:** For plans, policies, and contracts that are delivered, issued, executed, or renewed after April 10, 2026, a carrier or TPA shall not directly or indirectly set, alter, implement, or condition the terms of health benefit plan coverage based in part of entirely on the availability or amount of financial assistance available for a prescription drug. When calculating an enrollee's cost-sharing amount requirement, a carrier or TPA shall give credit for any cost-sharing amount paid by the enrollee or on behalf of the enrollee by another party. For high-deductible health plans, this requirement applies after the enrollee meets the federal minimum deductible. This does not apply to the following plans, policies, or contracts: accident only, disability, long-term care, Medicare supplemental coverage, TRICARE supplement coverage, Medicare prescription drug coverage, Medicaid, worker's compensation, the State Health Benefits Program, the School Employees' Health Benefits Program, and self-insured health benefits plans governed by ERISA. **Copay Cap:** Coverage for the purchase of a short-acting, intermediate-acting, rapid-acting, long-acting, and pre-mixed insulin product shall not be subject to any deductible, and no copayment or coinsurance for the purchase of insulin shall exceed $35 per 30-day supply.	NJ Rev Stat § 17B:27F-1 (2025) NJ Rev Stat § 17:48-6n

New Mexico

Issue	Summary	Citation
Licensing/Registration	A person shall not operate as a PBM unless licensed by the Superintendent of Insurance. PBMs must renew their license annually. An initial application and a renewal application for licensure as a PBM shall be made on a form and in a manner provided for by the superintendent.	NM Stat § 59A-61-3
Reporting Requirements	N/A	
PBM Income	**Rebate Pass-Through:** Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the	NM Stat § 13-7-47

	remainder shall be credited to the insurer. Any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.	

Pharmacy Contracting	**MAC Pricing:**
	A PBM shall determine a reimbursement amount for a generic drug based on objective and verifiable sources.
	
	A PBM shall reimburse a pharmacy an amount no less than the amount that the PBM reimburses a PBM affiliate in the same network for providing the same or equivalent service.
	
	A PBM using MAC pricing may place a drug on a MAC list if the drug:
	• Is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the "orange book", or has an "NR" or "NA" rating or a similar rating by a nationally recognized reference;
	• Is available for purchase by pharmacies in the state at the time of claim submission from national or regional wholesalers and is not obsolete; and
	• Is a drug with not fewer than two "A" or "B" rated therapeutically equivalent drugs in the most recent version of the FDA's approved drug products with therapeutic equivalence evaluations, also known as the "orange book".
	
	A PBM using MAC pricing shall:
	• Upon a network pharmacy's request, provide that network pharmacy with the sources used to determine the MAC pricing for the MAC list specific to that provider;
	• Review and update MAC price information at least once every 7 business days to reflect any modification of MAC pricing;
	• Establish and maintain a process for eliminating products from the MAC list or modifying MAC prices in at least 7 business days to remain consistent with pricing changes and product availability in the marketplace;
	• Provide a procedure that allows a pharmacy to choose the entity to which it will appeal reimbursement for generic drugs. A pharmacy may appeal:
	  ○ Directly to the PBM; or
	  ○ Through a PSAO;
	• Provide an appeals process that, at a minimum, includes the following:
	  ○ A dedicated telephone number and electronic mail address or website for the purpose of submitting appeals;
	  ○ The ability to submit an appeal directly to the PBM; and
		NM Stat § 59A-61-4
		
		NM Stat § 13-7-47

	○ The allowance of at least 21 business days to file an appeal after the date a pharmacy receives notice of the reimbursement amount; • Grant an appeal if the PBM fails to respond to a complete submission as defined by rules promulgated by the superintendent of the appealing party in writing within 14 business days after the PBM receives the appeal; • If an appeal is granted, notify the challenging pharmacy and its PSAO, if any, that the appeal is granted and make the change in the MAC effective for the appealing pharmacy and for each other pharmacy in its network and permit the appealing pharmacy to reverse and bill again the claim or claims that formed the basis of the appeal; • When an appeal is denied, provide the challenging pharmacy and its PSAO, if any, the NDC number and supplier that has the product available for purchase in New Mexico at or below the MAC; • Within 1 business day of granting or denying a network pharmacy's appeal, notify all network pharmacies of the decision; • Upon granting an appeal, allow other similarly situated network pharmacies to reverse and bill again for like claims that formed the basis of the granted appeal; and • Provide for each of its network pharmacy providers and the superintendent a process and mechanism to readily access the MAC list specific to that provider. **Patient Steering:** Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for: • Prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or • Administration of prescription drugs at different infusion sites; provided that an insurer may communicate with an insured regarding lower-cost sites of service.	
Patient Cost Sharing	**Copay Cap:** The amount an individual with diabetes may be required to pay for a preferred formulary prescription insulin drug or a medically necessary alternative is not to exceed $25 per 30-day supply. Group health care coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act shall cap the amount an insured is required to pay for a preferred formulary prescription insulin drug or a medically necessary alternative at an amount not to exceed a total of $25 per 30-day supply and shall provide coverage for individuals with diabetes as required by law for each health care insurer. **Copay Accumulator Programs:** When calculating an enrollee's cost-sharing obligation for covered prescription drugs, pursuant to group health	NM Stat § 59A-22-41 NM Stat § 13-7-25 NM Stat § 13-7-47

	coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act, the insurer shall credit the enrollee for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim. These provisions do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act [Chapter 59A, Article 23G NMSA 1978], catastrophic plans, tax-favored plans or high-deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law. **Maximum Cost-Sharing Levels:** Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the: • Applicable cost-sharing amount for the prescription drug; • Amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts; • Total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the cost-sharing amount paid by an insurer; or • Value of the rebate from the manufacturer provided to the insurer or its PBM for the prescribed drug.	

New York

Issue	Summary	Citation
Licensing/Registration	Every PBM that performs pharmacy benefit management services shall register with the Superintendent of Insurance in a manner acceptable to the superintendent and shall pay a fee of $4,000 each year. The superintendent, in consultation with the Commissioner of Health, may establish minimum registration standards required for a PBM. No person shall acquire control of any licensed PBM, whether by purchase of its securities or otherwise, unless such person receives the superintendent's prior approval. The superintendent shall disapprove such acquisition if the superintendent determines, after notice and an opportunity to be heard, that such action is reasonably necessary to protect the interests of the people of this State.	N.Y. Ins. Law § 2903 N.Y. Ins. Law 29 § 2905
Reporting Requirements	On or before July 1 of each year, every PBM shall report to the superintendent: • Any pricing discounts, rebates of any kind, inflationary payments, credits, clawbacks, fees, grants, chargebacks, reimbursements, other financial or other	N.Y. Ins. Law § 2904.28.29

	reimbursements, incentives, inducements, refunds or other benefits received by the PBM; • The terms and conditions of any contract or arrangement, including other financial or other reimbursement incentives, inducements, or refunds between the PBM and any other party relating to pharmacy benefit management services provided to a health plan, including dispensing fees paid to pharmacies; • The aggregated dollar amount of rebates, fees, price protection payments and any other payments the PBM received from drug manufacturers through rebate contracts; • The portion of aggregated rebates that were passed on to health plans or retained by the PBM; • For each rebate contract in effect during the reporting period, the names of the contracting parties; the execution date and the term of the contract, including extensions; and the name of the drugs and the associated NDCs covered by the rebate contract, and for each drug: ○ A summary of the contract terms regarding formulary placement, formulary exclusion, or prior authorization requirements or step edits, of any drugs considered to compete with each drug; ○ A summary of all terms requiring or incentivizing volume or market share for each drug, including base rebate amounts, bundled rebates and incremental rebates, stated separately, and price concession, stated separately for each drug; and ○ The total number of prescriptions filled and units dispensed for which a rebate, discount, price concession or other consideration was received by the PBM for each drug; • The rebate percentage and dollar amount retained by the PBM for every rebate, discount, price concession or other consideration under each rebate contract; and • The dollar amount of any other compensation paid by a drug manufacturer to a PBM for services including distribution management services, data or data services, marketing or promotional services, research programs, or other ancillary services, under each rebate contract. The superintendent may require the filing of quarterly or other statements, which shall be in such form and shall contain such matters as the superintendent shall prescribe.	
PBM Income	**Spread Pricing (Medicaid):** In Medicaid, a PBM shall not utilize any form of spread pricing in any contract or other arrangement with health care plans.	N.Y. Pub. Health L § 4406-C(10a)

	Rebate Pass-Through (Medicaid): Any contract or other arrangement entered into by a health care plan for the provision and administration of pharmacy benefit management services on behalf of individuals enrolled in a managed Medicaid plan shall be based on a pass-through pricing model. Payment to the PBM for pharmacy benefit management services shall be limited to the actual ingredient costs, dispensing fees paid to pharmacies, and an administrative fee that covers the cost of providing pharmacy benefit management services. The department may establish a maximum administrative fee.	
Pharmacy Contracting	**Patient Steering:** A PBM shall not directly or indirectly: • Engage in marketing, advertising, or promotional activities to covered individuals for the purpose of gaining dispensing opportunities at affiliated pharmacies, including providing incentives to a covered individual to use an affiliated pharmacy when unaffiliated pharmacies are available within the same network, provided, however, that nothing in this section shall be construed to restrict a PBM from communicating or operationalizing any element of plan design elected by a health plan; • In any manner on any material produced by the PBM, including identification cards, include the name of any affiliated pharmacy unless it specifically lists two or more unaffiliated pharmacies participating in the relevant pharmacy network, provided unaffiliated pharmacies are participating in the network; • Transfer or share records relative to prescription information containing a covered individual's identifiable or prescriber-identifiable data to an affiliated pharmacy; • Require a covered individual to purchase prescription drugs exclusively through a mail-order pharmacy or refer a covered individual to a mail-order pharmacy or an affiliated pharmacy unless contractually required to do so by the health plan; • Penalize a covered individual for using an in-network unaffiliated pharmacy, including by requiring a covered individual to pay the full cost for a prescription. Nothing in this paragraph shall be construed to prohibit a health plan's election to use a network or networks that only includes affiliated pharmacies; • Prohibit or limit any covered individual from selecting an in-network pharmacy of the individual's choice unless specifically required by the health plan for a particular covered individual. **MAC Pricing:** A PBM shall, with respect to contracts between a PBM and a pharmacy or, alternatively, a PBM and a pharmacy's contracting agent, such as a PSAO, include a reasonable process to appeal, investigate and resolve disputes	NY Pub. Health Law 2-D § 238-A N.Y. Pub. Health Law § 280-A (4)

	regarding multi-source generic drug pricing. The appeals process shall include the following provisions: • The right to appeal by the pharmacy and/or the pharmacy's contracting agent shall be limited to 30 days following the initial claim submitted for payment; • A telephone number and email address through which a network pharmacy may contact the PBM for the purpose of filing an appeal; • The PBM shall respond in an electronic message to the pharmacy and/or the pharmacy's contracting agent filing the appeal within 7 business days indicating its determination. If the appeal is determined to be valid, the MAC for the drug shall be adjusted for the appealing pharmacy effective as of the date of the original claim for payment. The PBM shall require the appealing pharmacy to reverse and rebill the claim in question to obtain the corrected reimbursement; • If an update to the MAC is warranted, the PBM or covered entity shall adjust the MAC of the drug effective for all similarly situated pharmacies in its network in the state on the date the appeal was determined to be valid; and • If an appeal is denied, the PBM shall identify the NDC of a therapeutically equivalent drug that is available for purchase by pharmacies in this state at a price which is equal to or less than the MAC for that drug as determined by the PBM.	
Patient Cost Sharing	**Copay Cap:** Starting January 1, 2025, upon the issuance, renewal, modification, alteration, or amendment of a health insurance policy or contract, cost-sharing for prescription insulin is prohibited. This applies to all state-regulated commercial plans including Essential Plan, individual and family plans, and small and large group plans. This applies to high-deductible health plans, except for individual catastrophic plans. **Copay Adjustment Programs:** Any policy that provides coverage for prescription drugs shall apply any third-party payments, financial assistance, discount, voucher or other price reduction instrument for out-of-pocket expenses made on behalf of an insured individual for the cost of a prescription drug to the insured's deductible, copayment, coinsurance, out-of-pocket maximum, or any other cost-sharing requirement when calculating such insured individual's overall contribution to any out-of-pocket maximum or any cost-sharing requirement. This requirement applies to high-deductible health plans once a covered individual meets the minimum deductible required to remain HSA-eligible. This paragraph only applies to a prescription drug that is either:	NY Ins. Law § 3216(15-a)(i)(B) N.Y. Ins. Law § 3216(37) N.Y. Pub. Health Law § 280-A (5)

	• A brand-name drug without an AB rated generic equivalent, as determined by the United States Food and Drug Administration; or • A brand-name drug with an AB rated generic equivalent, as determined by the United States Food and Drug Administration, and the insured has access to the brand-name drug through prior authorization by the insurer or through the insurer's appeal process, including any step-therapy process; or • A generic drug the insurer will cover, with or without prior authorization or an appeal process. **Maximum Cost-Sharing Levels:** No PBM shall require a contracted pharmacy to charge or collect from an individual a copayment that exceeds the total submitted charges by the pharmacy for which the pharmacy is paid.	

