



MINTZ

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PBM

Policy and Legislative Update



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The PBM regulatory landscape is rapidly evolving at both 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 developments in order to provide you with this quarterly *PBM Policy and Legislative Update*. This update builds on prior issues and highlights federal and state activity from mid-February 2026 to June 2026.

FEDERAL LEGISLATIVE ACTIVITY AND OVERSIGHT

Federal Legislative Activity

Although Congress included [landmark PBM reform](#) in the 2026 Consolidated Appropriations Act passed on February 3, 2026, legislators continue to introduce bills targeting the PBM industry and PBM-related practices. Below is a summary of federal legislative activity from mid-February through June 2026.

INSULIN Act (S. 4189). The INSULIN Act of 2026 would prohibit private-market group health plans and insurers from applying any deductible to selected insulin products and cap the cost of a 30-day supply of insulin at \$35 for plan years beginning on or after January 1, 2027; and for plan years beginning on or after January 1, 2028, the cap would drop to the lesser of \$35 or 25% of the plan's or insurer's net negotiated price. The bill also would require PBMs, third-party administrators, insurers, and other entities providing PBM services to pass through 100% of all rebates, fees, and other remuneration received from drug manufacturers or other third parties that are related to the plan's insulin utilization. For uninsured patients, the bill would establish a 10-state, 5-year pilot program through which each selected state would receive grant funding to help uninsured individuals access insulin at an "affordable" price. The bill defines "affordable" as an out-of-pocket cost of not more than \$35 for a one-month supply.

PBM Kickback Prohibition Act (H.R. 7895). The PBM Kickback Prohibition Act would amend ERISA to prohibit PBMs from directly or indirectly providing referral fees or other compensation to brokers, consultants, advisors, or similar parties for steering employer-sponsored health plan or health insurer business to a particular PBM. However, the bill does not specify penalties (monetary or otherwise) for violations. During an [April committee hearing about the PBM business model](#), the bill's sponsor, Rep. Rick Allen (R-GA), cited deceptive payment practices between PBMs and brokers and a broader lack of industry transparency as driving reasons for the bill.

Every Dollar Counts Act (H.R. 8270). Recognizing the increased availability and use of direct-to-consumer platforms for pharmaceuticals, the Every Dollar Counts Act would require commercial insurers and group health plans to count a patient's out-of-pocket spending on covered drugs (i.e., those on the plan's formulary) toward their plan deductible and out-of-pocket maximum, regardless of where the drug is purchased. This approach would align with the one taken by the [FTC in its February 2026 settlement with Express Scripts](#), which requires the PBM to count patient payments through the TrumpRx platform toward the patient's deductible and out-of-pocket maximums. While proponents of the bill maintain that all patient out-of-pocket drug spending should be treated equally, others note that imposing such requirements on insurers' benefit designs could lead to unintentional consequences, such as increased premiums.



Patients Before Monopolies Act (S. 4509 / H.R. 8779). As we [discussed](#), the reintroduced Patients Before Monopolies Act retains the core prohibition on direct or indirect ownership or control of both a pharmacy and an insurance company or PBM, with a few new enhancements. The updated version accelerates the timeline for compliance (reducing the divestment period to one year), introduces stronger enforcement provisions (including divestment milestones and an escrow requirement for missed milestones), and creates a private right of action with a possible award of treble damages. It also requires the Federal Trade Commission (FTC) and Department of Justice (DOJ) to submit quarterly reports to the relevant congressional committees on compliance with the Act. These changes align the bill more closely with the Break Up Big Medicine Act, which similarly restricts common ownership of certain medical services providers.

Health Data Access, Transparency, and Affordability Act (H.R. 9228). The Health Data Access, Transparency, and Affordability Act would amend ERISA to require that service agreements between group health plans and network service providers (or other entities) give plan fiduciaries the right to access all relevant claims and encounter data, along with supporting documentation such as medical records and policy documents. All required disclosures would remain subject to HIPAA. The bill also specifies a number of prohibited provisions within contracts between group health plans and service providers, including limitations on the amount of claims or encounter data that the plan fiduciary may access. Parties violating the disclosure obligations would be subject to a civil monetary penalty of up to \$10,000 per day per violation.

