MINTZ

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PBM

Policy and Legislative Update

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The PBM regulatory landscape is evolving rapidly at both the federal and state levels, making it critical for our clients involved in the PBM space to stay apprised of developments in the industry as they happen. Our team actively monitors these to provide you with this quarterly *PBM Policy and Legislative Update*. This update builds on prior issues and highlights federal and state activity from October 2025 to mid-February 2026.

FEDERAL LEGISLATIVE ACTIVITY AND OVERSIGHT

Federal Legislative Activity

Congress Enacts Landmark PBM Reforms in the 2026 Spending Bill. On February 3, 2026, Congress passed – and the President signed – the Consolidated Appropriations Act, 2026 (CAA 2026). The legislation includes a long-anticipated and far-reaching package of PBM reforms. These reforms draw from the PBM Reform Act of 2025 and other legislative proposals and will significantly reshape PBM operations across the commercial market and Medicare Part D beginning in 2028–2029. The reforms center on rebate pass-through, increased transparency, standardized reporting, and expanded federal oversight. Stakeholders should begin preparing for material operational and contractual changes well ahead of the effective dates. See our blog post for more information.

DOL Proposes New PBM Fee Disclosure Rule. On January 30, 2026, the Department of Labor released a proposed rule that would end long-running confusion about how ERISA disclosure obligations apply to PBMs under the Consolidated Appropriations Act, 2021, and give fiduciaries of ERISA-covered self-insured group health plans significantly expanded visibility into PBM services and compensation. The proposal pairs broad compensation transparency with comprehensive audit rights covering PBMs and their affiliates, agents, and subcontractors, including PBM-affiliated brokers and consultants. See our blog post for more information.

// Featured Webinar Recording 🎥

PBM Reform 2026: What Recent Legislation Means for the Industry

PBM reform 2026 is reshaping how PBMs and plan sponsors operate, as Congress and federal agencies introduce new compliance requirements and enforcement standards. With multiple reforms moving forward at once, many organizations are asking: what changed, what's required, and what comes next?

Mintz attorneys led a practical discussion on what these changes mean for organizations. They broke down the key provisions of the CAA 2026 PBM reforms, explored the DOL's proposed rule and its implications for plan sponsors and PBMs, examined recent FTC settlements, and assessed how the administration's drug pricing initiatives might shape the market going forward.

👉 Watch the webinar recording to gain practical insights into navigating PBM reform and preparing for what's next.

Break Up Big Medicine Act Reignites Debate Over Vertical Integration. Senators Warren and Hawley introduced the Break Up Big Medicine Act, which proposes structural separation requirements across multiple segments of the health care market. Compared to the earlier Patients Before Monopolies Act, the Break Up Big Medicine Act includes broader bans on common ownership between insurers, PBMs, pharmacies, wholesalers, and a wide range of health care providers. It would also accelerate divestiture timelines, introduce new private rights of action, and authorize treble damages. Although the bill's prospects remain uncertain, its introduction reflects bipartisan interest in addressing consolidation across the health care delivery and financing ecosystem.

Senate Finance Committee Democrats Outline 2026 Drug Pricing Priorities. Senate Finance Committee Democrats circulated a policy letter outlining their goals for lowering drug costs. Priorities include expanding Medicare's negotiation authority, incorporating international prices as reference points within the negotiation process, accelerating negotiation timelines, and addressing generic drug price markups. The letter also calls for delinking PBM compensation from list prices and improving cost-sharing alignment for patients. Committee staff indicated that draft legislative text would follow later in the year.

Congress Intensifies Scrutiny of PBMs and Drug Supply Chain Practices. Congress continued high-profile oversight of the prescription drug supply chain in early 2026, with the House Committee on Energy & Commerce Health Subcommittee holding a wide-ranging hearing on February 11. Witnesses from pharmaceutical manufacturers, PBMs, wholesalers, GPOs, community pharmacies, and employer groups described a system defined by consolidation, limited transparency, and conflicting incentives. Members of both parties pressed PBM executives on formulary design, rebate structures, offshore GPO arrangements, and reimbursement practices that independent pharmacies say pay below acquisition cost. Lawmakers on both sides expressed interest in increasing transparency and strengthening biosimilar competition, while noting that newly enacted PBM reforms in the FY2026 appropriations bill will require continued oversight as implementation progresses.

The February 11 hearing was the second in a three-part subcommittee series on health care affordability. The first, held January 22, featured testimony from CEOs of several major insurance companies, who faced bipartisan criticism on some of the same themes, particularly vertical integration and related consolidation concerns. A third hearing, focused on health care providers, was held in March.

House Judiciary Staff Report Highlights Concerns About CVS Practices. The House Judiciary Committee released an interim staff report describing CVS's actions to limit independent pharmacy use of hub services and digital pharmacy platforms. The report asserts that CVS leveraged network contracts, audits, and cease-and-desist letters to discourage pharmacies from partnering with competing service providers, raising questions about the impact of vertical integration on competition. According to the report, CVS asserted that its oversight efforts were driven by plan sponsor fraud allegations and were not designed to single out competing pharmacy support platforms. The findings signal growing congressional concern about cross-entity ownership structures and their effects on patient access and pharmacy choice.

CMS Advances Drug Pricing Reform Through Four CMMI Models. The CMS Innovation Center announced several models aligned with the Trump administration's drug pricing initiatives. The proposed models outline frameworks targeting different areas of federal health programs and introduce new ways to address the cost of high-spend drug therapies:

- **GLOBE** *(Global Benchmark for Efficient Drug Pricing).* Mandatory rebates for certain Medicare Part B

drugs if US prices exceed those paid in economically comparable countries, targeting high-cost drugs administered in clinical settings such as oncology and autoimmune therapies.