North Carolina

Issue	Summary	Citation
Licensing/Registration	A person or organization may not establish or operate as a PBM for health benefit plans in this State without obtaining a license from the Commissioner of the Department of Insurance. The Commissioner shall develop an application for licensure to operate in this State as a PBM and may charge an initial application fee of $2,000 and an annual renewal fee of $1,500.	N.C. Gen. Stat. § 58-56A-2
Reporting Requirements	No later than May 1 of every year, all PBMs shall report to the Commissioner all of the following information regarding prescription drug benefits specific to insurers within the State: • The aggregate amount of rebates that the PBM received from all drug manufacturers or wholesale distributors by therapeutic category; • The aggregated amount of difference between the amount paid by the health benefit plan for prescription drugs and the amount paid to pharmacies for claims paid under the health benefit plan, including point-of-sale and retroactive charges; • The spread between the aggregate amount paid to pharmacies for prescription drugs and the aggregate amount charged to insurers for prescription drugs; • A list of all pharmacies that are under common control or ownership of the PBM; • The aggregated amount of any differences between what the PBM reimburses or charges affiliated retail pharmacies and non-affiliated retail pharmacies; • The aggregate amount of all fees or other assessments, including point-of-sale or retroactive charges, that are imposed on contracted, preferred, or in-network pharmacies. Retroactive charges shall not	N.C. Gen. Stat. § 58-56A-22 N.C. Gen. Stat. §58-56A-6

	include any funds recouped from an audit that complies with §58-50-8; and • The highest, lowest, and mean aggregate percentages for retained rebates by the PBM. Beginning March 31, 2026, and quarterly thereafter, any PBM that conducts spread pricing shall report to applicable contracted insurers the aggregate difference between the price charged the insurer and the price paid to the pharmacy for each drug where there is a difference in price. Any insurer who receives a spread pricing report from a PBM shall make that report available on its website and to any employers who have purchased a health benefit plan from the insurer.	
PBM Income	**Rebate Pass-Through:** Starting January 1, 2027, when calculating an insured's defined cost-sharing for a covered prescription drug at the point of sale, an insurer offering a health benefit plan or a PBM shall base the calculation on the price of the prescription drug after taking into account all rebates associated with that prescription drug. The price of the prescription drug shall be reduced by an amount equal to 90% of all rebates received, or to be received, in conjunction with the dispensing or administration of the prescription drug.	N.C. Gen. Stat. § 58-3-182 N.C. Gen. Stat. § 58-56A-3
Pharmacy Contracting	**Minimum Reimbursement:** No PBM contract may require an independent pharmacy or any pharmacy in a pharmacy desert, as defined in §58-51-37, to accept reimbursement for providing a covered prescription drug, device, or service at a rate less than the acquisition cost. **Patient Steering:** An insurer or PBM shall not: • Prohibit or limit an insured from selecting a pharmacy of the insured's choice when the pharmacy has agreed to participate in the health benefit plan; • Impose upon an insured any copayment, fee, or condition that is not equally imposed upon all insureds in the same benefit category, class, or copayment level under the benefit plan when receiving services from a contract provider; • Impose a monetary advantage or penalty that would affect an insured's choice of pharmacy, including a higher copayment, a reduction in reimbursement for services, or the promotion of one contract provider over another. Prohibition of monetary advantages shall not apply to monetary advantages imposed upon a pharmacy located in a pharmacy desert or in a county with a population under 20,000; • Reduce reimbursement for pharmacy services to an insured because the insured selects a pharmacy of their choice; or • Require an insured to purchase pharmacy products or services exclusively through a mail-order pharmacy.	N.C. Gen. Stat. § 58-56A-4(g) N.C. Gen. Stat. § 58-51-37 N.C. Gen. Stat. § 58-56A-3 N.C. Gen. Stat. § 58-56A-20 N.C. Gen. Stat. § 58-56A-5

	A PBM shall not reimburse a pharmacy or pharmacist in this State an amount less than the amount that the PBM reimburses a PBM affiliate for providing the same pharmacist services or same prescription drug. In determining the amount of the reimbursement for the purposes of this section, the amount shall be calculated on a per-unit basis using the same generic product identifier or generic code number and shall reflect all drug manufacturer's rebates, all direct and indirect administrative fees, and any other cost-savings or discounts that may be given related to the drug or services. **MAC Pricing:** To place a prescription drug on the MAC price list, the drug must be available for purchase by pharmacies in North Carolina from national or regional wholesalers, must not be obsolete, and must meet one of the following conditions: • The drug is listed as "A" or "B" rated in the most recent version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book; or • The drug has a "NR" or "NA" rating, or a similar rating, by a nationally recognized reference. A PBM shall adjust or remove the MAC price for a prescription drug to remain consistent with changes in the national marketplace for prescription drugs. A review of the MAC prices for removal or modification shall be completed at least once every 7 business days, and any removal or modification shall occur within 7 business days of the review. A PBM shall provide a means by which the contracted pharmacies may promptly review current prices in an electronic, print, or telephonic format within 1 business day of the removal or modification. Dispensing fees shall not be included in the calculation of MAC prices. A PBM shall establish an administrative appeals procedure by which a contracted pharmacy or pharmacist, or a designee, may appeal the provider's reimbursement for a prescription drug subject to MAC pricing if the amount of reimbursement for the drug is less than the net amount that the network provider paid to the suppliers of the drug. The reasonable administrative appeal procedure must include all of the following: • A dedicated telephone number and email address or website for the purpose of submitting administrative appeals; • The ability to submit an administrative appeal regarding the pharmacy benefits plan or program directly to the PBM or through a pharmacy service administrative organization if the pharmacy service administrative organization has a contract with the PBM that allows for the submission of appeals;	

	• No less than 10 calendar days after the applicable prescription fill date to file an administrative appeal; • A period of no more than 10 calendar days after receipt of notice of the filing of the administrative appeal by the PBM for a decision to be made on the appeal; • A requirement that if an appeal is upheld, then, within 10 calendar days of the decision, the PBM shall notify the appellant of the decision, apply the change in the MAC effective as of the date the appeal was resolved and make the change effective for all similarly situated pharmacies or pharmacists, and permit the appellant to reverse and rebill the claim that was appealed; and • A requirement that if the appeal is denied, then, within 10 calendar days of the decision, the PBM shall notify the appellant of the decision, provide the reason for the denial, the NDC of the drug, and the names of the national or regional wholesalers operating in the state.	

Patient Cost Sharing	**Copay Adjustment Programs:**
	When calculating an insured's contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or other applicable cost-sharing requirement, the insurer or PBM shall include any amounts paid by the insured, or on the insured's behalf, for a prescription that is either:
	• Without an AB-rated generic equivalent.
	• With an AB-rated generic equivalent if the insured has obtained authorization for the drug through any of the following: a.
	  ○ Prior authorization from the insurer or PBM;
	  ○ A step therapy protocol; or
	  ○ The exception or appeal process of the insurer or PBM.
	
	This subsection shall not apply to an insured covered by a high-deductible health plan if its application would render the insured ineligible for a health savings account unless the insured has satisfied the minimum deductible or the prescription qualifies as preventive care.
	
	Maximum Cost-Sharing Levels:
	A PBM shall not charge, or attempt to collect from, an insured a copayment that exceeds the total submitted charges by the network pharmacy.
	
	Note: see PBM Income section for rules regarding point-of-sale rebate pass-throughs.
		N.C. Gen. Stat. § 58-56A-3

North Dakota

Issue	Summary	Citation
Licensing/Registration	PBMs must obtain a license from the Insurance Commissioner to operate in the state. Operating as an unlicensed PBM is considered a class C felony. PBM licenses must be renewed each year. The commissioner	N.D. Cent. Code § 26.1-27.1-02

	shall establish application and renewal forms as well as initial application and renewal fees not to exceed $10,000.	
Reporting Requirements	A PBM shall disclose to the commissioner any ownership interest of any kind with any insurance company responsible for providing benefits to any plan for which the PBM provides services. A PBM shall also disclose any ownership interest with any parent company, subsidiary, or other organization that is related to the provision of pharmacy services, the provision of other prescription drug or device services, or a pharmaceutical manufacturer. The commissioner shall examine contracts between covered entities (including insurers) and PBMs to determine whether rebates, discounts, and other fees transmitted to the covered entities have been applied to reduce the covered entities' rates or distributed to covered individuals. Covered entities shall annually disclose any payments received from PBMs and how those payments are applied to reduce rates or distributed to covered individuals. Contracts between covered entities and PBMs shall provide the covered entity the right to audit the PBM's books, accounts, and records, including de-identified utilization information, as necessary to confirm that the benefit of a payment received by the PBM is being shared as required by the contract. If requested by a plan sponsor contracted payer, a PBM that has an ownership interest, either directly or through an affiliate or subsidiary, in a pharmacy shall disclose to the plan sponsor contracted payer any difference between the amount paid to a pharmacy and the amount charged to the plan sponsor contracted payer.	N.D. Cent. Code § 26.1-27.1-03 N.D. Cent. Code § 26.1-27.1-05 N.D. Cent. Code § 26.1-27.1-06 N.D. Cent. Code §19-02.1-16.2
PBM Income	**Rebate Pass-Through:** PBMs shall offer covered entities several options for the treatment of rebates in their contracts, including a model where the PBM passes all payments received to the covered entity.	N.D. Cent. Code § 26.1-27.1-05
Pharmacy Contracting	**MAC Pricing:** These MAC pricing requirements do not apply to the state Medicaid program. A PBM shall not place a drug on a MAC list unless: • The drug has at least two nationally available, therapeutically equivalent, multiple source drugs, or a generic drug is available only from one manufacturer; • The drug is listed as therapeutically equivalent and pharmaceutically equivalent or "A" or "B" rated in the United States food and drug administration's most recent version of the "Orange Book" or the drug is "Z" rated; and • The drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and not obsolete.	N.D. Cent. Code § 19-02.1-14.2 N.D. Cent. Code §19-02.1-16.2

	With respect to each contract between a PBM and a pharmacy, each PBM shall: • Provide to the pharmacy, at the beginning of each contract and contract renewal, the sources utilized to determine the MAC pricing of the PBM. • Update any MAC price list at least every 7 business days, and provide prompt notification of the pricing changes to network pharmacies. • Disclose the sources utilized for setting MAC price rates on each MAC price list included under the contract and identify each MAC price list that applies to the contracted pharmacy. A PBM shall make the list of the MACs available to a contracted pharmacy in a format that is readily accessible and usable to the contracted pharmacy. • Ensure MAC prices are not set below sources utilized by the PBM. • Provide a reasonable administrative appeals procedure to allow a dispensing pharmacy provider to contest a listed maximum allowable price rate. The PBM shall provide a determination to a provider that has contested a maximum allowable price rate within 7 business days. If an update to the maximum allowable price rate for an appealed drug is warranted, the PBM shall make the change based on the date of the determination and make the adjustment effective for all similarly situated pharmacy providers in this state within the network. • Ensure dispensing fees are not included in the calculation of MAC price reimbursement to pharmacy providers. **Patient Steering:** A PBM or a PBM's affiliates or subsidiaries may not own or have an ownership interest in a patient assistance program and a mail order specialty pharmacy, unless the PBM, affiliate, or subsidiary agrees to not participate in a transaction that benefits the PBM, affiliate, or subsidiary instead of another person owed a fiduciary duty.	
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A PBM or third-party payer may not charge a patient a copayment that exceeds the cost of the medication. **Copay Cap:** A PBM may not require a covered individual to make a payment for a covered insulin drug or medical supplies for insulin dosing and administration in an amount exceeding the out-of-pocket limits below: • Covered insulin drugs may not exceed $25 per 30-day supply per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs. • Covered medical supplies for insulin dosing and administration may not exceed $25 per 30-day supply	N.D. Cent. Code § 19-02.1-16.1 N.D. Cent. Code § 26.1-36-09.16 N.D. Cent. Code § 26.1-36-09.17

	per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs. **Copay Adjustment Programs:** When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement for a prescription drug under the health benefit plan, the health benefit plan must provide for the inclusion of any amount paid by the enrollee or paid on behalf of the enrollee by another person. The health benefit plan may not vary the out-of-pocket maximum or cost-sharing requirements, or otherwise design benefits that account for the availability of a cost-sharing assistance program for a prescription drug. The requirements under this section do not apply with respect to an HSA-eligible high-deductible health plan until a covered individual meets their minimum deductible.	