Other Federal Regulatory Activities

CMMI Advances Several Drug Pricing Models. As discussed in our [Spring 2026 PBM Update](#), the Center for Medicare & Medicaid Innovation (CMMI) recently announced several alternative drug pricing models aimed at reducing prescription drug costs.

The public comment period for the mandatory GUARD and GLOBE models closed in late February 2026, with a limited number of public comments released. Both models have since advanced in the regulatory process, with the GUARD and GLOBE final proposed rules submitted to the White House's Office of Management and Budget (OMB) on June 15 and June 26, 2026, respectively, for final review. The pharmaceutical industry continues to [push back](#) on these models, and it's possible there will be legal challenges.

Meanwhile, progress has been uneven for the voluntary BALANCE model, under which CMS would negotiate prices for GLP-1 medications on behalf of state Medicaid agencies and Medicare Part D plan sponsors. Following limited participation from Part D sponsors, CMS [delayed](#) the Medicare component of the model, originally slated for a 2027 launch. The Medicaid component, however, has stayed on track with state participation applications open through July 31, 2026. In response to the delay of the Part D BALANCE model, CMS announced an extension of the Medicare GLP-1 Bridge Program, which will now run through the end of 2027. Through the Bridge Program, which [went live](#) on July 1, [eligible beneficiaries](#) will have access to select weight-loss drugs (Foundayo, Wegovy (injection and tablets), and Zepbound) with a \$50 copay.

CMS also [extended](#) participation deadlines for the GENEROUS Model. Manufacturer applications were due July 17, 2026, while states have until September 10, 2026 to apply to participate in the GENEROUS model, subject to any further extensions.

As CMS continues to expand its Innovation Center portfolio, including the alternative drug pricing models, the agency is [reportedly](#) seeking to increase staffing to accommodate the needs of these alternative payment models and other CMS initiatives.



CMS Seeks Input on Medicare Part D CAA 2026 Reform Implementation.

As we [reported](#), on June 16, 2026, CMS issued a request for information (RFI), [Pharmacy Benefit Manager Compensation and Data Collection](#), seeking stakeholder input on the implementation of Section 6224 of the Consolidated Appropriations Act, 2026 (CAA 2026). Section 6224 imposes new restrictions on PBM compensation in Medicare Part D and establishes reporting requirements that are slated to take effect on January 1, 2028. Through a series of questions focused on defining PBMs, affiliates, bona fide service fees, fair market value, pharmacy payment arrangements, and data collection, CMS signals a strong interest in identifying and monitoring pharmacy benefit compensation arrangements that may fall outside the statutory bounds. The RFI also suggests that CMS intends to prioritize transparency, closely scrutinize remuneration flowing through affiliated entities and indirect pharmacy benefit arrangements, and develop a robust reporting framework to support future oversight and enforcement in the industry.

For additional background on Section 6224 and the broader PBM reforms enacted by the CAA 2026, see our blog post [here](#)

DOL Receives Stakeholder Feedback on Proposed PBM Disclosure Rule Following the CAA 2026.

As discussed in our [Spring 2026 edition](#) of the PBM Update, the Department of Labor (DOL) [issued](#) a proposed rule, [Improving Transparency into Pharmacy Benefit Manager Fee Disclosure](#), earlier this year, aiming to clarify how the ERISA provider disclosure requirements under the Consolidated Appropriations Act, 2021 should apply to PBMs. Just days after the DOL announcement, Congress passed the CAA 2026, which included similar PBM disclosure and transparency requirements. This legislation prompted the DOL to [extend the comment period](#) for its proposed rule by 15 days to

allow stakeholders additional time to comment in light of the new legislation.

The comment period closed on April 15, 2026, with stakeholders submitting more than 550 comments. As previously [discussed](#), a central theme among commenters concerned the proposed rule's interaction with the PBM transparency framework of the CAA 2026. Several commenters also questioned the DOL's authority under ERISA and raised procedural concerns with the rulemaking process pursuant to the Administrative Procedure Act (APA).