- **GUARD** *(Guarding US Medicare Against Rising Drug Costs).* Mandatory rebates for certain Medicare Part D drugs if the US prices exceed those paid in economically comparable countries.
- **GENEROUS** *(Generating Cost Reductions for US Medicaid).* A voluntary supplemental model under which manufacturers, through CMS-led negotiations, will provide supplemental rebates to participating states for certain drugs to align Medicaid net prices with prices paid in certain other countries.
- **BALANCE** *(Better Approaches to Lifestyles and Nutrition for Comprehensive Health).* A voluntary model that seeks to expand access to GLP-1 medications alongside lifestyle interventions, aiming to prevent chronic disease and reducing the potential financial barriers to GLP-1 access in Medicare and Medicaid. Additionally, the BALANCE model seeks manufacturer commitment to participate in lifestyle-focused patient interventions.

Collectively, the CMMI models further signal the administration's commitment to formalizing international reference-based drug pricing as a federal policy tool and aim to embed global price comparisons into Medicare and Medicaid. For manufacturers, the proposed models signal continued scrutiny of US drug prices, along with the risk of substantial rebate obligations tied to international pricing benchmarks. In comments to CMS, industry groups (e.g., PhRMA and BIO) strongly opposed the models and questioned CMS's authority to implement them, signaling that legal challenges are likely.

FTC UPDATES

On February 4, 2026, the FTC announced a settlement with Express Scripts Inc. (ESI) resolving its 2024 lawsuit alleging that ESI's rebate practices were uncompetitive and led to the artificial inflation of insulin prices.

As part of the settlement, ESI agreed to, among other things:

- Stop preferring high-WAC drugs over low-WAC alternatives on its standard formulary
- Provide standard offering that ensures members' OOP costs are based on drug's net price, not list price
- Provide plans and beneficiaries with access to TrumpRx as part of its standard offering
- Provide a standard offering that allows plans to transition off rebate guarantees and spread pricing
- Delink manufacturer's compensation to ESI from list prices as part of its standard offering
- Increase transparency with drug-level reporting
- Standard offering to include retail pharmacies will receive cost-plus reimbursement
- Move Ascent Health Services GPO from Switzerland to US
- Promote standard offerings to plans & retail pharmacies
- Increased Oversight, Access, and Enforcement by the FTC, including compliance with multiyear monitoring requirements, submission 0f compliance reports as required by the FTC, cooperation with litigation in certain contexts, and granting FTC access to facilities, personnel, and records as FTC deems necessary

These requirements align with federal PBM reform activities and will transform ESI's offering. We expect CVS and Optum Rx to enter into similar settlement agreements.

Since we went to publication, CVS announced that it reached a settlement in principle with the FTC, which was sent to the Commission for review on March 23, 2026.

Updates on Trump Administration Initiatives

Direct-to-Consumer Platforms. Direct-to-Consumer (DTC) platforms are emerging as accessible and convenient alternatives for obtaining certain prescription medications. Rather than relying on traditional pharmacy channels and insurance coverage, DTC platforms allow patients to purchase their medications directly from manufacturers, often at heavily discounted prices. As discussed in the TrumpRx section below, lawmakers have raised questions and concerns about the DTC platforms that the administration has largely tried to address.

The "Great Healthcare Plan". On January 15, 2026, President Trump formally called on Congress to enact the "Great Healthcare Plan" (the Plan), which targets health insurance reform and reemphasizes the Trump administration's goal of reducing drug pricing.

The Plan Blueprint

1. *Lowering Drug Prices via MFN Deals and OTC Access.*

The Plan seeks to reduce costs by (1) codifying the recently negotiated Most Favored Nation (MFN) deals between the administration and manufacturers (discussed in more detail below), and (2) making more drugs available for over-the-counter (OTC) purchase. These changes are expected to increase price transparency and competition, and reduce costs associated with physician visits.

Although each MFN agreement was announced publicly, the exact details of the agreements remain largely confidential. As a result, the scope and impact of the MFN pricing deals cannot be independently evaluated. This limited information led to additional inquiries by congressional leaders who express concern over the opacity of the MFN agreements.

2. *Lowering Insurance Premiums*.

The Plan aims to lower insurance premiums by "sending money directly to the American people, lower[ing] health insurance premiums, and cut[ting] kickbacks that raise insurance premiums."

President Trump's call to Congress proposed the following:

- Replacing the ACA's premium subsidies (which expired in 2025) with direct payments to "eligible Americans to allow them to buy the health insurance of their choice."
- Resurrecting a cost-sharing reduction (CSR) program for ACA health care plans to reduce premiums on the most common ACA plans by over 10%.
- Ending "kickbacks paid by pharmacy benefit managers (PBMs) to the large brokerage middlemen that deceptively raise the cost of health insurance." The administration did not identify what payments from PBMs to brokers would be considered "kickbacks."

Notably, the announcement lacked detail regarding the criteria for eligibility, how funds would be delivered to those eligible, and the types of plans to be available for purchase, including whether such plans would be required to meet the ACA's minimum coverage requirements.

3. *Holding Health Insurers Accountable*.

The Plan calls for health insurers to make insurance rate and coverage comparisons available to consumers on their websites in "plain English." It also requires health insurers to engage in transparency efforts, including publication on their websites of total revenues, overhead costs, profits, claim costs, claim rejections, and average wait times for care. Some of this information is already published under the medical loss ratio requirement (e.g., claims revenue and administrative costs).

4. *Maximizing Price Transparency*.

The Plan requires Medicare and Medicaid providers and insurers to "prominently post their prices and fees…and ensure insurance companies are complying with price transparency requirements." This mirrors the measures that require hospitals and insurance companies to post prices in various forms, and will now require hospitals and insurance companies to provide patients with upfront cost information before services are delivered.

Updates on Trump Administration Initiatives (*con't*)

MFN Deals with Manufacturers. As noted in the Plan, the Trump administration struck a series of MFN pricing deals with most of the 17 manufacturers that received letters from President Trump on July 31, 2025. We closely follow these developments, for more information see our posts:

- A Pivotal Week for Pharmaceutical Policy: Trump Administration Advances Tariff and Drug Pricing Initiatives published October 7, 2025
- Pharmaceutical Policy in Motion: Updates on the Trump Administration's Drug Pricing Initiatives published November 13, 2025
- Pharmaceutical Policy in Motion: Trump Inks Nine New Drug Pricing Deals published December 23, 2025

Under these agreements, manufacturers voluntarily committed to lowering US drug prices to match the lowest prices in other wealthy nations. The MFN deals also include commitments for the manufacturers to reinvest in US-based drug research and development.