Ohio

Issue	Summary	Citation
Licensing/Registration	PBMs must obtain a dedicated Ohio PBM license to solicit Ohio-based plan sponsors or provide PBM services. The initial application fee is $2000 with a $3000 annual renewal fee.	Oh. Rev. Code § 3957.04
Reporting Requirements	A PBM shall disclose to the plan sponsor whether or not the PBM uses the same MAC list when billing a plan sponsor as it does when reimbursing a pharmacy. If a PBM uses multiple MAC lists, the PBM shall disclose in the aggregate to a plan sponsor any differences between the amount paid to a pharmacy and the amount charged to a plan sponsor. These disclosures shall be made within 10 days of a PBM and a plan sponsor signing a contract or on a quarterly basis. *Note: This disclosure requirement does not apply to ERISA or Medicare Part D plans.* **Medicaid:** The Ohio Medicaid program shall select a single PBM to administer pharmacy benefits for all Medicaid MCO plans. The state PBM shall provide to the Medicaid director a quarterly report containing the following information from the immediately preceding quarter: • The prices that the state PBM negotiated for prescribed drugs under the care management system. The price must include any rebates the state PBM received from the drug manufacturer; • The prices the state PBM paid to pharmacies for prescribed drugs; • Any rebate amounts the state PBM passed on to individual pharmacies;	Oh. Rev. Code § 3957.25 Oh. Rev. Code § 5167.243

	• The percentage of savings in drug prices that are passed on to participants in the care management system; • The information described in division (C) of section 5167.24 of the Revised Code; and • Any other information required by the director.	
PBM Income	N/A	
Pharmacy Contracting	**MAC Pricing:** In each contract between a PBM and a pharmacy, the pharmacy shall be given the right to obtain from the PBM, within 10 days after any request, a current list of the sources used to determine MAC pricing. In each contract between a PBM and a pharmacy, the PBM shall be obligated to update and implement the pricing information at least every 7 days and provide a means by which contracted pharmacies may promptly review MAC pricing updates in an electronic format. A PBM shall utilize the most up-to-date pricing data when calculating drug product reimbursements for all contracting pharmacies within 1 business day of any price update or modification. A PBM shall maintain a written procedure to eliminate products from the list of drugs subject to MAC pricing in a timely manner. A PBM may not place a drug on a MAC list unless: • The drug is listed as "A" or "B" rated in the most recent version of the FDA's approved drug products with therapeutic equivalence evaluations, or has an "NR" or "NA" rating or similar rating by nationally recognized reference; and • The drug is generally available for purchase by pharmacies in this state from a national or regional wholesaler and is not obsolete. Each contract between a PBM and a pharmacy shall include an electronic process to appeal, investigate, and resolve disputes regarding MAC pricing that includes all of the following: • A 21-day limit on the right to appeal following the initial claim; • A requirement that the appeal be investigated and resolved within 21 days after the appeal; • A telephone number at which the pharmacy may contact the PBM to speak to a person responsible for processing appeals; • A requirement that a PBM provide a reason for any appeal denial, including the NDC and the identity of the national or regional wholesalers from whom the drug was generally available for purchase at or below the benchmark price determined by the PBM; • A requirement that if the appeal is upheld or granted, then the PBM shall adjust the drug product reimbursement to the pharmacy's upheld appeal price;	Oh. Rev. Code § 3957.25

	• A requirement that a PBM make an adjustment not later than 1 day after the date of determination of the appeal. The adjustment shall be retroactive to the date the appeal was made and shall apply to all similarly situated pharmacies.	
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** No health plan issuer, PBM, or any other administrator shall require cost-sharing in an amount, or direct a pharmacy to collect cost-sharing in an amount, greater than the lesser of either of the following from an individual purchasing a prescription drug: • The amount an individual would pay for the drug if the drug were to be purchased without coverage under a health benefit plan; • The net reimbursement paid to the pharmacy for the prescription drug by the health plan issuer, PBM, or administrator.	Oh. Rev. Code § 3957.26

Oklahoma

Issue	Summary	Citation
Licensing/Registration	A PBM must obtain a license from the Insurance Department, and the department may charge a fee for such licensure. The department shall establish, by regulation, licensure procedures, required disclosures for PBMs (PBMs), and other necessary rules.	59 O.S. § 358 (OSCN 2026)
Reporting Requirements	A PBM shall fully disclose to insurers, self-funded employers, unions, or other PBM clients the existence of the respective aggregate prescription drug discounts, rebates received from drug manufacturers, and pharmacy audit recoupments. PBM contracts with these entities shall grant unrestricted audit rights and access to the respective PBM pharmaceutical manufacturer and provider contracts, plan utilization data, plan pricing data, pharmacy utilization data and pharmacy pricing data. A PBM shall report to the Attorney General on a quarterly basis for each health insurer: • The aggregate amount of rebates received by the PBM; • The aggregate amount of rebates distributed to the appropriate health insurer payor; • The aggregate amount of rebates passed on to the enrollees of each health insurer payor at the point of sale that reduced the applicable deductible, copayment, coinsurance or other cost-sharing amount of the enrollee; • The individual and aggregate amount paid by the health insurer payor to the PBM for pharmacy services itemized by pharmacy, drug product and service provided; and • The individual and aggregate amount a PBM paid a provider for pharmacy services itemized by pharmacy, drug product and service provided.	36 O.S. § 6962 (OSCN 2026) 59 O.S. § 359 (OSCN 2026)

	A PBM shall provide, upon request by the covered entity, information regarding the difference in the amount paid to providers for prescription services rendered to covered individuals and the amount billed by the PBM to the covered entity or plan sponsor to pay for prescription services rendered to covered individuals.	
PBM Income	**Spread Pricing:** A PBM shall not conduct spread pricing.	36 O.S. § 6962 (OSCN 2026)
Pharmacy Contracting	**MAC Pricing:** Starting November 1, 2025, a PBM shall, with respect to contracts between a PBM and a provider, including a pharmacy service administrative organization: • Include the specific sources utilized to determine the MAC pricing of the pharmacy, update MAC pricing at least every 7 calendar days, and establish a process for providers to readily access the MAC list specific to that provider; • Ensure that the drug is listed as "A" or "B" rated in the most recent version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, and the drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete; • Ensure dispensing fees are not included in the calculation of MAC price reimbursement to pharmacy providers; • Provide a reasonable administration appeals procedure to allow a provider, a provider's representative, or a pharmacy service administrative organization to contest reimbursement amounts within 14 calendar days of the final adjusted payment date. The PBM shall not prevent the pharmacy or the pharmacy service administrative organization from filing reimbursement appeals in an electronic batch format. The PBM must respond to a provider, a provider's representative, or a pharmacy service administrative organization who have contested a reimbursement amount through this procedure within 10 calendar days. The PBM must respond in an electronic batch format to reimbursement appeals filed in an electronic batch format. The PBM shall not require a pharmacy or PSAO to log into a system to upload individual claim appeals or to download individual appeal responses. If a price update is warranted, the PBM shall make the change in the reimbursement amount, permit the dispensing pharmacy to reverse and rebill the claim in question, and make the reimbursement amount change retroactive and effective for all contracted providers; and • If a below-cost reimbursement appeal is denied, the PBM shall provide the reason for the denial, including the NDC number and name of the specific national or regional wholesalers doing business in this state where	59 O.S. § 360 (OSCN 2026) 36 O.S. § 6961 (OSCN 2026) 36 O.S. § 6962 (OSCN 2026) 36 O.S. § 6963 (OSCN 2026)

	the drug is currently in stock and available for purchase by the dispensing pharmacy at a price below the PBM's reimbursement price. If the NDC number provided by the PBM is not available below the acquisition cost obtained from the pharmaceutical wholesaler from whom the dispensing pharmacy purchases the majority of the prescription drugs that are dispensed, the PBM shall immediately adjust the reimbursement amount, permit the dispensing pharmacy to reverse and rebill the claim in question, and make the reimbursement amount adjustment retroactive and in effect for all contracted providers for future claims billed. **Minimum Reimbursement:** If a drug is placed on the FDA Drug Shortages Database, PBMs shall reimburse claims to pharmacies at no less than the WAC for the specific NDC number being dispensed. No PBM or third-party payor shall enter into any contract that establishes payment for services or medications based on an effective rate of reimbursement. **Patient Steering:** A PBM shall not: • Restrict an individual's choice of in-network provider for prescription drugs. • Require or incentivize using any discounts in cost-sharing or a reduction in copay or the number of copays to individuals to receive prescription drugs from an individual's choice of in-network pharmacy. • Reimburse a pharmacy or pharmacist in the state an amount less than the amount that the PBM reimburses a pharmacy owned by or under common ownership with a PBM for providing the same covered services; • Require patients to use pharmacies that are directly or indirectly owned by the PBM, including all regular prescriptions, refills, or specialty drugs regardless of day supply; • Use mail-order pharmacies to meet access standards for retail pharmacy networks; or • Include the name of any pharmacy, hospital or other providers unless it specifically lists all pharmacies, hospitals and providers participating in the preferred and nonpreferred pharmacy and health networks.	
Patient Cost Sharing	**Copay Adjustment Programs:** Failure to include any amount paid by an enrollee or on behalf of an enrollee by another person when calculating the enrollee's total contribution to an out-of-pocket maximum, deductible, copayment, coinsurance or other cost-sharing requirement constitutes an unfair claims settlement practice. This does not apply to individuals enrolled in an HSA-eligible high-deductible health plan until they meet their minimum deductible. **Copay Cap:**	36 O.S. § 1250.5 (OSCN 2026) 36 O.S. § 6060.2 (OSCN 2026)

	Any health benefit plan that provides coverage for insulin shall cap the total amount that a covered person is required to pay for insulin at an amount not to exceed $30 per 30-day supply or $90 per 90-day supply of insulin for each covered insulin prescription, regardless of the amount or type of insulin needed to fill the prescription or prescriptions of the covered person.	

Oregon

Issue	Summary	Citation
Licensing/Registration	A PBM must obtain a license from the Department of Consumer and Business Services. To obtain a license, a PBM must submit an application to the department in a form determined by the department and pay a fee adopted by the department by rule. PBMs must renew their licenses every 12 months and pay a renewal fee. Initial application fees and renewal fees are set at $1,100.	Or. Rev. Stat. § 735.532 Administrative Order ID6-2025

Reporting Requirements	Not later than June 1 of each calendar year, a PBM shall file a report with the Department of Consumer and Business Services. The report must contain, for the immediately preceding calendar year:
	• The aggregated dollar amount of rebates, fees, price protection payments and any other payments the PBM received from manufacturers:
	  ○ Related to managing the pharmacy benefits for carriers issuing health benefit plans in this state; and
	  ○ That were:
	  ▪ Passed on to carriers issuing health benefit plans in this state or enrollees at the point of sale of a prescription drug in this state; or
	  ▪ Retained as revenue by the PBM.
	• The total dispensing fees paid to the PBM and to pharmacies.
	• The total administrative fees obtained and retained from manufacturers and carriers.
	• Money obtained through spread pricing, pay-for-performance, or similar means.
	
	Upon the request of the Department of Consumer and Business Services, a PBM shall submit to the department its contracts with pharmacies or PSAOs and its provider manuals.
		Or. Rev. Stat. § 735.537
		
		Or. Rev. Stat. § 735.538

PBM Income	N/A	
Pharmacy Contracting	**MAC Pricing:** A PBM: • May not place a drug on a list unless there are at least two multiple-source drugs, or at least one generic drug generally available for purchase. • Shall ensure that all drugs on a list are generally available for purchase. • Shall ensure that no drug on a list is obsolete.	Or. Rev. Stat. § 735.534

	• Shall make available to each network pharmacy at the beginning of the term of a contract, and upon renewal of a contract, the specific source the PBM uses to determine the MAC set by the PBM.
	• Shall make a list available to a network pharmacy upon request in a format that:
	  ○ Is electronic;
	  ○ Is computer accessible and searchable;
	  ○ Identifies all drugs for which MACs have been established; and
	  ○ For each drug specifies:
	  ▪ The NDC; and
	  ▪ The MAC.
	• Shall update each list maintained by the PBM every 7 business days and make the updated lists, including all changes in the price of drugs, available to network pharmacies.
	• Shall ensure that dispensing fees are not included in the calculation of MAC.
	• A PBM must establish a process by which a network pharmacy may appeal its reimbursement for a drug subject to MAC pricing. A network pharmacy may appeal a MAC if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug. The process must allow a network pharmacy a period of no less than 60 days after a claim is reimbursed in which to file the appeal. An appeal requested under this section must be completed within 30 calendar days of the pharmacy making the claim for which appeal has been requested.
	• A PBM must provide as part of the appeals process:
	  ○ A telephone number at which a network pharmacy may contact the PBM and speak with an individual who is responsible for processing appeals;
	  ○ A final response to an appeal of the reimbursement for a drug within seven business days; and
	  ○ If the appeal is denied, the reason for the denial and the NDC of a drug that may be purchased by similarly situated pharmacies at a price that is equal to or less than the MAC.
	• If an appeal is upheld, a PBM shall:
	  ○ Make an adjustment for the pharmacy that requested the appeal from the date of initial adjudication forward; and
	  ○ Allow the pharmacy to reverse the claim and resubmit an adjusted claim without any additional charges.
	• If the request for an adjustment has come from a critical access pharmacy, as defined by the Oregon Health Authority by rule for purposes related to the Oregon Prescription Drug Program, an adjustment approved under an appeal shall apply only to critical access pharmacies.	

Patient Cost Sharing	**Copay Adjustment Programs:**
	To the extent permitted by federal law, an insurer offering a health plan that provides pharmacy benefits and a PBM shall include all amounts paid by an enrollee or paid by another person on behalf of an enrollee toward the cost of a covered prescription drug when calculating the enrollee's contribution to an out-of-pocket maximum, deductible, copayment, coinsurance or other cost-sharing requirement applied to the drug if:
	• The drug does not have a generic equivalent; or
	• The drug has a generic equivalent and the enrollee has:
	  ○ Obtained prior authorization from the insurer or PBM;
	  ○ Complied with a step therapy protocol; or
	  ○ Received approval from the insurer or PBM through the insurer's or the PBM's exceptions, appeal or review process.
	