OIG: Vertical Integration of Medicare Part D Sponsors and Potential Impact on Drug Costs.

On May 19, 2026, amid ongoing concerns about market consolidation and its effect on drug costs and competition, the HHS Office of Inspector General (OIG) posted a report examining the effects of vertical integration and consolidation of Part D sponsors with PBMs and pharmacies, [Impacts of Vertical Integration in Medicare Part D on Sponsors' Drug Costs, Pharmacy Reimbursement, and Enrollee Cost Sharing](#).

OIG [found](#) that although vertically integrated sponsors and nonintegrated sponsors generally achieved similar net drug costs for selected drugs reviewed in the report, these parties generally used different reimbursement strategies in contracting practices. Specifically, OIG noted that while those sponsors that were vertically integrated typically paid pharmacies more upfront, they also recouped more rebates and fees later in the reimbursement process. The report also found that enrollees in plans offered by vertically integrated Part D sponsors generally had lower monthly premium payments, but these enrollees often faced higher out-of-pocket costs when paying for prescription drugs. OIG noted that limitations in available data and ongoing market changes make it difficult to fully assess the impact of vertical integration in the pharmacy benefit space.



FTC PBM Enforcement and Health Care Oversight

The Federal Trade Commission (FTC) reached proposed settlements with the remaining two PBMs, Optum Rx and CVS. In September 2024, the FTC sued three major PBMs (Express Scripts, Optum Rx, and CVS) alleging anticompetitive practices that increased the price of insulin. As we reported, Express Scripts settled earlier this year and agreed to a slew of changes in its drug pricing and rebating process. Recently, it was noted that the FTC reached a settlement in principle with the two remaining PBMs, Optum Rx and CVS. (Notably, in response to a joint stipulation, the Eighth Circuit dismissed the PBMs' countersuit against the FTC.) Although the details are not yet public, the proposed settlements of Optum Rx and CVS are expected to mirror that of Express Scripts and include large overhauls of the companies' drug benefit designs. These settlements — and the associated changes — come in the wake of congressional probes concerning the drug rebating process and the role PBMs have in it.

Update Since Publication: The FTC announced its settlement with Caremark Rx, LLC and Zinc Health Services, LLC on July 14, 2026, which is the second of the insulin pricing settlements to be made public. The settlement closely tracks the previously announced settlement with Express Scripts, with some notable differences. See our [discussion](#) for more information.

FTC Launches Healthcare Task Force. As we [previously reported](#), the FTC announced [the launch of a Healthcare Task Force](#) on March 20, 2026, signaling a significant escalation in the FTC's approach to health care oversight. The multi-bureau group, comprised of members of the Bureaus of Competition, Consumer Protection, and Economics, as well as the Office of Policy Planning and the Office of Technology and possibly others from law enforcement and health departments, "will devise coherent agencywide strategies on new and nascent investigations, institute a proactive and strategic approach to identifying amicus and statement of interest opportunities and conduct ongoing horizon-scanning exercises to identify emerging issues and new priority areas for enforcement and advocacy," according to FTC Chairman Andrew Ferguson. The launch indicates a transition away from ad hoc health care enforcement toward an institutionalized and coordinated approach. The Task Force is directed to partner with the Department of Health and Human Services (HHS) and DOJ to capitalize on subject-matter expertise, access to data, regulatory insights, and enforcement options that do not reside within the FTC itself. Direct Task Force action remains to be seen, but industry observers agree that the FTC is positioning itself as a central enforcement player in health care regulation.



Updates on Trump Administration Initiatives

Most Favored Nations Deals

As previously [reported](#), despite bipartisan hesitation in Congress, the White House continued efforts to codify President Trump's MFN drug pricing deals. According to reports from March 2026, in an effort to gain industry support for federal legislative efforts to codify the deals, the administration drafted legislative text and invited a small group of pharmaceutical manufacturers to discuss the proposals. However, members of Congress [demanded](#) answers and detailed information about the terms of the MFN agreements before considering legislation to codify the deals. For example:

- On March 5, 2026, Rep. Daniel Meuser (R-PA) introduced the [Most Favored Patient Act of 2026](#) (H.R. 7837), which would require CMS to test a model implementing MFN pricing starting in 2029.
- On April 21, 2026, Sen. Ron Wyden (D-OR) and 18 co-sponsoring senators introduced the [Drug Deal Disclosure Act](#) (S. 4355), which would require HHS to disclose documents and information related to any agreements entered into by the Trump administration and any drug manufacturer related to: MFN pricing (including the specific agreements the administration announced and any future agreements), direct-to-consumer sales or discounts, import duty exclusions or exemptions, investments in or repatriation of revenue to the United States, special treatment under CMS demonstration projects, contributions to or agreements regarding the Strategic National Stockpile, or receipt of a Commissioner's National Priority Review Voucher through the FDA's pilot program.

On April 23, 2026, Regeneron, the last of the 17 manufacturers that originally received letters from the Trump administration, [announced](#) an MFN pricing deal. As with the deals we covered in our [Spring 2026 PBM Update](#), Regeneron agreed to provide select products, including its cholesterol medicine Praluent, at a discounted rate through TrumpRx, and has pledged more than \$9 billion in US manufacturing and research and development investments. Regeneron also agreed to provide its brand-new gene therapy, Otarmeni (used to treat a rare genetic deafness), at no cost to patients in the United States. As with the other 16 MFN pricing deals, the Trump administration will exempt Regeneron from future pricing mandates and provide tariff relief for three years in exchange for reaching an MFN pricing and onshoring agreement.

With the MFN deals now in place, attention has turned to whether the agreements will deliver meaningful cost savings.

- In May 2026, the Council of Economic Advisers for the Trump administration [published](#) a report, "Savings from Most-Favored-Nation (MFN) Drug Pricing Policy," in which the Council notes that it projects to see \$529 billion in MFN pricing-related savings over the next decade, which will result from "tying US drug prices to international prices, [which] will lower US prices and put pressure on prices paid in other wealthy nations."
- In the same month, AARP [published](#) a report examining the price trajectory of the top 25 brand-name drugs, finding that the price of these drugs rose by an average of 81% in the US, while prices for the same drugs fell an average of 13% across other comparable countries.



Updates on Trump Administration Initiatives (cont.)

- In addition, PhRMA recently [published](#) a report highlighting that high US drug spend is about more than just the price of drugs — it is also due to the availability and coverage of new medications, with 88% of new medicines covered by US public insurance compared to 36% abroad; and compared to patients in foreign nations, US patients wait a fraction of the time to access new medications.

These competing analyses underscore the uncertainty surrounding MFN pricing's real-world impact, leaving stakeholders to watch how savings projections hold up against entrenched market dynamics.

Tariffs

Citing the International Emergency Economic Powers Act, the Trump administration has used tariff threats and tariffs themselves to negotiate trade deals with foreign nations. However, on February 20, 2026, the Supreme Court [ruled](#) that the International Emergency Economic Powers Act does not allow President Trump to unilaterally impose tariffs. Many foreign nations now [question](#) the status of their trade deals. The ruling also calls into question the impact on tariffs related to pharmaceutical drugs, which were originally levied under Section 232 of the Trade Expansion Act and which led manufacturers to pledge billions of dollars toward US-based research and development in exchange for tariff relief. In [response](#) to the Supreme Court's ruling, President Trump signed an order imposing a 10% global tariff under Section 122 of the Trade Act of 1974, which allows for the imposition of this tariff for 150 days, provided the global tariff excludes pharmaceuticals and pharmaceutical ingredients.

As we [reported](#), to separately target pharmaceuticals, President Trump [announced](#) a new 100% tariff on patented pharmaceutical products and ingredients under Section 232.

Notably, the administration exempts from tariffs, through January 20, 2029, companies that have entered into both an MFN pricing agreement with the HHS and an onshoring agreement with the Department of Commerce. The Presidential Proclamation related to the new tariff also includes total or partial exemptions for countries with trade deals, generic pharmaceuticals, and certain specialty pharmaceutical products.