During the February 11 House Committee on Energy & Commerce Health Subcommittee meeting, members of Congress raised concerns that MFN pricing, as currently structured, may not address underlying affordability issues and could create additional uncertainty for the drug supply chain. In addition, witness testimony noted that the lack of public information about the MFN agreements limits the ability of plans, PBMs, and patients to evaluate their impact.

Since we went to publication, Congress increased its oversight of the Trump administration's MFN initiatives. As we recently reported, congressional leaders sent several letters to President Trump and manufacturers requesting details about the MFN deals.

Tariffs

Tariffs on Manufacturers and Manufacturer Commitments to US-Based Pharmaceutical Production. As we previously reported, the Trump administration is investigating ways to levy Section 232 tariffs on manufacturers. However, manufacturers that entered into an MFN deal will be granted immunity from potential Section 232 tariffs for three years in exchange for their commitment to investing hundreds of millions of dollars into US-based manufacturing efforts, including medication research and development. Additionally, some manufacturers also agreed to donate substantial quantities of active pharmaceutical ingredients for key products to the Strategic Active Pharmaceutical Ingredients Reserve as a way to "reduce [the United States'] reliance on foreign nations and ensure [it] has an adequate supply of such products in the event of an emergency."

TrumpRx

Congress Members' Concerns Over DTC Federal Programs. On October 23, 2025, following the Trump administration's announcements of the development of the DTC platform TrumpRx, the House Committee on Ways and Means, House Committee on Energy & Commerce, and the Senate Committee on Finance sent a letter to the Secretary of the US Department of Health & Human Services (HHS) requesting information about the DTC platform contemplated by the administration and expressing concern over whether any such DTC platform will meaningfully reduce drug prices for the American people. In the letter, the committees also state their apprehension regarding the federal government's involvement in developing and running DTC programs and inquire as to whether this practice could benefit manufacturers and other third parties in ways that outweigh the benefit to consumers. The questions directed at Robert F. Kennedy Jr. and HHS in the committees' letter request detailed information regarding the program, including, among other things, questions pertaining to data ownership, treatment of PHI, consumer access, and the selection of drugs.

The Launch of TrumpRx. On February 5, 2026, the Trump administration officially launched TrumpRx.gov, resolving many of the questions the committees posed in their October 23 letter. As of the launch date, the website displays discounted drug pricing from manufacturers and provides instructions for patients to access the discounted pricing. The platform currently contains pricing information for drugs offered by the first five manufacturers that reached MFN pricing deals (AstraZeneca, Eli Lilly, EMD Serono, Novo Nordisk, and Pfizer). Additional MFN-priced drugs from other manufacturers that reached pricing deals with the

Updates on Trump Administration Initiatives (*con't)*

Trump administration are expected to go live in the coming months.

Via the TrumpRx.gov website, patients will have access to discounted pricing on 40 brand drugs, which include GLP-1s, fertility medications, and asthma inhalers, among other drugs. Patients can print or download coupons with the discounted pricing from the website or otherwise retrieve the coupons through manufacturer-integrated channels within TrumpRx.gov.

A patient who uses TrumpRx.gov coupons will need to pay out-of-pocket for the prescription drug (i.e., the patient cannot use their pharmacy insurance benefits). The website notes that "these coupon programs can be used at local pharmacies on a nationwide basis, with the exception of certain specialty drugs" and that some drugs "are only available at discounted prices through the manufacturer's website." The website also notes that for those drugs that do not have a coupon listed on TrumpRx.gov, the discounted pricing can be accessed "through the manufacturer's own direct-to-consumer website or through a limited set of mail order pharmacies."

OIG Special Advisory Bulletin. On January 27, 2026, the Office of the Inspector General (OIG) issued a Special Advisory Bulletin stating that direct-to-consumer sales by manufacturers is low risk under the Anti-Kickback Statute (AKS). OIG states that a manufacturer is unlikely to violate the AKS when providing DTC access to patients as long as "(i) the prescription drug is not billed to a Federal health care program, (ii) the sale of the prescription drug is not conditioned on the current or future order or purchase of any other item or service that is or could become billable to a Federal health care program, (iii) the arrangement aligns with the other characteristics [of the AKS requirements]."

While the OIG limited its AKS analysis to the patient-manufacturer relationship as it relates to DTC programs, OIG noted that it intends to expand its analysis to other manufacturer relationships (e.g., with physicians, pharmacies, and PBMs) and will issue separately a "request for information to seek public feedback with respect to rulemaking or guidance, if any, that is needed regarding the application of certain fraud and abuse laws to such arrangements as they relate to DTC sales."

STATE LEGISLATION AND LITIGATION

Recently Enacted State Legislation

Between October 2025 and mid-February 2026, several states enacted legislation imposing new requirements on PBMs across a wide range of regulatory areas.[1] These enactments reflect the continued expansion and refinement of state PBM oversight frameworks, with significant implications for PBMs, pharmacies, health insurers, and other stakeholders in the prescription drug supply chain.

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
Alabama	S.B. 43. This law establishes the right of a health care provider (including a pharmacist) to provide a patient with information about the cost of a drug (including the cost without insurance), the amount allowed for payment, and cost-sharing amounts, as well as information about less-expensive treatments or drugs and comparative effectiveness of treatments or drugs. A health insurer (defined to include a PBM) cannot cancel or refuse to renew a contract or take other adverse action against a health care provider for providing such information to a patient or customer. Any contractual provision between a health insurer and a health care provider that prohibits sharing such information or imposes a penalty or disincentive for sharing such information is unenforceable.	5/14/2025	10/1/2025
California	S.B. 40. This law caps copayments, coinsurance, deductibles, or other cost-sharing for a 30-day supply of insulin at $35, effective January 1, 2026 for large-group health plans and January 1, 2027 for individual and small-group plans. It also requires that at least one insulin in each drug type, form, and concentration be included on the formulary and prohibits step therapy protocols for insulin coverage, except where at least one insulin per drug type is available without step therapy. These provisions do not apply to Medi-Cal managed care plans.	10/13/2025	1/1/2026 (Large-group plans) 1/1/2027 (Small-group plans)

[1] This section primarily covers state laws enacted between October 2025 and mid-February 2026. It also includes select state laws enacted during 2025 that were not addressed in prior editions of this publication, reflecting ongoing review of state legislative activity and the evolving practical significance of these measures.