	For high-deductible health plans, this requirement applies only to preventive services until the enrollee has satisfied the minimum deductible.
	
	Copay Cap:
	A health benefit plan offered in this state may not require an enrollee in the plan to incur cost-sharing or other out-of-pocket costs that exceed $35 for each 30-day supply of a type of insulin prescribed for the treatment of diabetes or $105 for each 90-day supply.
		Or. Rev. Stat. § 743B.603
		
		Or. Rev. Stat. § 743A.069

Pennsylvania

Issue	Summary	Citation
Licensing/Registration	A PBM or auditing entity must register with the Department of Insurance. The Department shall make an application form available on its website and establish application and renewal fees not to exceed $10,000. Registrations expire 2 years from the date of issuance. *Note: Chapter 5 is the only part of the Pharmacy Benefit Reform Act that applies to ERISA plans.*	40 PA Cons Stat § 4521 (2025)
Reporting Requirements	Beginning July 1, 2026, and annually thereafter, each registered PBM shall submit to the department a transparency report containing data for each health insurer client in this Commonwealth from the prior calendar year. The transparency report shall contain the following information: • The aggregate amount of all rebates that the PBM received from all pharmaceutical manufacturers for all health insurer clients and for each health insurer client; • The aggregate administrative fees that the PBM received from all manufacturers for all health insurer clients and for each health insurer client;	40 P.S. Insurance § 4533.1

	• The aggregate-retained rebates that the PBM received from all pharmaceutical manufacturers and did not pass through to health insurer clients; • The highest, lowest and mean aggregate retained rebate percentage for all health insurer clients and for each health insurer client; and • For a PBM that controls or is affiliated with a pharmacy, a description of any differences between what the PBM reimburses or charges affiliated and nonaffiliated pharmacies. The department may, by regulation, direct PBMs to include additional categories for aggregated data from health insurer clients in the annual transparency report.	
PBM Income	**Rebate Pass-Through:** A PBM shall pass through to the health benefit plan no less than 95% of any prescription drug manufacturer rebate obtained by the PBM on behalf of a health insurer client if the health benefit plan delegates negotiation of the rebate to the PBM. **Spread Pricing:** The department may conduct an analysis on the impact of spread pricing and patient steering on the cost of prescription drugs to consumers and pharmacy access.	1 40 P.S. § 4503 40 P.S. Insurance § 4533.1
Pharmacy Contracting	**Patient Steering:** A PM may not reimburse a retail pharmacy an amount less than the amount that the PBM reimburses a PBM-affiliated retail pharmacy for providing the same pharmacy services. A health benefit plan, health insurer or PBM contracting with a health benefit plan or insurer may not: • Require a covered individual, as a condition of payment or reimbursement, to purchase pharmacy services exclusively through a mail-order pharmacy or PBM retail pharmacy affiliate; • Prohibit or limit a covered individual from selecting an in-network pharmacy or pharmacist of the individual's choice if that pharmacy or pharmacist meets and agrees to the terms and conditions in the PBM's contract; • Require a covered individual to use a PBM-affiliated retail pharmacy; • Transfer a covered individual's prescriptions from an in-network pharmacy to another pharmacy unless requested by the covered individual; • Use financial incentives, including, but not limited to, adjustments in cost sharing obligations of a covered individual, to the exclusive benefit of a PBM-affiliated retail pharmacy; or • Auto-enroll a covered individual in mail-order pharmacy services, except in the case of maintenance medications, provided the auto-enrollment may not take place in the first 90 days of a new maintenance	40 P.S. Insurance § 4526 2016 Act 169 Ch. 7-9 55 Pa. Code § 1121.56

	medication and the covered individual shall have the opportunity to opt-out of mail-order pharmacy services. Under Pennsylvania's network adequacy law, a PBM may not limit its retail pharmacy network to only affiliated pharmacies. **MAC Pricing:** In order to place a particular drug on a multiple source generic list, a PBM shall ensure that: • The drug is listed as "A" or "B" rated in the most recent version of the FDA's "Approved Drug Products with Therapeutic Equivalence Evaluations," commonly known as the orange book, or "NR" or "NA" rated, or similar rating, by a nationally recognized reference; • There are at least two therapeutically equivalent multiple source drugs or at least one generic drug available from only one manufacturer; and • The drug is available for purchase by all pharmacies in this Commonwealth from national or regional wholesalers and is not obsolete or temporarily unavailable. A PBM must maintain a procedure to eliminate drugs from the list of drugs subject to multiple source drug pricing or modify the MAC in a timely fashion. Upon each contract execution or renewal, a PBM shall, with respect to contracts between a PBM and a pharmacy, or its representative, including a PSAO: • Include in the contract the sources utilized to determine multiple source drug pricing, including, if applicable, the MAC or any successive pricing formula of the PBM; • Update the pricing information every 7 calendar days; and • Establish a reasonable process by which pharmacies have a method to access relevant or current MAC pricing lists in effect and any successive pricing formulas in a timely fashion. All contracts between a PBM and a pharmacy or PSAO shall include a process to appeal, investigate, and resolve disputes regarding multiple source drug pricing, which shall include: • The right to appeal shall be limited to 14 calendar days following the initial claim; • The appeal shall be investigated and resolved by the PBM through an internal process within 14 calendar days of receipt of the appeal by the PBM; • A telephone number at which a pharmacy may contact the PBM and speak with an individual who is involved in the appeals process; • If a PBM denies an appeal, the PBM shall provide the reason for the denial and identify the NDC of an equivalent drug that is available for purchase by	

	network retail pharmacies in this Commonwealth from wholesalers at a price that is equal to or less than the MAC for the appealed drug as determined by the PBM; and
	• If a PBM grants an appeal, the PBM shall make the price correction, permit the reporting pharmacy to reverse and rebill the appealed claim and make the price correction effective for all similarly situated pharmacies from the date of the approved appeal.
	
	Minimum Reimbursement (Study):
	The department may conduct an analysis of the impact to consumers and pharmacies of requiring a health benefit plan or PBM contracting with a health benefit plan to reimburse a pharmacy utilizing the NADAC plus a professional dispensing fee of $10.49.
	
	Minimum Reimbursement (PACE and PACENET):
	• The Department of Aging shall pay for prescription drugs under the following formula:
	  ○ If the NADAC per unit is available, the payment shall be the lower of:
	  ▪ The NADAC per unit plus a professional dispensing fee of $13, minus the applicable copayment; or
	  ▪ The pharmacy's usual and customary charge for the drug, minus the copayment.
	  ○ If the NADAC per unit is not available, the department shall substitute using the drug's WAC plus 3.2%.
	• For generic drugs, the department shall reimburse providers based on the most current listing of the NADAC per unit plus a professional dispensing fee of $13 per prescription.	

Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A pharmacy may not charge a patient an amount for a covered drug that exceeds the lesser of: • The net reimbursement paid to the pharmacy for the prescription drug by the health benefit plan, health insurer or PBM contracting with a health benefit plan or health insurer; or • The amount an individual would pay for the prescription drug if the prescription drug were purchased without coverage under a health benefit plan. A health benefit plan, health insurer, or PBM may not collect from the member any difference in cost sharing the member pays to the pharmacy and the member's defined cost sharing in the member's benefit plan.	40 P.S. Insurance § 4527

Rhode Island

Issue	Summary	Citation
Licensing/Registration	PBMs must register as a third-party administrator with the Department of Insurance. Certificates of authority remain valid for so long as the administrator continues business in the state and remains compliant with applicable rules. The department shall establish an application form. **Certificate of Authority Requirement:** No entity may act as a PBM without holding a valid certificate of authority issued by the Health Insurance Commissioner. The application and renewal fees are $10,000, and each certificate expires after two years.	R.I. Gen. Laws § 27-20.7-12 R.I. Gen. Laws § 27-29.1-7 R.I. Gen. Laws § 27-84-3

Reporting Requirements	Each administrator shall file an annual report for the preceding calendar year with the department on or before July 1. The report shall be in the form and contain any matters that the commissioner prescribes, but shall include
	• The complete names and addresses of all insurers with which the administrator had an agreement during the preceding fiscal year.
	• Pricing discounts, rebates, inflationary payments, credits, clawbacks, fees, grants, chargebacks, reimbursements or other incentives
	• Terms and conditions of any contract or agreement
	• Patient utilization information including;
	  ○ Dollar amounts of rebates and fees collected from manufacturers passed to insurers
	  ○ Dollar amounts of rebates and fees passed to covered individuals at the point of sale
	  ○ Dollar amounts of rebates and fees retained by the PBM
	• Rebate percentage and dollar amount under each rebate contract
	
	Administrators must also provide a complete description of the financial arrangements between the third-party administrator and each of the insurers covering benefit contracts delivered in Rhode Island; and if the third-party administrator is owned by or affiliated with another entity or entities, it shall include an organization chart and brief description that shows the relationships among all affiliates within a holding company or otherwise affiliated.
	
	No PBM shall;
	• Prohibit or penalize a pharmacy or pharmacist from disclosing information to a person purchasing a prescription regarding;
	  ○ Cost to the individual or pharmacy
	  ○ The pharmacy's reimbursement
	  ○ Availability of therapeutically equivalent medications
	  ○ Alternative methods of purchasing the prescription including paying cash
		R.I. Gen. Laws § 27-20.7-14
		
		R.I. Gen. Laws § 27-29.1-7
		
		R.I. 2026 H 8582
		
		R.I. 2026 H 8579

	○ Charge or collect a copayment that exceeds the total submitted charges by the pharmacy for which the pharmacy is paid	
PBM Income	All funds received by the PBM in relation to providing PBM services shall be received by the PBM—including spread pricing--and shall be used or distributed pursuant to the PBM's contract with the insurer and applicable law. Beginning August 1, 2027, a PBM shall provide to an insurer for whom it is providing services the following; • Pricing discounts, rebates, credits, clawbacks, fees, grants, reimbursements, and other benefits • Contract terms and conditions • Activities, policies, and practices that constitute a conflict of interest	R.I. 2026 H 8582
Pharmacy Contracting	A PBM shall not substitute or cause the substitution of one prescription drug for another, including generic or therapeutically equivalent drugs, without the approval of the prescriber.	R.I. 2026 H 8582
Patient Cost Sharing	**Copay Cap:** A health plan that provides coverage for prescription insulin drugs shall cap the total amount that a covered person is required to pay for a covered prescription insulin drug at an amount not to exceed $40 per 30-day supply of insulin. Coverage for prescription insulin drugs shall not be subject to any deductible.	R.I. Gen. Laws § 27-20.8-3

South Carolina

Issue	Summary	Citation
Licensing/Registration	A person or organization may not establish or operate as a PBM in this State for health benefit plans without obtaining a license from the Director of the Department of Insurance. The director shall prescribe the application for a license to operate in this State as a PBM and may charge an initial application fee of $1,000 and an annual renewal fee of $500.	S.C. Code Ann. § 38-71-2210
Reporting Requirements	N/A	
PBM Income	N/A	
Pharmacy Contracting	**Patient Steering:** A PBM must not directly or indirectly engage in patient steering to a pharmacy that is a PBM affiliate without first making a written disclosure to the patient informing such patient of the PBM's relationship with the pharmacy and providing the patient with access to information about unaffiliated, in-network pharmacies that are located near the patient. A PBM must not prohibit a patient from choosing to use an alternative in-network pharmacy. A PBM shall not require the use of mail order for filling prescriptions unless required to do so by the health benefit plan or the health benefit plan design.	S.C. Code Ann. § 38-71-2230 S.C. Code Ann. § 38-71-2245 S.C. Code Ann. § 38-71-2240

	A PBM shall not engage in an anticompetitive pattern of reimbursing independent or unaffiliated pharmacies or pharmacists in this State consistently less than the amount that the PBM reimburses a PBM affiliate for providing the same pharmacist services or prescription drug unless the difference in reimbursement is justified according to uniform, defined standards that apply to each network provider. A PBM may neither limit an insured from selecting an in-network pharmacy or pharmacist of the insured's choice nor deny the right of a pharmacy or pharmacist to participate in a network if the pharmacy or pharmacist meets the requirements for network participation set forth by the PBM, and the pharmacy or pharmacist agrees to the contract terms, conditions, and rates of reimbursements. This requirement does not apply to high-cost prescription drugs, defined as having a WAC greater than 300% of the federal poverty level for a single-member household. **MAC Pricing:** Before a PBM places or continues to place a particular drug on a MAC List, the drug must: • Be listed as "A" or "B" rated in the most recent version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, or has an "NR" or "NA" rating, or a similar rating, by a nationally recognized reference; • Be available for purchase in the State from national or regional wholesalers operating in this State; and • Not be obsolete. A PBM shall: • Provide a process for network pharmacy providers to readily access the MAC specific to that provider; • Update its MAC List at least once every 7 calendar days; • Provide a process for each pharmacy subject to the MAC List to access any updates to the MAC List; • Ensure that dispensing fees are not included in the calculation of MAC; • Establish a reasonable internal appeal procedure by which a contracted pharmacy can appeal the provider's reimbursement for a drug subject to MAC pricing if the reimbursement for the drug is less than the net amount that the network provider paid to the suppliers of the drug. A pharmacy must be allowed no less than 10 calendar days after the applicable fill date to file an internal appeal or request for an external review of a denied internal appeal. The reasonable internal appeal procedure must include: ○ A dedicated telephone number and email address or website for the purpose of submitting internal appeals; and	