Following President Trump's direction to impose 100% tariffs on pharmaceutical companies that did not previously enter into MFN and onshoring agreements, the Department of Commerce [released](#) guidance for how other pharmaceutical companies can apply to enter into onshoring agreements that would reduce the tariff to 20%, with the possibility of being further reduced to 0% if such company enters into an MFN deal with HHS. The application requires companies to provide current and prospective (i.e., January 20, 2025 through January 20, 2029) responses describing the companies' plans for, among other things, (1) new US-based investments including manufacturing plants, (2) onshoring of global production of pharmaceuticals and pharmaceutical ingredients, (3) percentage of US sales consisting of patented pharmaceuticals with active ingredients, and (4) products that will not be manufactured in the US with an explanation for why it is not commercially feasible to do.

As a response to the Trump administration's tariff practices, on May 22, 2026, Sen. Gary Peters (D-MI) and Sen. Susan Collins (R-ME) introduced a bipartisan bill [aimed](#) at increasing transparency requirements related to tariff investigations conducted by the Department of Commerce under the Trade Expansion Act. The bill seeks to [amend](#) the Section 232 Public Transparency Act by requiring the Secretary of Commerce to "publish summaries of its investigations examining alleged national security risks tied to imports of certain goods," which the Trump administration has used as its

Updates on Trump Administration Initiatives (cont.)

explanation for levying tariffs on the importation of pharmaceuticals, among other things.

TrumpRx

Since launching TrumpRx, the Trump administration has made efforts to expand the platform offerings by adding over 700 drugs to the original list of 43 branded prescription drugs.

- To date, many manufacturers that previously reached MFN deals with the administration now sell medications through the TrumpRx website. In addition to AstraZeneca, Eli Lilly, EMD Serono, Novo Nordisk, and Pfizer, other manufacturers, including [Johnson & Johnson](#), [Amgen](#), [GSK](#), [Boehringer Ingelheim](#), [Abbvie](#), and [Genentech](#) have since started selling some of their most popular medications through TrumpRx (e.g., Abbvie's Humira).
- To further expand the reach of the TrumpRx platform, on May 18, 2026 President Trump [announced](#) that TrumpRx would be adding over 600 generic drugs, with a second expansion [announcement](#) on June 6, 2026 making another 160 prescription drugs available through TrumpRx.
- Expansion efforts also include partnerships and integration efforts with Mark Cuban and the Cost Plus Drugs platform, as well as drug savings and low-cost prescription

programs offered through GoodRx and Amazon Pharmacy.

Echoing the uncertainty surrounding MFN pricing's projected savings, critics have questioned whether TrumpRx fulfills the administration's promise of offering "the world's lowest prices on prescription drugs." [Comparative analyses suggest](#) the claim falls short in many cases — Novo Nordisk's Wegovy, for instance, costs less through TrumpRx than in Canada but more than what patients pay in Germany, Britain, or Japan, and [reports](#) indicate that about one-third of TrumpRx drugs would be cheaper in the United Kingdom. Additional concerns include the program's prohibition on insurance use or applying purchases toward deductibles, the reality that many patients' existing copays are lower than TrumpRx prices, and the impact on pharmacies that must absorb the difference between wholesale costs and reduced reimbursement rates.

Update Since Publication: On August 13, 2026, PCMA and 10 PBMs — CaredonRx, CVS Health, Express Scripts, Humana, MedImpact Healthcare Systems, Navitus Health Solutions, Optum Rx, Prime Therapeutics, VytOne, and WellDyne — [announced](#) an agreement to list their negotiated plan prices alongside the cash prices on TrumpRx, allowing enrolled patients to compare PBM benefit pricing with direct-to-consumer prices available through the platform.