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	S.B. 41. This law requires PBMs contracting with health plans or insurers to be licensed by the California Department of Managed Health Care by January 1, 2027 and subjects them to audits, investigations, and civil penalties for violations. It bans spread pricing in PBM contracts executed or amended on or after January 1, 2026 and voids such terms by January 1, 2029. PBMs must use a pass-through pricing model, disclose PBM fees, and remit 100% of manufacturer rebates to payers to reduce member costs. The legislation prohibits steering patients exclusively to affiliated pharmacies, bars discriminatory reimbursement against nonaffiliated pharmacies, and requires patient cost-sharing to reflect the actual amount paid by the plan or insurer.	10/11/2025	1/1/2027 (licensure and compliance requirements) 1/1/2026 (Spread pricing ban)
Colorado	H.B. 1094. This law prohibits a PBM from earning any income based on the price or cost of a drug, including spread pricing. It also prohibits a PBM from favoring a branded drug or biologic in its formulary unless it has a lower net acquisition cost and lower out-of-pocket expense than the equivalent generic or biosimilar. Under this law, a PBM must reimburse a pharmacy in an amount equal to the national average drug acquisition cost for the drug ingredients plus a reasonable and adequate dispending fee. The law also requires that a contract between a PBM and a health plan obligate the PBM to disclose certain drug cost information to the plan and must allow the plan to annually audit the PBM for compliance with the contract.	5/30/2025	1/1/2027
	H.B. 1222. This law requires a PBM to reimburse a rural independent pharmacy in an amount that is at least the national average drug acquisition cost for the drug ingredients plus a dispensing fee. The law also requires a PBM to follow certain procedures when recouping funds from, or assessing a penalty against, a rural independent pharmacy of more than $1,000. It also prohibits a PBM from restricting a rural independent pharmacy from using a private courier or delivery service to deliver a drug to a patient.	5/27/2025	8/6/2025 1/1/2026 (minimum reimbursement rates to rural independent pharmacies)

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
Georgia	H.B. 196. This law requires an insurer (defined to include a PBM) that provides coverage or services for a state employee health insurance plan to reimburse a pharmacy for a self-administered drug in an amount at least equal to the national average drug acquisition cost plus a dispensing fee not less than $10.50 for chain pharmacies and $11.50 for independent pharmacies.	5/14/2025	1/1/2026
Illinois	H.B. 767. This law amends several provisions of the law enacted by H.B. 1697, which took effect on July 2025 and imposed significant new obligations and restrictions on PBMs. Among key changes, the law extends certain substance requirements to insurers in addition to PBMs, and clarifies that PBM reports and the $15-per-member fee due under Section 513b2(f) are calculated based on the number of Illinois residents who are covered individuals. The law also revises and expands key definitions by expressly adopting federal plan definitions from ERISA and the Public Health Service Act, and requires PBMs that over- or under-reported their initial 2025 covered individual counts to file revised reports and make corresponding fee adjustments.	12/2/2025	12/2/2025
Indiana	S.B. 140. This law requires an insurer, PBM, or other administrator of pharmacy benefits to ensure that its pharmacy network is reasonably adequate and accessible, which includes offering an adequate number of pharmacies that are not mail-order pharmacies. An annual report to the insurance commissioner on the pharmacy network is required. The law also imposes limitations on recoupment of payments from pharmacies, sets a floor on pharmacy reimbursements (which must be at least the amount paid to affiliated pharmacies for the same drug), prohibits restricting a pharmacist from providing insureds with information about lower-cost alternatives, and prohibits discrimination against pharmacies in network participation.	5/6/2025	1/1/2026
	H.B. 1666. This law requires that each insurer, PBM, and TPA doing business in the state file an annual	5/6/2025	7/1/2025

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	report disclosing the name (and certain other information) of each person or entity with (1) an ownership interest of at least 5%, (2) a controlling interest, or (3) an interest as a private equity partner.		
	H.B. 1604. This law requires a PBM to apply to an insured's cost-sharing requirement any amounts paid by the individual or on behalf of the individual by another person. The PBM may not set, alter, implement, or condition coverage or benefit design based on the financial assistance available for a drug.	5/6/2025	1/1/2026
Maryland	H.B. 970 / S.B. 646. This law prohibits an insurer (including through a PBM) from imposing step therapy requirements for insulin to treat diabetes.	5/20/2025	1/1/2026
	H.B. 820. This law applies to insurers or PBMs using AI, algorithms, or other software tools for utilization review. The law sets standards for use of such tools, including, among other things, that the tool does not result in unfair discrimination and is open for inspection or audit by the insurance commissioner.	5/20/2025	10/1/2025
	H.B. 1243 / S.B. 975. This law prohibits an insurer (including through a PBM) from excluding coverage for specialty drugs administered or dispensed by a provider, if certain conditions are met.	5/20/2025	1/1/2026
	H.B. 1087 / S.B. 921. This law prohibits an insurer (including through a PBM) from imposing step therapy requirements for a drug prescribed to treat a symptom or side effect of stage four advanced metastatic cancer.	5/20/2025	1/1/2026
Montana	H.B. 740. This law sets a floor for reimbursement of independent pharmacies, which is not less than the national average drug acquisition costs plus a minimum $15 dispensing fee (subject to annual increase). It also prohibits insurers and PBMs from charging pharmacies fees, such as fees for submitting claims, fees for enrolling in a retail pharmacy network, or credentialing fees. The law establishes	5/8/2025	10/1/2025