	○ The ability to submit an internal appeal directly to the PBM regarding the pharmacy benefits plan or program, or through a pharmacy service administrative organization if the pharmacy service administrative organization has a contract with the PBM that allows for the submission of such appeals; • If an internal appeal is filed, the PBM shall respond within 10 calendar days. ○ If an appeal is upheld, the PBM shall notify the pharmacy or pharmacist or his designee of the decision, make the change in the MAC effective as of the date the internal appeal is resolved, permit the appealing pharmacy or pharmacist to reverse and rebill the claim in question, and make the change effective for each similarly situated pharmacy. ○ If an appeal is denied, the PBM shall provide the appealing pharmacy or pharmacist the reason for the denial, the NDC number, and the name of the national or regional pharmaceutical wholesalers operating in this State; and notify the pharmacy or pharmacist in writing of the right to request an external review of the internal appeal and include clear and concise documents describing the external review process. • Participate in a reasonable external review procedure by which a contracted pharmacy can request an external review of a PBM's denial of an internal appeal by an independent review organization in accordance with the procedures promulgated by the director; and • Permit an unaffiliated retail pharmacy to participate in programs that reconcile payments with actual cost on the same basis as retail PBM affiliates. The MAC pricing regulations do not apply to the MAC List maintained by the State Medicaid Program, the Medicaid-managed care organizations under contract with the South Carolina Department of Health and Human Services, or the South Carolina Public Employee Benefit Authority.	
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A PBM shall not collect or require a pharmacy or pharmacist to collect from an insured a copayment for a prescription drug at the point of sale in an amount that exceeds the lesser of: • The contracted copayment amount; • The amount an individual would pay for a prescription drug if that individual was paying cash; or The contracted amount for the drug.	S.C. Code Ann. § 38-71-2230(4)

South Dakota

Issue	Summary	Citation

Licensing/Registration	A PBM must obtain a license to operate as a third-party administrator from the Director of Insurance. A PBM shall apply in a form furnished by the director along with a fee of $500.	S.D. Code Ann. § 58-29E-2
Reporting Requirements	A third-party payor may request that a PBM disclose the amount of all rebate revenues and the nature, type, and amounts of all other revenues that the PBM receives from each pharmaceutical manufacturer. Annually, at the time of contract renewal, the PBM shall disclose in writing: • The aggregate amount, and for a list of drugs to be specified in the contract, the specific amount, of all rebates and other retrospective utilization discounts that are received by the PBM, directly or indirectly, from each pharmaceutical manufacturer, and which are earned in connection with the dispensing of prescription drugs to covered individuals of the health benefit plans issued by the third-party payor or for which the third-party payor is the designated administrator; • The nature, type, and amount of all other revenue received by the PBM, directly or indirectly, from each pharmaceutical manufacturer, for any other products or services, provided to the pharmaceutical manufacturer by the PBM, with respect to programs that the third-party payor offers or provides to its covered individuals; and • Any prescription drug utilization information requested by the third-party payor and relating to covered individuals. A third-party payor that has contracted with a licensed PBM may audit the PBM once each calendar year. As part of the audit, a third-party payor may request: • All reimbursements paid to retail pharmacies, on a claim level, for all customers of the PBM in this state, including ancillary charges, claw backs, dispensing fees, drug-specific reimbursements, other fees, rebates, and reimbursement adjustments; • Differences in reimbursement amounts paid to affiliated and unaffiliated pharmacies, including differences in dispensing fees and reimbursed ingredient costs; • Historical claims data, including: o Acquisition costs; o Administrative fees associated with claims; o Amounts paid by a covered individual; o Amounts paid by a third-party payor; o Channels, whether mail or retail; o Dispensing fees; Formulary tiers; o Ingredient costs; o Ingredient quantity; o Sales tax; o Supply availability by the number of days; and o Usual and customary prices; and	S.D. Code Ann. § 58-29E-4 S.D. Code Ann. § 58-29E-7 S.D. Code Ann. § 58-29E-20

	• Aggregate rebate amounts, received by calendar quarter, directly or indirectly from manufacturers, including rebates from other entities affiliated with or related to the PBM, if those entities negotiate or contract with manufacturers. At the request of the Division of Insurance, a licensed PBM shall provide: • The amount charged or claimed by the PBM, in a format that allows the division to identify all instances of spread pricing; and • Information regarding a shared ownership interest by any person defined in § 58-29E-1.	
PBM Income	N/A	
Pharmacy Contracting	**MAC Pricing:** Prior to placing a prescription drug on a MAC list, a PBM shall ensure that the prescription drug is: • Listed as therapeutically and pharmaceutically equivalent in the latest edition of, or any supplement to, the FDA's publication entitled Approved Drug Products with Therapeutic Equivalence Evaluations, as adopted by the State Board of Pharmacy; • Not obsolete or temporarily unavailable; and • Available for purchase, without limitation, by every pharmacy in this state, from a national or regional wholesale distributor licensed in this state. A PBM shall: • Provide each pharmacy in a pharmacy network with reasonable access to each MAC list to which the pharmacy is subject; • Update a MAC list within 7 calendar days from the date of any increase above 10% in the price charged for a prescription drug on the list by one or more wholesale distributors doing business in this state; • Update the MAC list within 7 calendar days from the date of any change in the methodology, or any change in the value of a variable applied in the methodology, on which the MAC list is based; and • Provide a process under which each pharmacy in a pharmacy network may receive prompt notice of any change in a MAC list applicable to the pharmacy. **Patient Steering:** A PBM may not reimburse any pharmacy located in this state an amount that is less than that which the PBM reimburses a PBM affiliate for dispensing the same prescription drug as that dispensed by the pharmacy.	S.D. Code Ann. § 58-29E-17 S.D. Code Ann. § 58-29E-18 S.D. Code Ann. § 58-29E-19
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A PBM may not require a pharmacy that is a participating provider in a health benefit plan to charge a covered individual a cost share for a prescription drug or pharmacy service that exceeds the amount retained by the pharmacist or pharmacy from all payment sources, for filling the prescription or providing the pharmacy service.	S.D. Code Ann. § 58-29E-12

Tennessee

Issue	Summary	Citation
Licensing/Registration	No person or entity shall administer the medication or device portion of pharmacy benefits coverage provided by a covered entity or otherwise act as a PBM in this state unless the person or entity has obtained licensure through the Department of Commerce and Insurance. A PBM's license shall be renewed biennially. An applicant shall pay a $100 fee for an initial application and $50 to renew a license.	Tenn. Code Ann. § 56-7-3113
Reporting Requirements	N/A	
PBM Income	N/A	
Pharmacy Contracting	**Patient Steering:** A PBM shall allow patients, participants, and beneficiaries of the pharmacy benefits plans and programs that the PBM serves to utilize any pharmacy within this state that is licensed to dispense the prescription pharmaceutical product that the patient, participant, or beneficiary seeks to fill, as long as the pharmacy is willing to accept the same terms and conditions that the PBM has established for at least 1 of the networks of pharmacies that the PBM has established to serve patients, participants, and beneficiaries within this state. A PBM shall not charge a patient, participant, or beneficiary of a pharmacy benefits plan or program that the PBM serves a different copayment obligation or additional fee, or provide any inducement or financial incentive, for using any pharmacy within a given network of pharmacies established by the PBM to serve patients, participants, and beneficiaries within this state. **MAC Pricing:** Before a PBM or covered entity may place a drug on a MAC list, the PBM or covered entity must find that the drug is generally available for purchase by pharmacies in this state from a national or regional wholesaler. The drug shall be removed from the MAC list by the PBM or covered entity within 5 business days after the date that the PBM or covered entity becomes aware that the drug no longer meets the requirements. A PBM or covered entity shall make available to each pharmacy with which the PBM or covered entity has a contract and to each pharmacy included in a network of pharmacies served by a PSAO with which the PBM or covered entity has a contract, at the beginning of the term of a contract and upon renewal of a contract: • The sources used to determine the MACs for the drugs and medical products and devices on each MAC list;	Tenn. Code Ann. § 56-7-3121 Tenn. Code Ann. § 56-7-3106 Tenn. Code Ann. § 56-7-3107 Tenn. Code Ann. § 56-7-3108 Tenn. Code Ann. § 56-7-3206

	• Every MAC for individual drugs used by that PBM or covered entity for patients served by that contracted pharmacy; and • Upon request, every MAC list used by that PBM or covered entity for patients served by that contracted pharmacy. A PBM or covered entity shall: • Update each MAC list at least every 3 business days; • Make the updated lists available to every pharmacy with which the PBM or covered entity has a contract and to every pharmacy included in a network of pharmacies served by a PSAO with which the PBM or covered entity has a contract, in a readily accessible, secure, and usable web-based format or other comparable format or process; and • Utilize the updated MACs to calculate the payments made to the contracted pharmacies within 5 business days. A PBM or covered entity shall establish a clearly defined process through which a pharmacy may contest the listed MAC for a particular drug or medical product or device. A PBM or covered entity shall make available on its secure web site information about the appeals process, including, but not limited to, a telephone number or process that a pharmacy may use to submit MAC appeals. • The pharmacy must file its appeal within 7 business days of its submission of the initial claim for reimbursement for the drug or medical product or device. The PBM or covered entity must make a final determination resolving the pharmacy's appeal within 7 business days of the PBM or covered entity's receipt of the appeal; • If the final determination is a denial of the pharmacy's appeal, the PBM or covered entity must state the reason for the denial and provide the NDC of an equivalent drug that is generally available for purchase by pharmacies in this state from national or regional wholesalers at a price which is equal to or less than the MAC for that drug; • If a pharmacy's appeal is determined to be valid by the PBM or covered entity, the PBM or covered entity shall adjust the MAC of the drug or medical product or device for the appealing pharmacy. The adjustment for the appealing pharmacy shall be effective from the date the pharmacy's appeal was filed, and the PBM or covered entity shall provide reimbursement to the appealing pharmacy and may require the appealing pharmacy to reverse and rebill the claim in question in order to receive the corrected reimbursement; • Once an appealing pharmacy's appeal is determined to be valid by the PBM or covered entity, the PBM or covered entity shall adjust the MAC of the drug or medical product or device to which the MAC applies for	

	all similar pharmacies in the network as determined by the PBM within 3 business days for claims submitted in the next payment cycle. **Minimum Reimbursement:** A PBM shall not reimburse a contracted pharmacy for a prescription drug or device an amount that is less than the actual cost to that pharmacy for the prescription drug or device. A PBM shall establish a process for a pharmacy to appeal a reimbursement for failing to pay at least the actual cost to the pharmacy for the prescription drug or device. This requirement does not apply to a PBM when utilizing a reimbursement methodology that is identical to the methodology provided for in the state plan for medical assistance. A PBM shall pay a professional dispensing fee at a rate that is not less than the amount paid by the TennCare program to a pharmacy, if: • The pharmacy dispenses a prescription drug or device pursuant to an agreement with the PBM or a covered entity; and • The pharmacy's annual prescription volume is at a level that, if the pharmacy were a TennCare-participating ambulatory pharmacy, would qualify the pharmacy for the enhanced amount of professional dispensing fee for a low-volume pharmacy under the operative version of the Division of TennCare Pharmacy Provider Manual, or a successor manual.	
Patient Cost Sharing	**Copay Adjustment Programs:** When calculating an enrollee's contribution to an applicable cost-sharing requirement, an insurer shall include cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. This requirement does not apply to a prescription drug for which there is a generic alternative, unless the enrollee has obtained access to the brand name prescription drug through prior authorization, a step therapy protocol, the insurer's exceptions and appeals process.	Tenn. Code Ann. § 56-7-3205
Vertical Integration	Beginning July 1, 2028, state law prohibits a PBM from directly or indirectly acquiring, holding, controlling, or otherwise possessing ownership of or a beneficial interest in a pharmacy license or a pharmacy license holder, including through contract. The prohibition applies regardless of the percentage of ownership interest. Compliance is made a condition of the issuance, renewal, and validity of the pharmacy license. Exceptions are made for customary payer-pharmacy network contracts or minority ownership interests that do not convey managerial control or exclusive dispensing authority. Until September 1, 2028, the board is authorized to issue a limited-use pharmacy license solely for certain rare,	TN Code § 63-10-3 (2025)

	orphan, or FDA-designated limited-distribution drugs otherwise unavailable in the state.	