STATE LEGISLATION AND LITIGATION

Recently Enacted State Legislation

Between mid-February 2026 and June 2026, several states enacted legislation imposing new requirements on PBMs across a wide range of regulatory areas. 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)
Arizona	S.B. 1497 amends Arizona's school district self-insurance statute to require each insurer, TPA, and PBM (among other entities supporting a school district's self-insurance program) to provide specified information to the school district in an electronic, machine readable format. It requires the applicable entity to provide specified information to the school district at least 60 days prior to the end of the benefit program year, including: monthly enrollment counts by tier/plan for the prior two calendar years; monthly total claims paid for each plan for the prior two years; a detailed report on enrollees whose total claims paid exceed \$50,000 in any of the prior four years or who are projected to exceed that amount in the current year; detailed prescription drug data for the preceding 12-month period; complete documentation for each benefit plan currently available to the school's employees; and a report of comprehensive eligibility census data for all employees and dependents who participate in the school's self-insurance program.	6/22/2026	9/12/2026
Colorado	H.B. 1139 applies to carriers, PBMs, private utilization review organizations, behavioral health administrative services organizations, and managed care entities that use AI systems or algorithms for utilization review. The law requires these entities must ensure that the AI system: (1) bases coverage determinations on the individual's medical or clinical history, individual clinical circumstances, and other relevant clinical information in the individual's record; (2) does not rely solely on group data; (3) is not used in a discriminatory manner; (4) is fairly and equitably applied; (5) maintains	6/2/2026	1/1/2027

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	documentation, audit logs, and model-governance records; (6) is periodically reviewed for performance, use, and outcomes; (7) limits use of health data to its intended or stated purpose; and (8) complies with applicable state and federal utilization review and coverage laws. The entities must provide written disclosures to certain state agencies that identify: (1) the utilization review functions for which the AI system will be used; (2) the points in the utilization review process when the AI system is used; (3) the human oversight process; and (4) the process for maintaining audit information. The law prohibits a carrier's denial of coverage based on medical necessity from being made solely on the output of an AI system without human review by a licensed clinician, licensed physician, or other regulated professional who is competent to evaluate the specific clinical issues and review the health benefit plan's coverage terms. The law also prohibits carriers from offering a health benefit plan that provides coverage for psychotherapy services provided directly to an individual by an AI system.		
Connecticut	H.B. 5375 prohibits health carriers, TPAs, and PBMs from denying reimbursement for a clinical service solely on the basis of the provider's license type when the service is performed by a pharmacist and would otherwise be eligible for reimbursement if performed by a physician, physician assistant, or advanced practice registered nurse, provided the service falls within the pharmacist's scope of practice and would otherwise be eligible for reimbursement. The law does not require coverage of any service not otherwise covered under the health benefit plan, nor does it prevent a health carrier, TPA, or PBM from establishing reasonable participation, credentialing, or contracting standards.	5/27/2026	1/1/2028
Florida	H.B. 697 requires that a PBM's administrative appeal procedure allow a pharmacy to consolidate multiple claims that involve the same drug, day supply, and	3/25/2026	7/1/2026

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	month of service. The law also creates two new prohibited practices applicable to PBMs: one barring PBMs from preventing a pharmacy or pharmacist from declining to dispense a drug when reimbursement would fall below actual acquisition cost, and another prohibiting PBMs from reimbursing nonaffiliated pharmacies or pharmacists at rates lower than those paid to their affiliated pharmacies or pharmacists.		
Georgia	H.B. 1344 increases the maximum penalty for violating the chapter of law governing PBMs, including operating without a license, from \$2,000 to \$4,000 per transaction or violation. If the person or entity knew or reasonably should have known it was in violation of the law, the penalty may be increased to an amount up to \$20,000 (increased from \$10,000) per transaction or violation.	5/12/2026	1/1/2027
Hawaii	H.B. 1643 establishes a framework governing how PBMs and other entities must conduct audits of pharmacists and pharmacies, imposing procedural requirements including two weeks' written notice before on-site audits, a two-year lookback limit on audited claims, and a prohibition on extrapolation for calculating recoupments or penalties. Among other things, the law restricts recoupment to prescriptions specifically disclosed in the audit, bars recoupment of dispensing fees except in cases of fraud, invalid prescriptions, prescriptions not actually dispensed, or prescriptions outside the contract, and prohibits sharing audit information between PBMs absent suspected fraud. PBMs must establish a formal appeals process for unfavorable audit findings and may not finalize recoupments until that process concludes, with pharmacies provided at least 60 days to respond to preliminary reports if their contract is silent on the time frame. The law also provides that audits may not be initiated during the first seven calendar days of any month without the pharmacy's consent, that audits involving clinical judgment must be conducted in consultation with a registered pharmacist, and that recoupment for excess days' supply is limited to the cost of the quantity in excess of the allowed supply. Additionally, the law	5/26/2026	5/26/2026