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	required timelines for processing of pharmacy credentialing applications and ownership changes. It prohibits a PBM or insurer from excluding new or recently opened pharmacies from a pharmacy network. It prohibits effective rate contracting and spread pricing and contains provisions to prevent steering to affiliated pharmacies.		
Nebraska	L.B. 198. This law, which amends existing PBM licensure law, adds several new restrictions on PBMs. It prohibits a PBM from applying terms and conditions to an unaffiliated specialty pharmacy that are stricter than those applied to an affiliated specialty pharmacy and prohibits a PBM from requiring unnecessary reporting from specialty pharmacies. The law also restricts PBMs from imposing certain requirements on pharmacies or covered persons in the context of clinician-administered drugs. It also contains anti-steering and pharmacy choice provisions, as well as other protections for pharmacies. The law bans spread pricing in new contracts as of January 1, 2026 and in all contracts (including extensions of existing contracts) as of January 1, 2029.	6/6/2025	1/1/2026
New Jersey	A.B. 5217. This law requires health plans to count any amount paid by an enrollee, or by another party on the enrollee's behalf, toward the enrollee's applicable cost-sharing obligations, including copayments, coinsurance, deductibles, and out-of-pocket maximums. The bill would also prohibit copay maximizer programs and alternative funding programs for prescription drugs. Each PBM operating in the state would be required to annually certify compliance with these requirements.	1/9/2026	4/9/2026 (90 days after enactment)
	S.B. 2019. This law authorizes pharmacists to dispense HIV preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) without an individual prescription under specified clinical protocols. Health plans across all plan types would be required to cover pharmacist-dispensed PrEP and PEP without prior authorization or step therapy. The law also requires pharmacist reimbursement at rates no less than	1/9/2026	1/9/2026

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	those provided to other non-physician practitioners for equivalent services. Coverage for pharmacist-dispensed PrEP without an individual prescription would be limited to a 90-day supply per patient within any two-year period.		
New Mexico	S.B. 39. This law adds to the list of conditions for which prior authorization or step therapy are prohibited or restricted.	4/7/2025	7/1/2025
North Dakota	H.B. 1584. This law creates a process for a PBM to apply for a license. It also requires PBMs to offer pharmacies opt-in contracts with at least 30 days to respond and to allow a pharmacy to opt out of a contract with 90 days' notice. It also creates new administrative penalties for violations of the law governing PBMs, as well as an enforcement fund available to the insurance commissioner to enforce such law.	4/28/2025	4/28/2025 1/1/2026 (licensing provisions)
Oklahoma	S.B. 993. This law amends the existing Pharmacy Audit Integrity Act. The law places new limits on pharmacy audits conducted by PBMs, insurers, and similar entities, including establishing limits on fines and penalties and introducing new procedural and reporting requirements. The law also amends existing law governing a pharmacy's appeal of below-cost reimbursement.	5/22/2025	5/22/2025
	S.B. 789. This law, which amends existing law, adds requirements for PBMs that lease provider networks to other PBMs. The law requires such PBMs to provide notice to all contracted pharmacies of the lease arrangement and information about which contract a claim was adjudicated against. The law also prohibits effective rate contracting.	5/28/2025	11/1/2025
	H.B. 1808. This law addresses prior authorization requirements for prescription drugs. It includes transparency and notice requirements for prior authorization, requires that adverse determinations are made (and appeals are reviewed) by certain medical professionals, sets time frames for prior	5/29/2025	11/1/2025

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	authorization determinations, and prohibits prior authorization for drugs administered as part of emergency health care services.		
Rhode Island	H.B. 5248 / S.B. 314. This law modifies existing law governing audits of pharmacies by establishing a new requirement that a pharmacy may not be subject to more than one on-site audit in connection with a carrier every 12 months, except if there is an identified problem or suspicion of fraud or misrepresentation.	6/30/2025	6/30/2025
Tennessee	H.B. 37. This law permits an insurer offering a plan that covers state employees to adopt or amend a state preferred drug list. The state preferred drug list must ensure that a non-opioid drug approved to treat pain is not disadvantaged or discouraged with respect to coverage relative to an opioid or narcotic drug.	4/28/2025	1/1/2026
	H.B. 1244 / S.B. 881. This law removes existing caps on penalties imposed by the insurance commissioner for violation of any statute, rule, or order by a PBM. The law also makes PBMs subject to prompt payments requirements to pharmacists and the penalties set forth therein.	5/9/2025	5/9/2025

Pending State Legislation

State legislators introduced over 124 bills between October 2025 and mid-February 2026. Please click here for our standard chart categorizing the state proposals by topic.

State Law Challenges

Industry Groups Press Eighth Circuit on Enforcement of Arkansas Law Prohibiting PBM Pharmacy Ownership. In an appeal to the Eighth Circuit, pharmacy and provider trade groups are urging the court to reject a lower court's decision to preliminarily enjoin an Arkansas law banning PBMs from owning or operating in-state pharmacies. The law, Act 624, was enacted in April 2025 and was quickly challenged by major PBMs and their trade association, the Pharmaceutical Care Management Association (PCMA). As we discuss in our blog, a federal judge granted a preliminary injunction to those entities, prompting a swift appeal by the Arkansas State Board of Pharmacy. In support of the Board, the National Community Pharmacists Association (NCPA) and the Arkansas Pharmacists

Association (APA) filed a brief with the court, highlighting what they view as an "inherent conflict of interest" resulting from PBM ownership and operation of pharmacies. The Community Oncology Alliance (COA) similarly emphasized what it views as "structural conflicts of interest" created by PBM industry consolidation and vertical integration within "large health-care conglomerates" in a separate brief supporting the state pharmacy board.

Voicing support for the PBMs, America's Health Insurance Plans (AHIP), submitted its own brief arguing that Act 624's pharmacy ownership restrictions would further exacerbate existing lack of pharmacy access ("pharmacy deserts") and drug affordability issues for patients within Arkansas and beyond its borders.

As other states such as Oklahoma, Pennsylvania, and Tennessee consider similar measures to restrict PBMs' ability to own and operate pharmacies, the outcome of this litigation will provide useful insight on how those legislatures may move forward with such efforts — or, perhaps, whether to move forward at all.