Texas

Issue	Summary	Citation
Licensing/Registration	PBMs are classified as third-party administrators and must obtain an annual license.	Tex. Ins. Code § 4151.001

Reporting Requirements	Not later than March 1 of each year, each PBM shall file a report with the commissioner. The report must state for the immediately preceding calendar year:
	• The aggregated rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers; and
	• The aggregated dollar amount of rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers that were:
	  ○ Passed to health benefit plan issuers or enrollees at the point-of-sale; or
	  ○ Retained by the PBM
		Tex. Ins. Code § 1369.502

PBM Income	N/A	
Pharmacy Contracting	**Patient Steering:** A health benefit plan issuer or a PBM may not steer or direct a patient to use an affiliated provider through any oral or written communication. This does not prohibit a health benefit plan issuer or PBM from including the issuer's or manager's affiliated provider in a patient or prospective patient communication, if the communication: • Is regarding information about the cost or service provided by pharmacies or durable medical equipment providers in the network of a health benefit plan in which the patient or prospective patient is enrolled; and • Includes accurate comparable information regarding pharmacies or durable medical equipment providers in the network that are not the issuer's or manager's affiliated providers. A health benefit plan issuer or PBM may not: • Require a patient to use an affiliated provider to receive the maximum benefit for the service under the patient's health benefit plan; • Offer or implement a health benefit plan that requires or induces a patient to use an affiliated provider, including by providing for reduced cost-sharing if the patient uses the affiliated provider; • Solicit a patient or prescriber to transfer a patient's prescription to an affiliated provider; or • Require a pharmacy or durable medical equipment provider that is not the issuer's or manager's affiliated provider to transfer a patient's prescription to an affiliated provider without the prior written consent of the patient.	Tex. Ins. Code § 1369.554 Tex. Ins. Code § 1369.555 Tex. Ins. Code § 1369.604 Tex. Ins. Code § 1369.351 Tex. Ins. Code § 1369.352 Tex. Ins. Code § 1369.353 Tex. Ins. Code § 1369.354 Tex. Ins. Code § 1369.355 Tex. Ins. Code § 1369.356 Tex. Ins. Code § 1369.357 Tex. Ins. Code § 1369.358

	A PBM may not pay an affiliated pharmacist or pharmacy a reimbursement amount that is more than the amount the PBM pays a nonaffiliated pharmacist or pharmacy for the same pharmacist service. **MAC Pricing:** A health benefit plan issuer or PBM may not include a drug on a MAC list unless: • The drug has an "A" or "B" rating in the most recent version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book; or is rated "NR" or "NA" or has a similar rating by a nationally recognized reference; and • The drug is generally available for purchase by pharmacists and pharmacies in this state from a national or regional wholesaler; and not obsolete. A health benefit plan issuer or PBM must disclose to a pharmacist or pharmacy the sources of the pricing data used in formulating MAC prices, both at the date the contract begins and at the request of the pharmacy or pharmacist. A health benefit plan issuer or PBM shall establish a process that will in a timely manner eliminate drugs from MAC lists or modify MAC prices to remain consistent with changes in pricing data used in formulating MAC prices and product availability. The entity shall review and update MAC price information for each drug at least once every 7 days to reflect any modification of MAC pricing. A health benefit plan issuer or PBM must provide in the contract with each pharmacist or pharmacy a procedure for the pharmacist or pharmacy to appeal a MAC price of a drug on or before the 10th day after the date a pharmacy benefit claim for the drug is made. The health benefit plan issuer or PBM shall respond to an appeal in a documented communication not later than the 10th day after the date the appeal is received. • If the appeal is successful, the health benefit plan issuer or PBM shall adjust the MAC price that is the subject of the appeal effective on the day after the date the appeal is decided, apply the adjusted MAC price to all similarly situated pharmacists and pharmacies as determined by the health benefit plan issuer or PBM, and allow the pharmacist or pharmacy that succeeded in the appeal to reverse and rebill the pharmacy benefit claim giving rise to the appeal. • If the appeal is not successful, the health benefit plan issuer or PBM shall disclose to the pharmacist or pharmacy each reason why the appeal is denied and the NDC number from the national or regional wholesalers from which the drug is generally available for purchase by pharmacists and pharmacies in this state at the MAC price that is the subject of the appeal.	

Patient Cost Sharing	**Copay Cap:** A health benefit plan may not impose a cost-sharing provision for insulin that is included in the health benefit plan's formulary if the total amount the enrollee is required to pay exceeds $25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the enrollee's prescription. A health benefit plan must include at least one insulin from each therapeutic class in the plan's formulary. **Copay Adjustment Programs:** A health benefit plan issuer that covers prescription drugs or a PBM shall apply any third-party payment, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug to the enrollee's deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum applicable to health benefits under the enrollee's plan. This requirement only applies to a reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug covered by the enrollee's health benefit plan for which: • A generic equivalent or interchangeable biological product does not exist; or • A generic equivalent or interchangeable biological product does exist but the enrollee has obtained access to the prescription drug under the enrollee's health benefit plan using a prior authorization process, a step therapy protocol, or the issuer's exceptions and appeals process.	Tex. Ins. Code § 1358.103 Tex. Ins. Code § 1369.0542

Utah

Issue	Summary	Citation
Licensing/Registration	A PBM must obtain a license from the Department of Insurance to operate in the state. PBMs must submit an application form and an initial application fee designated by the department. Licenses are valid for 1 year	Utah Code § 31A-46-201 Utah Code § 31A-46-202
Reporting Requirements	Before April 1 of each year, a PBM operating in the state shall report to the department, for the previous calendar year: • Any insurer, pharmacy, or pharmacist in the state with which the PBM had a contract; • Total aggregate rebates and administrative fees that are attributable to enrollees of a contracting insurer; and • The percentage of aggregate rebates that the PBM retained under its agreement with the contracting insurer.	Utah Code § 31A-46-301 Utah Code § 31A-46-307

	A PBM may not enter into or renew a contract with an insurer on or after January 1, 2021, to administer or manage rebate contracting or rebate administration unless the PBM agrees to regularly report to the insurer information regarding pharmaceutical manufacturer rebates received by the PBM under the contract. The information disclosed shall be detailed, claims-level data unless the PBM and insurer agree to waive this requirement.	
PBM Income	**Rebate Pass-Through:** A health benefit plan renewed or entered into on or after July 1, 2026, shall ensure that each pharmaceutical manufacturer rebate is used exclusively to benefit enrollees using one or multiple of the following methods: • Passing down the rebate at the point of sale to offset an enrollee's deductible or coinsurance; • Using the rebate to reduce premiums paid by the enrollee; or • Using the rebate to enhance enrollee health benefits. **Spread Pricing:** A PBM shall offer a self-funded health benefit plan, as an option for the self-funded health benefit plan's design, pharmacy benefit management services that: • Comply with the rebate pass-through requirements in s. 31A-22-643; and • Do not include spread pricing.	Utah Code § 31A-22-643 Utah Code § 31A-46-312
Pharmacy Contracting	**MAC Pricing:** A PBM shall not use MAC as a basis for reimbursement to a pharmacy unless: • The drug is listed as "A" or "B" rated in the most recent version of the FDA's approved drug products with therapeutic equivalent evaluations, also known as the "Orange Book," or has an "NR" or "NA" rating or similar rating by a nationally recognized reference; and • The drug is generally available for purchase in this state and not obsolete. • For every drug which the PBM uses MAC to reimburse a contracted pharmacy, the pharmacy shall make a list available to a network pharmacy upon request in a format that is electronic, accessible, searchable, specifies MAC and NDC and identifies al drugs which MAC is established The MAC may be determined using comparable and current data on drug prices obtained from multiple nationally recognized, comprehensive data sources, including wholesalers, drug file vendors, and pharmaceutical manufacturers for drugs that are available for purchase by pharmacies in the state. For every drug on a PBM's MAC list, the PBM shall: • Include in the contract with the pharmacy information identifying the national drug pricing compendia and other data sources used to obtain the drug price data;	Utah Code § 31A-46-303 Utah Code § 31A-46-305 Utah Code § 31A-46-308

	• Review and make necessary adjustments to the MAC at least once per week; • Provide a process for the contracted pharmacy to appeal the MAC; and • Include in each contract with a contracted pharmacy a process to obtain an update to the pharmacy product pricing files used to reimburse the pharmacy in a format that is readily available and accessible. The right to appeal shall be: • Limited to 21 days following initial claim adjudication; and • Investigated and resolved by the PBM within 14 business days. If an appeal is denied, the PBM shall provide the contracted pharmacy with the reason for the denial and the NDC of the drug that may be purchased by the pharmacy at a price at or below the price determined by the PBM. These requirements do not apply to a PBM providing pharmacy benefit management services on behalf of the Medicaid program. **Patient Steering:** A PBM shall reimburse a network pharmacy, in the aggregate, in an amount no less than the amount that the PBM reimburses an affiliate of the PBM in the same network, in the aggregate, for providing the same or equivalent pharmacy service. An insurer or PBM may not require a covered individual to obtain pharmacy services from an out-of-state mail-order pharmacy. This requirement does not apply if a prescription drug or device is not readily available in all retail pharmacies.	
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A PBM shall not require a covered individual to pay more than the lesser of the following for a covered prescription drug or device: • The applicable cost share of the prescription drug or prescription device being dispensed; • The applicable allowable claim amount of the prescription drug or prescription device being dispensed; • The applicable pharmacy reimbursement of the prescription drug or prescription device being dispensed; or • The retail price of the prescription drug or prescription device without prescription drug coverage. **Copay Cap:** If a health benefit plan entered into or renewed on or after January 1, 2021, provides coverage for insulin for diabetes, the health benefit plan shall:	Utah Code § 31A-46-302 Utah Code § 31A-22-626

	• Cap the total amount that an insured is required to pay for at least one insulin in each therapy category at an amount not to exceed $30 per prescription of a 30-day supply of insulin for the treatment of diabetes; and • Apply the cap to an insured regardless of whether the insured has met the plan's deductible. This requirement does not apply to health benefit plans that: • Cover at least one insulin for the treatment of diabetes in each therapy category under the lowest tier of drugs; and • Do not require cost-sharing other than a copayment of an insured before the plan will cover insulin at the lowest tier. This requirement also does not apply to health benefit plans that: • Guarantee a covered individual shall not pay more out-of-pocket for insulin than if the insured would pay to obtain the insulin through the state's discount program described in Section 49-20-421; and • Cap the total amount that an insured is required to pay for at least one insulin in each therapy category at an amount not to exceed $100 per prescription of a 30-day supply of insulin for the treatment of diabetes. A health benefit plan may condition coverage of insulin using the above cost-sharing methods on: • The insured's participation in wellness-related activities for diabetes; • Purchasing a covered insulin product at an in-network pharmacy; or • Choosing an insulin from the plan's lowest formulary tier. The department shall annually update the applicable insulin copay caps to adjust for inflation and provide insurers with insulin pricing under the state's discount program.	

Vermont

Issue	Summary	Citation
Licensing/Registration	PBMs must obtain a license from the Commissioner of Financial Regulation. Applicants for an initial PBM license shall submit an application form established by the department, a nonrefundable application fee of $1,600, and an initial licensure fee of $10,000. PBMs must renew their licenses each year and pay a renewal fee of $12,000.	18 V.S.A. § 3611
Reporting Requirements	For plans renewed or initiated after July 1, 2024, a PBM shall allow access by contracted health insurers to financial and contractual information necessary to conduct	18 V.S.A. § 3621

	a complete and independent audit designed to verify the following: • Full pass-through of negotiated drug prices and fees associated with all drugs dispensed to beneficiaries of the health benefit plan in both retail and mail-order settings or resulting from any of the pharmacy benefit management functions defined in the contract; • Full pass-through of all financial remuneration associated with all drugs dispensed to beneficiaries of the health benefit plan in both retail and mail-order settings or resulting from any of the pharmacy benefit management functions defined in the contract; and • Any other verifications relating to the pricing arrangements and activities of the PBM required by the contract, if required by the Commissioner. A PBM shall disclose to a contracted health insurer all financial terms and arrangements for remuneration of any kind that apply between the PBM and any prescription drug manufacturer that relate to benefits provided to beneficiaries under or services to the health insurer's health benefit plan, including formulary management and drug-switch programs, educational support, claims processing, and pharmacy network fees charged from retail pharmacies and data sales fees.	18 V.S.A. § 3622
PBM Income	**Spread Pricing:** Effective July 1, 2024, a PBM shall not conduct or participate in spread pricing. A PBM must ensure that the total amount required to be paid by a health benefit plan and a covered person for a prescription drug covered under the plan does not exceed the amount paid to the pharmacy for dispensing the drug. **Rebate Pass-Through:** If the PBM derives any payment or benefit for the dispensation of prescription drugs based on volume of sales for certain prescription drugs or classes or brands of drugs, that PBM shall pass that payment or benefit on in full to the health insurer.	18 V.S.A. § 3612 18 V.S.A. § 3622
Pharmacy Contracting	**MAC Pricing:** In order to be subject to MAC, a drug must be widely available for purchase by all pharmacies in the State, without limitations, from national or regional wholesalers and must not be obsolete or temporarily unavailable. For each drug for which a PBM establishes a MAC to determine the reimbursement rate, the PBM shall do all of the following: • Make available, in a format that is readily accessible and understandable by a pharmacist, the actual MAC for each drug and the source used to determine the MAC, which shall not be dependent upon individual beneficiary identification or benefit stage; • Update the MAC at least once every 7 calendar days;	18 V.S.A. § 3631 8 V.S.A. § 4093c (2)

	• Establish or maintain a reasonable administrative appeals process to allow a dispensing pharmacy provider to contest a listed MAC;
	• Respond in writing to any appealing pharmacy within 10 calendar days after receipt of an appeal, provided that the dispensing pharmacy shall file any appeal within 10 calendar days from the date its claim for reimbursement is adjudicated;
	  ○ A PBM shall allow a pharmacy to appeal after the 10-day period if a claim is subject to an audit by the PBM or its auditing agent.
	• For a denied appeal, provide the reason for the denial and identify the NDC and a Vermont-licensed wholesaler of an equivalent drug product that may be purchased by contracted pharmacies at or below the MAC;
	• For a successful appeal:
	  ○ Make the change in the MAC within 30 business days after the redetermination; and
	  ○ Allow the appealing pharmacy or pharmacist to reverse and rebill the claim in question.
	