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	amends the definition of “pharmacy benefit manager” to exclude a health maintenance organization that is part of a fully integrated delivery system in which enrollees primarily use pharmacies owned and operated by the HMO.		
Illinois	H.B. 2949 amends the Prescription Drug Affordability Fund provisions in Illinois’ PBM licensure law to authorize use of the fund for the Department of Insurance’s costs associated with administering and operating the Prescription Drug Affordability Act. The bill also modifies the fund-transfer provision to require transfer to the General Revenue Fund only of amounts remaining in the Prescription Drug Affordability Fund in excess of \$1.5 million.	6/16/2026	6/16/2026
Kansas	S.B. 20 expands on existing PBM regulation. Among other things, the law requires all “auditing entities” to register with the insurance commissioner, prohibits auditing entities from compensating employees based solely on the amount claimed or the actual amount recouped, prohibits use of extrapolation to calculate penalties, and places limits on fines, chargebacks, and recoupments for dispensed products. The law also establishes new reporting requirements for PBMs. PBMs must annually report to the commissioner aggregate rebates received, rebates distributed to each contracted health plan or covered entity, and itemized amounts paid by the health plan to the PBM and by the PBM to pharmacies. On a quarterly basis, PBMs must report to the commissioner all drugs reimbursed at 10% or more above or below the national average drug acquisition cost (NADAC), along with the net acquisition cost charged to each health benefit plan. This quarterly report must be published on the PBM’s publicly available website for at least 24 months. The law also establishes reimbursement floors for pharmacies (NADAC plus a minimum dispensing fee) and prohibits spread pricing, except for self-funded plans subject to ERISA. A PBM is also prohibited from	4/9/2026	7/1/2026

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	reimbursing a pharmacy or pharmacist less than it would reimburse an affiliate for the same drug or service. PBMs are prohibited from imposing a point-of-sale or retroactive fee or deriving any revenue from a pharmacy or covered person in connection with performing PBM services.		
Kentucky	H.B. 527 amends insurance regulatory provisions to expressly subject PBMs to the insurance commissioner's examination authority and to require each licensed PBM to designate one or more individuals licensed as an administrator to act under the business entity's license.	4/7/2026	7/15/2026
Louisiana	S.B. 465 amends Louisiana's pharmacy and pharmacist claim-payment provisions to shorten the payment deadlines for nonelectronic claims covering prescription drugs, other products or supplies, and pharmacist services. For claims submitted within 45 days of the date of service, the payment deadline is reduced from 45 days to 21 days after submission of a complete claim. For claims submitted more than 45 days after the date of service — or for resubmitted claims where the original was incomplete — the payment deadline is reduced from 60 days to 30 days after submission of a complete claim. The law also requires that PBMs and other entities responsible for pharmacist or pharmacy claim payment, when acting on behalf of a health insurance issuer, maintain Department of Insurance–approved procedures for accepting nonelectronic claims and paying late-payment adjustments. It also extends the electronic claim submission standards to those entities. Previously, these requirements only applied directly to health insurance issuers.	6/1/2026	1/1/2027
	H.B. 766 amends existing law requiring coverage parity for orally administered anti-cancer medications. As amended, a health plan may not impose any prior authorization, dollar limit, copayment, deductible, coinsurance, specialty tier placement, formulary classification, benefit category determination, or other cost-sharing or utilization management requirement	6/8/2026	8/1/2026