Seventh Circuit Asked to Affirm Dismissal of ERISA Preemption Challenge. The Arkansas Insurance Commissioner is urging the Seventh Circuit not to revive a legal challenge to Arkansas's Rule 128, which regulates PBM reimbursements to pharmacies. Rule 128 requires group health plans to pay pharmacies a drug-dispensing fee if a PBM that manages the plan's prescriptions fails to reimburse a pharmacy in amounts that the commissioner determines are not "fair and reasonable." Central States Teamsters' self-funded health plan challenged the rule, arguing that it impermissibly regulates ERISA plans. An Illinois district court previously upheld Rule 128 in September 2025, finding that the rule did not "relate to" ERISA plans in a way that would trigger preemption, and emphasizing that the rule applies broadly to all health plans and functions primarily as a cost regulation. This reasoning builds directly on the Supreme Court's 2020 *Rutledge* ruling, which allowed states to regulate PBM reimbursement rates without violating ERISA and which sparked the wave of state-level PBM reform legislation that has followed. The Seventh Circuit's decision could further clarify the boundaries of ERISA preemption and states' authority to regulate PBM practices.

PCMA Challenges California's PBM Fiduciary Duty to ERISA Plans. PCMA filed suit in the US District Court for the Eastern District of California, challenging the fiduciary duty imposed on PBMs serving ERISA-governed plans under California's Senate Bill 41 (S.B. 41). S.B. 41 imposes sweeping new requirements on PBMs operating in the state, and PCMA is arguing that S.B. 41's fiduciary duty requirements are preempted by ERISA as applied to self-funded employer plans. The complaint contends that imposing fiduciary obligations on PBMs effectively regulates the administration of ERISA plans, which falls squarely within federal preemption. The case could test whether state PBM fiduciary duty laws survive ERISA preemption scrutiny and its outcome could set important precedent for similar reforms nationwide.

Iowa Senate File 383: PBM Reform Law Faces Mounting Legal Challenges. Iowa Senate File 383 (S.F. 383), signed into law on June 11, 2025, imposed wide-ranging new requirements on PBMs operating in the state's commercial insurance market. The law mandates pass-through pricing, requires 100% rebate pass-through, sets minimum pharmacy reimbursement at NADAC (or WAC) plus a $10.68 dispensing fee, prohibits patient steering, imposes any-willing-provider requirements, and bans copay accumulator programs. On July 21, 2025, following a lawsuit by the Iowa Association of Business and Industry (ABI) and several ERISA-covered plans, the U.S. District Court for the Sothern District of Iowa issued a preliminary injunction in *Iowa Association of Business and Industry (ABI) et al v. Ommen*, blocking enforcement of several core provisions, including the dispensing fee, anti-steering rules, and any-

willing-provider requirements, finding them preempted by ERISA and, in part, violative of the First Amendment. Critically, the court limited relief to the named plaintiffs, leaving S.F. 383 enforceable against all other regulated entities.

On September 24, 2025, Iowa Insurance Commissioner Doug Ommen issued a bulletin announcing his intent to enforce S.F. 383 "in its entirety" against all non-party entities, prompting additional lawsuits, which triggered additional litigation. The preliminary injunction in *ABI v. Ommen* was appealed to the U.S. Court of Appeals for the Eighth Circuit by both sides — Commissioner Ommen seeking to reinstate the enjoined provisions and ABI cross-appealing to broaden the injunction's scope beyond the named plaintiffs. Amicus activity has been significant: pharmacy trade groups filed a brief in October 2025 supporting the state's defense of S.F. 383, while the ERISA Industry Committee, the American Benefits Council, and America's Health Insurance Plans filed a brief in December 2025 urging the court to uphold and expand the injunction. On February 13, 2026, the State filed its appellate brief urging the Eighth Circuit to lift the preliminary injunction, arguing that the blocked provisions are valid exercises of traditional state insurance regulation and that the lower court misapplied ERISA preemption and the First Amendment doctrine.

The Eighth Circuit's decision in *ABI v. Ommen* remains pending and is expected to be a pivotal development in State PBM reform, which we are watching closely.

State Regulation of PBMs and ERISA Preemption. In *McKee Foods Corp. v. BFP, Inc.*, a Tennessee district court struck down key provisions of the state's laws regulating PBMs and other covered entities, including plans governed by ERISA. The challenged laws required PBMs and covered entities to admit any willing pharmacy into their pharmacy networks while prohibiting them from incentivizing plan participants to use specific pharmacies via differential copays or other financial incentives. The court concluded that both the "any willing pharmacy" requirements and the restrictions on participant incentives were preempted by ERISA because they impermissibly interfered with ERISA plan design and administration. The case is now on appeal in the Sixth Circuit, which heard oral arguments in December 2025. Given the Supreme Court's June 2025 decision not to review *Mulready v. PCMA*, in which the Tenth Circuit invalidated similar "any willing provider" and patient incentive restriction laws in Oklahoma, the extent of states' ability to regulate PBMs without violating ERISA remains uncertain as conflicting views take hold among appeals courts.

Since we went to publication, the Sixth Circuit affirmed the district court's ruling, agreeing that ERISA preempts Tennessee's "any willing provider" law and related restrictions on financial incentives designed to steer plan participants to specific pharmacies, casting further doubt on the enforceability of the expanding body of state legislation targeting PBM practices.

State Enforcement

CVS and Oklahoma AG Reach $5 Million Settlement Regarding Below-Cost Pharmacy Reimbursements. CVS agreed to pay more than $5 million to settle allegations from the Oklahoma Attorney General that it reimbursed Oklahoma pharmacies less than the actual acquisition cost of certain drugs. The settlement will compensate pharmacies for more than 68,000 prescriptions filled between January 2024 and August 2025, with 75% of the funds going directly to the affected pharmacies. In addition to monetary payments, CVS must implement reforms such as reviewing payment disputes against national pricing benchmarks, accepting pharmacy cost documentation, and responding to disputes within statutory deadlines. CVS denied wrongdoing but settled to avoid the expense of further administrative proceedings and continued litigation.