	Patient Steering:
	A PBM shall not reimburse a pharmacy or pharmacist in this State an amount less than the amount the PBM reimburses a PBM affiliate for providing the same pharmacist services.
	
	A health insurer or PBM shall not do any of the following:
	• Require a covered individual, as a condition of payment or reimbursement, to purchase pharmacist services, including prescription drugs, exclusively through a mail-order pharmacy or a PBM affiliate;
	• Offer or implement plan designs that require a covered individual to use a mail-order pharmacy or a PBM affiliate;
	• Order a covered individual, orally or in writing, including through online messaging, to use a mail-order pharmacy or a PBM affiliate; or
	• Offer or implement plan designs that increase plan or patient costs if the covered individual chooses not to use a mail-order pharmacy or a PBM affiliate.	

Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A PBM shall not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of: • The cost-sharing amount under the terms of the health benefit plan; • The MAC for the drug; or • The amount the covered person would pay for the drug, after application of any known discounts, if the covered person were paying the cash price. **Copay Adjustment Programs:**	18 V.S.A. § 3612 8 V.S.A. § 4092g

	A PBM shall attribute any amount paid by or on behalf of a covered person, including any third-party payment, financial assistance, discount, coupon, or any other reduction in out-of-pocket expenses made by or on behalf of a covered person for prescription drugs, toward: • The out-of-pocket limits for prescription drug costs; • The covered person's deductible, if any; and • The annual out-of-pocket maximums applicable to the covered person's health benefit plan. This requirement shall only apply to prescription drugs for which there is no generic drug or interchangeable biological product, or drugs for which the covered person has obtained access through prior authorization, a step therapy protocol, or the PBM's or health benefit plan's exceptions and appeals process. For enrollees in high-deductible health plans, this requirement shall only apply after the individual meets their minimum deductible to remain eligible for an HSA. **Copay Cap:** A health insurance or other health benefit plan offered by a health insurer or PBM shall limit a beneficiary's total out-of-pocket responsibility for prescription insulin medications to not more than $100 per 30-day supply, regardless of the amount, type, or number of insulin medications prescribed for the beneficiary. The monthly limit shall apply regardless of whether the beneficiary has satisfied any applicable deductible requirement under the health insurance or health benefit plan.	

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;	Va. Code Ann. § 38.2-3468

	• 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.	
PBM Income	**Spread Pricing:** No carrier, PBM, or representative of a PBM shall conduct spread pricing in the Commonwealth. **Pass Through Pricing:** 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.	Va. Code Ann. § 38.2-3467
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:	Va. Code Ann. § 38.2-4312.1 Va. Code Ann. § 38.2-3467 Va. Code Ann. § 38.2-3407.15:3

	• 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 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. **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	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

Issue	Summary	Citation
Licensing/Registration	PBMs are considered health care benefit managers (HCBMs) and must register with the Commissioner of Insurance and annually renew their registration. PBMs must submit an application on forms designated by the commissioner as well as either an initial registration fee of $500 or a renewal fee of $750.	Wash. Rev. Code § 48.200.030
Reporting Requirements	An HCBM must file with the commissioner in the form and manner prescribed by the commissioner, every benefit management contract and contract amendment between the HCBM and a health carrier, provider, pharmacy, pharmacy services administration organization, or other health care benefit manager, entered into directly or indirectly in support of a contract with a carrier or employee benefits programs, within 30 days following the effective date of the contract or contract amendment. By March 1st of each year, a PBM must submit to the Health Care Authority the following data from the previous calendar year: • All discounts, including the total dollar amount and percentage discount, and all rebates received from a manufacturer for each drug on the PBM's formularies; • The total dollar amount of all discounts and rebates that are retained by the PBM for each drug on the PBM's formularies; • Actual total reimbursement amounts for each drug the PBM pays retail pharmacies after all direct and indirect administrative and other fees that have been retrospectively charged to the pharmacies are applied; • The negotiated price health plans pay the PBM for each drug on the PBM's formularies; • The amount, terms, and conditions relating to copayments, reimbursement options, and other payments or fees associated with a prescription drug benefit plan; • Disclosure of any ownership interest the PBM has in a pharmacy or health plan with which it conducts business; and • The results of any MAC pricing appeals pursuant to s. 48.200.280. The authority may examine or audit the financial records of a PBM for purposes of ensuring the information submitted under this section is accurate.	Wash. Rev. Code § 48.200.040 Wash. Rev. Code § 43.71C.030
PBM Income	**Spread Pricing:** Effective January 1, 2026, a PBM may not reimburse a network pharmacy for an amount less than the contract price between the PBM and the insurer, third-party payor, or the prescription drug purchasing consortium with which the PBM has contracted.	Wash. Rev. Code § 48.200.310
Pharmacy Contracting	**MAC Pricing:** A PBM: • May not place a drug on a list unless there are at least two therapeutically equivalent multiple source drugs, or	Wash. Rev. Code § 48.200.280

	at least one generic drug available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers; • Shall ensure that all drugs on a list are readily available for purchase by pharmacies in this state from national or regional wholesalers that serve pharmacies in Washington; • Shall ensure that all drugs on a list are not obsolete; • Shall make available to each network pharmacy at the beginning of the term of a contract, and upon renewal of a contract, the sources utilized to determine the reimbursement costs for multiple source drugs of the PBM; • Shall make a list available to a network pharmacy upon request in a format that is readily accessible to and usable by the network pharmacy; • Shall update each list maintained by the PBM every 7 business days and make the updated lists, including all changes in the price of drugs, available to network pharmacies in a readily accessible and usable format; • Shall ensure that dispensing fees are not included in the calculation of the reimbursement costs for multiple source drugs; or • Reimburse a pharmacy an amount less than the amount the PBM reimburses an affiliate for providing the same pharmacy services. A PBM must establish a process by which a network pharmacy, or its representative, may appeal its reimbursement for a drug. A network pharmacy may appeal a reimbursement amount paid by a PBM for a drug if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug. • Before a pharmacy or pharmacist files an appeal, upon request by a pharmacy or pharmacist, a PBM must provide a current and accurate list of bank identification numbers, processor control numbers, and pharmacy group identifiers for health plans and self-funded group health plans that have opted in to this section and RCW **48.200.310** and **48.200.320** pursuant to RCW **48.200.330** with which the PBM either has a current contract or had a contract that has been terminated within the past 12 months to provide pharmacy benefit management services. • An appeal requested under this section must be completed within 30 calendar days of the pharmacy submitting the appeal. • If, after 30 days, the network pharmacy has not received the decision on the appeal from the PBM, then the appeal is considered denied. • The PBM shall uphold the appeal of a pharmacy with fewer than 15 retail outlets within the state of Washington if the pharmacy or pharmacist can demonstrate that it is unable to purchase a	Wash. Rev. Code § 48.200.310

	therapeutically equivalent interchangeable product from a supplier doing business in Washington at the PBM's list price.
	• A PBM must provide as part of the appeals process:
	  ○ A telephone number at which a network pharmacy may contact the PBM and speak with an individual who is responsible for processing appeals;
	  ○ If the appeal is denied, the reason for the denial and the NDC of a drug that has been purchased by other network pharmacies located in Washington at a price that is equal to or less than the reimbursement amount paid by the PBM for the drug. A pharmacy with 15 or more retail outlets within the state of Washington may submit information to the commissioner about an appeal for purposes of information collection and analysis;
	  ○ If an appeal is upheld under this section, the PBM shall make a reasonable adjustment on a date no later than 1 day after the date of determination. If the request for an adjustment has come from a critical access pharmacy, the adjustment shall apply only to critical access pharmacies.
	• If a network pharmacy's appeal to the PBM is denied, or if the network pharmacy is unsatisfied with the outcome of the appeal, the pharmacy or pharmacist may dispute the decision and request review by the commissioner within 30 calendar days of receiving the decision.
	
	Patient Steering:
	A PBM may not require or coerce a patient to use their owned or affiliated pharmacies.
	
	A PBM shall:
	• Apply the same utilization review, fees, days allowance, and other conditions upon a covered person when the covered person obtains a prescription drug from a pharmacy that is included in the PBM's pharmacy network, including mail order pharmacies;
	• Permit the covered person to receive delivery or mail order of a prescription drug through any network pharmacy that is not primarily engaged in dispensing prescription drugs to patients through the mail or common carrier; and
	• For new prescriptions issued after January 1, 2026, receive affirmative authorization from a covered person before filling prescriptions through a mail-order pharmacy.
	
	If a covered person is using a mail-order pharmacy, the PBM shall:	

	• Allow for dispensing at local network pharmacies under the following circumstances to ensure patient access to prescription drugs if the prescription is delayed more than one day after the expected delivery date provided by the mail order pharmacy, or arrives in an unusable condition; and • Ensure patients have easy and timely access to prescription counseling by a pharmacist.	

Patient Cost Sharing	**Maximum Cost-Sharing Levels:**
	The maximum amount a health carrier or PBM may require a person to pay at the point of sale for a covered prescription medication is the lesser of:
	• The applicable cost sharing for the prescription medication; or
	• The amount the person would pay for the prescription medication if the person purchased the prescription medication without using a health plan.
	
	Copay Adjustment Programs:
	When calculating an enrollee's contribution to any applicable cost-sharing or out-of-pocket maximum, a health carrier offering a non-grandfathered health plan with a pharmacy benefit, or an HCBM administering benefits for the health carrier, shall include any cost-sharing amounts paid by the enrollee directly or on behalf of the enrollee by another person for a covered prescription drug that is:
	• Without a generic equivalent or a therapeutic equivalent preferred under the health plan's formulary;
	• With a generic equivalent or a therapeutic equivalent preferred under the health plan's formulary where the enrollee has obtained access to the drug through:
	  ○ Prior authorization;
	  ○ Step therapy; or
	  ○ The plan's prescription drug exception request process; or
	• With a generic equivalent or therapeutic equivalent preferred under the health plan's formulary, throughout an exception request process under RCW **48.43.420**, including any appeal of a denial of an exception request. If the health carrier utilizes an HCBM to approve or deny exception requests, the exception request process also includes any time between the completion of the exception request process, including any appeal of a denial, and when the HCBM communicates the status of the request to the health carrier.
	
	This section does not apply to a qualifying health plan for a health savings account to the extent necessary to preserve the enrollee's ability to claim tax-exempt contributions and withdrawals from the enrollee's health savings account under Internal Revenue Service laws, regulations, and guidance.
	
	Copay Cap:
		Wash. Rev. Code § 48.43.430
		
		Wash. Rev. Code § 48.43.435
		
		Wash. Rev. Code § 48.43.780

	A health plan issued or renewed on or after January 1, 2023, that provides coverage for prescription insulin drugs for the treatment of diabetes must cap the total amount that an enrollee is required to pay for a covered insulin drug at an amount not to exceed $35 per 30-day supply of the drug. Prescription insulin drugs must be covered without being subject to a deductible, and any cost-sharing paid by an enrollee must be applied toward the enrollee's deductible obligation. A health plan issued or renewed on or after January 1, 2025, that provides coverage for prescription asthma inhalers for the treatment of asthma shall cap the total amount that an enrollee is required to pay for at least 1 covered inhaled corticosteroid and at least 1 covered inhaled corticosteroid combination that is FDA-approved for the treatment of asthma at an amount not to exceed $35 per 30-day supply of the drug. A health plan must ensure that a covered inhaled corticosteroid and a covered inhaled corticosteroid combination is always available to a patient at the amount required. Prescription asthma inhalers must be covered without being subject to a deductible, and any cost-sharing paid by an enrollee must be applied toward the enrollee's deductible obligation, except in the case of HSA-eligible high-deductible plans. A health plan issued or renewed on or after January 1, 2025, that provides coverage for prescription epinephrine autoinjectors for the treatment of allergic reaction, shall cap the total amount that an enrollee is required to pay for at least 1 covered epinephrine autoinjector product containing at least 2 autoinjectors at an amount not to exceed $35. A health plan must ensure that a covered epinephrine autoinjector is always available to a patient at the amount required. Prescription epinephrine autoinjectors must be covered without being subject to a deductible, and any cost-sharing paid by an enrollee must be applied toward the enrollee's deductible obligation, except in the case of HSA-eligible high-deductible plans.	