Ohio Suit Against PBMs Remanded to Federal Court. The Sixth Circuit recently addressed jurisdictional concerns in a suit brought by the state of Ohio accusing several PBMs of conspiring to inflate drug prices. The PBMs removed the case to federal court under the federal officer removal statute, arguing that their pricing negotiations under the FEHBA and TRICARE programs were strictly controlled by federal officers. The district court sided with Ohio, sending the case back to state court, but the Sixth Circuit remanded the case to federal court. The Sixth Circuit found that the PBMs were indeed "acting under" federal officers, noting that their negotiations for federal and non-federal clients were conducted simultaneously to maximize leverage and receive better pricing, and the alleged misconduct could not be neatly pulled apart from federally directed activity. The Sixth Circuit also emphasized that the PBMs had presented plausible federal-preemption defenses. *Ohio ex rel. Dave Yost v. Ascent Health Servs. LLC et al.*, No. 24-3033, in the US Court of Appeals for the Sixth Circuit.

State Prescription Drug Boards

Colorado Prescription Drug Affordability Board Activity. Colorado remains the only state to establish an upper payment limit for a prescription drug, and litigation surrounding the state's decision to cap certain prices continued to advance last year. After setting an upper payment limit in October 2025 (scheduled to take effect on January 1, 2027), Colorado's Prescription Drug Affordability Board became the focus of renewed legal challenges.

Colorado is the first state to implement a binding upper payment limit, and the lawsuits represent the first major constitutional challenges to such authority. Additional states continue to explore similar policies, and future rulings may influence whether state-level affordability boards can impose enforceable price ceilings on high-cost drugs.

OTHER INDUSTRY NEWS

Insulin Cases

We continuously monitor the lawsuits accusing manufacturers and PBMs of conspiring to inflate insulin costs. Note these recent updates:

More plaintiffs joined the multidistrict litigation (MDL) against drugmakers (Eli Lilly, Novo Nordisk, and Sanofi) and PBMs (Optum Rx, ESI, and CVS). In our Summer / Fall 2025 PBM Update, we reported on the MDL in the District Court of New Jersey with over 500 cases. Plaintiffs include state and local governments, self-funded payors, unions, and other private companies. The MDL combines suits alleging that insulin manufacturers conspired to artificially raise prices and paid PBMs secret rebates in exchange for placement on their formularies, resulting in higher list prices that harm the public. Although certain claims were partially dismissed, others will proceed. Since our last update, the following notable plaintiffs have joined the MDL or filed similar suits in their respective states (for example, under state racketeering and/or consumer protection laws):

- the states of Oregon, Delaware, Missouri, Indiana, Iowa, and Virginia;
- the cities of Providence and Philadelphia; and
- Dover Corporation and Jefferson Health (a large, Philadelphia-based health system).

The Michigan Supreme Court heard oral arguments on whether the state can investigate Eli Lilly's insulin price. In November 2025, the Michigan Attorney General argued for subpoena power under the Michigan Consumer Protection Act (MCPA) to investigate manufacturers' insulin pricing practices. The district and appeals courts rejected this

argument, holding that drugmakers are exempt from the MCPA. Although the Supreme Court's decision does not directly affect PBMs, if the state is successful, investigations of manufacturer pricing strategies will likely include their PBM arrangements.

Opioid Cases Against PBMs and the Statute of Limitations

Boston. On March 2, 2026, the US Court of Appeals for the First Circuit affirmed an earlier federal district court opinion that dismissed a case brought by the City of Boston against ESI and Optum Rx for, among other things, colluding with manufacturers to misrepresent the risk of opioids. As discussed in our Spring 2025 PBM Update, the case was previously dismissed because Boston brought the suit after the expiration of the relevant statute of limitations.

In its March 2026 decision, the First Circuit rejected Boston's new argument, raised for the first time on appeal, that its public nuisance claim should escape the three-year statute of limitations because the PBMs allegedly created an ongoing harmful condition. The court held that issues not raised before the district court cannot be advanced for the first time on appeal. It further explained that even if the argument had been preserved, it lacked merit; the court found that unlike a case involving pollutants that continued to create harm during a statute of limitations period, Boston's complaint alleged no comparable continuing condition within the statutory time frame. As a result, the First Circuit affirmed that the claims remain time-barred, leaving the city without a viable path to revive its public nuisance or RICO theories against the PBMs.

Philadelphia. Similarly, in January 2026 in Philadelphia, CVS and other PBM-defendants asked the US District Court for the Eastern District of Pennsylvania to dismiss the city's opioid suit, arguing that Philadelphia waited too long to bring its claims and lacks standing. They maintain that the city had been aware of its alleged injuries for years, citing earlier opioid actions against manufacturers, distributors, and pharmacies, and that it cannot now blame PBMs for the misuse of a lawful, FDA-approved product. The PBMs also argue that Philadelphia failed to show direct harm to the city itself, and that its RICO, public nuisance, negligence, and consumer protection claims depend on injuries to third parties and long chains of intervening actors. Finally, they assert that municipalities cannot bring consumer protection claims meant for individual purchasers. The district court has yet to decide on the PBMs' motion to dismiss.

Other Industry News

Former J&J Employees Appeal Dismissal of PBM ERISA Lawsuit. Former Johnson & Johnson (J&J) employees have filed notice of appeal to the US Court of Appeals for the Third Circuit for their lawsuit alleging J&J's fiduciary breach in health plan administration. In February 2024, former J&J employees brought a class action lawsuit in federal court alleging that (1) J&J and other group health insurance plan fiduciaries breached their duties under ERISA by failing to take the proper measures to ensure its plan costs were reasonable; and (2) did not exercise prudence in choosing its PBM, ultimately agreeing to undesirable contract terms that led to inflated costs. The District Court of New Jersey dismissed the fiduciary duty counts in the plaintiffs' initial and second amended complaints for lack of standing. In January 2026, the District Court of New Jersey issued a final judgment dismissing the plaintiffs' complaint (without prejudice) for lack of subject matter jurisdiction. Plaintiffs' counsel filed notice of appeal in January 2026. *Lewandowski v. Johnson & Johnson et al.*, No. 3:24-cv-00671, in the US District Court for the District of New Jersey.

Federal Judge Dismisses Consumer Class Action Antitrust Suit Against the Big 3 PBMs. US District Judge Beth Phillips dismissed a proposed class action brought by a consumer and two third-party payors accusing the Big 3 PBMs of engaging in anticompetitive steering practices and conspiring to a rebate scheme to increase and retain rebate fees via aggregators. The judge ruled that the plaintiffs failed

to show the PBMs engaged in parallel conduct, noting their rebate aggregators were formed in different years and that similar business activity alone does not prove a conspiracy. She also rejected the plaintiffs' Robinson-Patman Act claim, finding they alleged consumer-type injuries rather than the competitive harm that statute is designed to address. *Clements et al. v. CVS Health Corp. et al.*, No. 4:25-cv-00126, in the US District Court for the Western District of Missouri.

Independent Pharmacies' Antitrust Suits Against Optum Rx Sent to Arbitration. A federal judge ruled that independent pharmacies must arbitrate their antitrust claims against Optum Rx, finding that the pharmacies failed to show the arbitration and delegation clauses in their contracts were unconscionable. In December 2023, a group of independent pharmacies filed an antitrust lawsuit against Optum Rx, claiming that Optum Rx prevents independent pharmacies from serving its network of Medicare patients unless the pharmacies pay extra fees and penalties. Optum Rx moved to compel arbitration in April 2025, arguing that the fees at issue are part of provider agreements subject to binding arbitration clauses. Although the independent pharmacies argued they were essentially coerced into signing such agreements because of their lack of bargaining power in comparison to Optum Rx, US District Judge Robert S. Lasnik emphasized that the pharmacies had engaged pharmacy service administrative organizations (PSAOs) to negotiate their agreements with Optum Rx and that the plaintiffs failed to provide evidence that the PSAOs lacked the bargaining power to negotiate such agreements. Judge Lasnik pointed out that in fact evidence showed the PSAOs could specifically negotiate terms, including arbitration provisions. The case is now stayed pending arbitration, after which the parties may seek judicial review of the resulting arbitral order. *Osterhaus Pharmacy Inc. et al. v. UnitedHealth Grp. Inc. et al.*, No. 2:23-cv-01944, in the US District Court for the Western District of Washington.

Connecticut Courts Deny Injunction on Drug Price Cap. The Healthcare Distribution Alliance (HDA) is challenging the constitutionality of a new Connecticut law that seeks to cap prices charged by manufacturers and wholesale distributors for off-patent branded drugs, generic drugs, and interchangeable biologic products. The Drug Price Cap, Public Act No. 25-168, which went into effect on January 1, 2026, imposes penalties on wholesale distributors for the sale of any covered product at prices exceeding the manufacturer's list price (WAC). HDA argues that the Drug Price Cap is not only unconstitutional but also relies on outdated WAC reference prices, forcing wholesale distributors to choose between either selling the products at a loss or selling the products above the outdated WAC reference price and facing a civil penalty. The US Court of Appeals for the Second Circuit has denied HDA's motion for an injunction pending appeal of the Drug Pricing Cap, meaning the Drug Pricing Cap will remain in effect until further notice. *Healthcare Distrib. Alliance v. Boughton et al.*, No. 3:25-cv-01724, in the US District Court for the District of Connecticut.

Illinois Court Rules Antitrust and RICO Class Action Against Biogen May Proceed. US District Judge April Perry ruled that a class action brought by health plans alleging Biogen bribed PBMs to block cheaper generics of its multiple sclerosis drug Tecfidera can proceed. The health plans allege, among other things, that Biogen paid PBMs to (1) place generic drugs in higher formulary tiers or in the same tier as Tecfidera, even though generics were cheaper; (2) classify generics as specialty drugs; and (3) switch patients from Tecfidera to Biogen's newer patented drug Vumerity, which has no generics. The judge denied Biogen's motion to dismiss, finding the plans plausibly alleged injury from a bribery scheme that limited access to cheaper alternatives. In denying Biogen's motion to dismiss the RICO action, the judge noted that "absent Biogen's payments, the PBMs would lack any freestanding profit motive to place generic dimethyl fumarate in the same tier as Tecfidera or Vumerity." As a result, the litigation will move forward. *In re Tecfidera Antitrust Litig.*, No. 1:24-cv-07387, in the US District Court for the Northern District of Illinois.

Cigna Announces Shift to a Pass-Through PBM Model. Cigna announced in October 2025 that ESI, its affiliated PBM, is shifting to a rebate-free model for pharmacy benefit services that will make negotiated manufacturer discounts available to the patient at the point of sale. The new rebate-free model will be adopted for fully insured plans starting in 2027 and will be the standard option for all plan clients beginning in 2028. Cigna estimates that patients paying the full cost of medication, such as those with high-deductible plans, will see an average of 30% savings on brand-name drugs. In the same press release, Cigna announced it will implement a new cost-plus pharmacy reimbursement model; starting in 2026, all in-network pharmacies will be reimbursed for their drug costs plus a dispensing fee.

Optum Rx Cuts Reauthorizations, Moves to Cost-Based Model. As we noted in our Summer / Fall 2025 PBM Update, Optum Rx previously announced plans to shift to a cost-based payment model for many of its pharmacies, with aims of combating drug shortages and increasing accessibility for patients. In December 2025, Optum Rx announced that all of the community and independent pharmacies in its network have transitioned to the cost-based reimbursement model.

Last March, Optum Rx launched an effort to reduce reauthorizations on drugs by 25% with an initial focus on 80 drugs. By December, Optum Rx announced it would reduce reauthorizations for another 40 drugs, surpassing its initial goal of a 25% reduction. The PBM also announced that it is expanding the list of drugs that are covered by PreCheck, the automated system it uses to quickly provide approvals and reduce the administrative burden involved with reauthorizations. Optum Rx notes that its PreCheck tool reduces the amount of time a patient would wait for authorization approval from hours to less than a minute.

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