West Virginia

Issue	Summary	Citation
Licensing/Registration	A PBM must obtain a license from the Insurance Commissioner to operate in the state. A PBM must apply using an application form developed by the commissioner and pay an initial application fee or a renewal fee determined by the commissioner. Initial application and renewal fees may not exceed $10,000. Licenses are valid for 2 years and must be renewed by October 1 of even years. If a PBM only serves self-funding employee benefit plans governed by ERISA, the PBM does not have to obtain a	W. Va. Code § 33-51-8

	license. However, they do have to register as a third-party administrator.	
Reporting Requirements	Any methodologies utilized by a PBM in connection with reimbursement shall be filed with the commissioner at the time of initial licensure and at any time thereafter that the methodology is changed by the PBM for use in determining MAC appeals. A PBM shall report to the commissioner on an annual basis, or more often as the commissioner deems necessary, for each health plan or covered entity the following information: • The aggregate amount of rebates received by the PBM; • The aggregate amount of rebates distributed to each health plan or covered entity contracted with the PBM; • The aggregate amount of rebates passed on to the enrollees of each health plan or covered entity at the point of sale that reduced the enrollees applicable deductible, copayment, coinsurance, or other cost-sharing amount; • The individual and aggregate amount paid by the health plan or covered entity to the PBM for pharmacist services itemized by pharmacy, by product, and by goods and services; and • The individual and aggregate amount a PBM paid for pharmacist services itemized by pharmacy, by product, and by goods and services. A PBM shall annually report in the aggregate to the commissioner and to a health plan or covered entity the difference between the amount the PBM reimbursed a pharmacy and the amount the PBM charged a health plan. A health benefit plan or covered entity shall annually report to the commissioner the aggregate amount of credits, rebates, discounts, or other such payments received by the health benefit plan or covered entity from a PBM or drug manufacturer and disclose whether or not those credits, rebates, discounts or other such payments were passed on to reduce insurance premiums or rates. A PBM shall produce a quarterly report to the commissioner of all drugs appearing on the national average drug acquisition cost list reimbursed at least 10% below the national average drug acquisition cost, as well as all drugs reimbursed at least 10% above the national average drug acquisition cost. For each drug in the report, a PBM shall include the month the drug was dispensed, the quantity of the drug dispensed, the amount the pharmacy was reimbursed, whether the dispensing pharmacy was an affiliate of the PBM, whether the drug was dispensed pursuant to a government health plan, and the average national drug acquisition cost for the month the drug was dispensed. This report shall exclude 340B drugs.	W. Va. Code § 33-51-9 W. Va. Code §33-51-12

	A PBM is required to report to the agency the following, at least quarterly; • The overall total amount charged to the agency for all claims processed by the PBM • Overall total amount of reimbursements paid to pharmacy providers • Total number of claims where the PBM reimbursed a pharmacy provider less than the amount charged to the agency • Amount paid to the pharmacy provider per claim including total cost of drug reimbursement, dispensing fees, copayments, etc.	
PBM Income	**Spread Pricing:** A PBM shall charge a health benefit plan administered by or on behalf of the state or a political subdivision of the state, the same price for a prescription drug as it pays a pharmacy for the prescription drug. A PBM shall offer a health plan the option of charging the plan the same price for a prescription drug as it pays a pharmacy for the prescription drug. **Rebate Pass-Through:** A covered individual's defined cost-sharing for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to at least 100% of all rebates received, or to be received, in connection with the dispensing or administration of the prescription drug. Any rebate over and above the defined cost-sharing would then be passed on to the health plan to reduce premiums. Nothing precludes an insurer from decreasing a covered individual's defined cost-sharing by an amount greater than what is previously stated. **Cost Containment (Medicaid):** • A PBM may not reimburse a pharmacy/pharmacist for a drug or service in an amount less than the amount the PBM reimburses itself or an affiliate for the same drug or service. • By July 1, 2026 the Medicaid program shall establish a pilot program to implement a pharmacy cost containment vendor. The vendor shall be separate and distinct from any PBM.	W. Va. Code § 33-51-9
Pharmacy Contracting	**Minimum Reimbursement:** A PBM may not reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the NADAC for the prescription drug or pharmacy service at the time the drug is administered or dispensed, plus a professional dispensing fee of $10.49. If the national average drug acquisition cost is not available at the time a drug is administered or dispensed, a PBM may not reimburse in an amount that is less than the	W. Va. Code § 33-51-9 W. Va. Code §33-51-11

	wholesale acquisition cost of the drug plus a professional dispensing fee of $10.49. A PBM may not discriminate in reimbursement or exclude a pharmacy from the PBM's network on the basis the pharmacy is a 340B entity. A PBM may not base pharmacy reimbursement for a drug on patient outcomes, scores, or metrics **Patient Steering:** A PBM may not reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the amount the PBM reimburses itself or an affiliate for the same prescription drug or pharmacy service. A PBM may not: • Prohibit or limit any covered individual from selecting a pharmacy or pharmacist of his or her choice who has agreed to participate in the health benefit plan according to the terms offered by the health benefit plan; • Impose upon a beneficiary of pharmacy services under a health benefit plan any copayment, fee, or condition that is not equally imposed upon all beneficiaries in the same benefit category, class, or copayment level under the health benefit plan when receiving services from a contract provider; • Impose a monetary advantage or penalty under a health benefit plan that would affect a beneficiary's choice among those pharmacies or pharmacists who have agreed to participate in the plan according to the terms offered by the insurer. Monetary advantage or penalty includes higher copayment, a reduction in reimbursement for services, or promotion of one participating pharmacy over another by these methods; • Reduce allowable reimbursement for pharmacy services to a beneficiary under a health benefit plan because the beneficiary selects a pharmacy of his or her choice, so long as that pharmacy has enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage area; • Prohibit or otherwise limit a beneficiary's access to prescription 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 unreasonably designating the covered prescription drug as a specialty drug; • Require a beneficiary, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy; or • Impose upon a beneficiary any copayment, amount of reimbursement, number of days of a drug supply for which reimbursement will be allowed, or any other	

	payment or condition relating to purchasing pharmacy services from any pharmacy, including prescription drugs, that are more costly or more restrictive than that which would be imposed upon the beneficiary if such services were purchased from a mail-order pharmacy or any other pharmacy that is willing to provide the same services or products for the same cost and copayment as any mail order service. • Limit a pharmacist, pharmacy, or pharmacy technician from providing a covered individual with information related to lower cost alternatives and cost share • Penalize a pharmacist, pharmacy, or pharmacy technician from discussing lower cost options including paying without a policy • Collect a cost share charged to covered individual that exceeds the total submitted charges to the PBM • Reimburse a 340B entity at a rate lower than that paid for the same drug in non-340B pharmacies • Place additional requirements, restrictions or burdens upon 340B entities that increase cost or administrative burden • Discriminate against a 340B entity in a manner that interferes with patient choice	
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A PBM may not collect from a pharmacy, a pharmacist, or a pharmacy technician a cost share charged to a covered individual that exceeds the total submitted charges by the pharmacy or pharmacist to the PBM. Cost sharing for each drug shall be calculated at the point of sale based on a price that includes all rebates received. **Copay Adjustment Programs:** When calculating an insured's contribution to any applicable cost-sharing requirement, a PBM shall include any cost-sharing amounts paid by the insured or on behalf of the insured by another person. For high-deductible health plans, this requirement shall only apply after a covered individual meets their minimum deductible to remain eligible for an HSA. **Copay Cap:** This requirement only applies to West Virginia public employee plans. A policy, plan, or contract that is issued or renewed on or after January 1, 2024, shall provide coverage for prescription insulin drugs and equipment. Cost sharing for a 30-day supply of a covered prescription insulin drug may not exceed $35 in aggregate, including situations where the covered person is prescribed more than one insulin drug, per 30-day supply, regardless of the amount or type of insulin needed to fill such covered person's prescription. Cost sharing for a 30-day supply of covered device(s) may not exceed $100 in aggregate, including situations where	W. Va. Code § 33-51-9 W. Va. Code §33-15-4t W. Va. Code §5-16-7g

	the covered person is prescribed more than one device, per 30-day supply. Each cost-share maximum is covered regardless of the person's deductible, copayment, coinsurance, or any other cost-sharing requirement.	

Wisconsin

Issue	Summary	Citation
Licensing/Registration	PBMs are required to obtain a license from the Insurance Commission. PBMs must apply and renew their license annually, in a form prescribed by the commissioner, along with a fee of $100.	WI Stat § 632.865 (3) WI Stat § 633.14
Reporting Requirements	By June 1 of each year, PBMs must submit a report related to contracts held with pharmacies located in Wisconsin that provides the following information from the prior calendar year: • The aggregate rebate amount that the PBM received from all pharmaceutical manufacturers. • Aggregate rebate amount retained but did to pass through to health benefit plan sponsors. • The percentage of the aggregate rebate amount that is retained.	WI Stat. § 632.865 (7)
PBM Income	N/A	
Pharmacy Contracting	**MAC Pricing:** The PBM shall agree in each contract or renewal to do all of the following: • Update MAC pricing information for prescribed drugs or devices at least every 7 business days and provide a means by which contracted pharmacies may promptly review pricing updates in a format that is readily available and accessible. • Reimburse pharmacists and pharmacies for prescribed drugs or devices subject to MAC information that has been updated at least every 7 business days. • Eliminate prescribed drugs or devices from the MAC information or modify MAC in a timely fashion consistent with availability of prescribed drugs or devices and pricing changes in the marketplace. A pharmacy benefit manger shall include in each contract with a pharmacy a process to appeal, investigate, and resolve disputes regarding MAC pricing that includes all of the following: • A 21-day limit on the right to appeal following the initial claim. • A requirement that the appeal be investigated and resolved within 21 days after the date of the appeal. • A dedicated telephone number at which the pharmacy may contact the PBM to speak to a person responsible for processing appeals. • A requirement that a PBM provide a reason for any appeal denial and the NDC published in a directory	WI Stat § 632.865 (2)

	by the federal food and drug administration of a prescribed drug or device that may be purchased by retail network pharmacies at a price at or below the MAC. • A requirement that a PBM make a pricing adjustment no later than 1 day after the date of the final determination of the appeal.	
Patient Cost Sharing	**Maximum Cost-Sharing Levels:** A PBM may not require a covered individual to pay an amount at the point of sale that exceeds the lesser of: • The cost-sharing amount for the prescription drug under the terms of the plan or policy, or • The amount the enrollee or insured would pay without using any health plan of health insurance coverage.	WI Stat § 632.861 (3)

Wyoming

Issue	Summary	Citation
Licensing/Registration	PBMs must obtain a license from the Department of Insurance. Licenses must be renewed annually. Both initial application and renewal fees are currently set at $500.	Wyo. Stat. § 26-52-101
Reporting Requirements	N/A	
PBM Income	N/A	
Pharmacy Contracting	**MAC Pricing:** To place a drug on a MAC list, a PBM shall ensure that the drug is: • A generically equivalent drug, rated "A" or "B" in the most recent version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book), or rated "NR" or "NA," or has a similar rating, by a nationally recognized reference; • Generally available for purchase by retail pharmacies in the state from national or regional wholesalers; and • Not obsolete or temporarily unavailable. A PBM shall: • Make available to each network provider at the beginning of the term of the network provider's contract, and upon renewal of the contract, the sources utilized to determine the MAC pricing; • Provide a telephone number, email address and website at which a network pharmacy or the pharmacy's designee who holds a contract with the PBM may contact an employee of a PBM to discuss the pharmacy's appeal; • Provide a process for network providers to readily access the MAC applicable to that provider; • Review and update applicable MAC price information at least once every 7 business days to reflect any modification of MAC pricing; and • Ensure that dispensing fees are not included in the calculation of MAC.	Wyo. Stat. § 26-52-104

	A PBM shall establish a process by which a contracted pharmacy, or the pharmacy's designee who holds a contract with the PBM, can appeal the provider's reimbursement for a drug subject to MAC pricing. • A contracted pharmacy, or the pharmacy's designee who holds a contract with the PBM, shall have up to 10 business days after dispensing a drug subject to a MAC in which to appeal the amount of the MAC. • A PBM shall respond to the appeal within 10 business days after the contracted pharmacy or the pharmacy's designee who holds a contract with the PBM makes the appeal. • If a MAC appeal is denied, the PBM shall provide to the appealing pharmacy, or the pharmacy's designee who holds a contract with the PBM, the reason for the denial and the NDC number for the drug that is available for purchase by similarly situated pharmacies in the state and the names of national or regional wholesalers that have the product available for purchase at a price that is at or below the MAC. • If an appeal is upheld, the PBM shall make an adjustment to the applicable MAC no later than 1 day after the date of the determination and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the insurer or PBM. The PBM shall allow the appealing pharmacy to reverse and rebill the claim which was the subject of the appeal. • A PBM shall not prevent a network pharmacy or the pharmacy's designee who holds a contract with the PBM from filing appeals in an electronic batch format. The PBM shall respond in an electronic format to valid reimbursement appeals filed in an electronic batch format. A batch appeal shall not be considered a valid appeal unless all required information for each claim in the batch is submitted electronically with the correct, contractually required information and in the required format. An appeal shall not be considered valid for purposes of the 10-day response timeframe until all information is received.	
Patient Cost Sharing	N/A	