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	on orally administered anti-cancer medications that results in greater out-of-pocket costs or more restrictive access than imposed on intravenously administered or injected anti-cancer medications. Additionally, cost sharing for orally administered anti-cancer medications must be applied toward deductibles and annual out-of-pocket maximums in the same manner as other covered benefits. The law also prohibits a health insurance issuer from reclassifying or increasing cost sharing for anti-cancer medications to achieve compliance. A health insurance issuer that limits total cost-sharing requirements to no more than \$80 per filled prescription (reduced from \$100) for any orally administered anti-cancer medication is considered in compliance with these requirements. The law also prohibits a health insurance issuer from using any copayment adjustment program that adjusts, reduces, excludes, or otherwise fails to credit any manufacturer-sponsored or third-party payment, discount, voucher, coupon, or financial assistance toward an enrollee's deductible, cost-sharing obligation, or annual out-of-pocket maximum for anti-cancer medications as part of certain high-deductible health plan policies.		
	S.B. 387 amends Louisiana's PBM law to add new fiduciary duty, compensation, rebate, formulary, audit, contract, and pharmacy protection requirements. The law establishes a PBM duty of care and good faith and fair dealing to enrollees, health plans, and providers. It also restricts PBM formulary practices, including by prohibiting a PBM from using its formulary to obtain inducements, favor certain drugs over lower-cost substantially similar drugs, charge more than the PBM's net acquisition cost for a drug, or effectively ban an insured's use of certain pharmacies. The law also establishes new restrictions on PBM compensation. The law generally limits PBM compensation to flat-dollar pharmacy benefit management fees and flat-dollar performance bonuses and prohibits a PBM from retaining rebates or fees, including through related entities. PBM fees may not be based on drug price, savings, rebates,	6/12/2026	1/1/2027 (most provisions) 6/12/2026 (PBM audits, penalty provisions) 1/1/2028 (PBM compensation restrictions; certain other restrictions on rebates/formulary preferences)

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	premiums, deductibles, or other cost-sharing amounts. The law authorizes the insurance commissioner and any contracted health insurance issuer or health plan to audit the PBM once per calendar year, including specified books and records, and protects confidential and proprietary information through a public records exemption. PBM contracts must specify all forms of revenue to be paid by the health insurance issuer or health plan to the PBM and must acknowledge that spread pricing is not permitted. The law also adds pharmacy and pharmacist protections, including restrictions on PBM interference with pharmacist or pharmacy activities intended to increase drug cost transparency, access, or affordability, and prohibitions on retaliation for those activities. The law further requires continuity-of-care protections when a formulary revision affects an enrollee and restricts PBMs from steering enrollees to affiliated or higher-cost drugs or biological products when lower-cost generic or biosimilar alternatives are available.		
	H.B. 1236 amends existing law regulating reimbursement for local pharmacies (pharmacies domiciled in Louisiana with fewer than 10 retail outlets). As amended, a PBM must use a reimbursement formula based on NADAC as the drug pricing benchmark or, if NADAC is not available, wholesale acquisition cost. The reimbursement formula must also use a professional dispensing fee that is not less than the professional dispensing fee established for the Louisiana Medicaid program and must reflect the actual costs of the professional services provided by the pharmacists and dispensing expenses. The law adopts new definitions of “acquisition cost” and “professional dispensing fee” and makes the dispensing fee a nonrecoverable cost. The law also amends the provisions governing the appeals process for pharmacists to challenge claim	6/12/2026	6/12/2026

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	payment errors. When a claim payment error occurs and the PBM makes an additional payment to the pharmacy, this law prohibits a PBM from changing the amount a consumer must pay in out-of-pocket costs.		
Maine	S.P. 821 / L.D. 2005 requires a PBM to allow a covered person to have a prescription filled at a network pharmacy when the person's mail-order pharmacy delivery is delayed by more than one day after the expected delivery date, in which case the network pharmacy must provide up to a seven-day supply or the smallest prepackaged unit supply. If the drug arrives in an unusable condition, the network pharmacy must dispense the prescription drug in accordance with the covered person's prescription. A covered person who receives a prescription drug under either circumstance may not be subject to any payment exceeding the total of one copayment, coinsurance payment, or other out-of-pocket payment for that prescription drug.	4/13/2026	7/29/2026
	S.P. 135 / L.D. 378 clarifies that health insurers administering health plans on behalf of plan sponsors are considered "administrators" and are therefore subject to the existing statutory plan sponsor audit rights that previously applied only to third-party administrators and PBMs. The law also clarifies that audit data must be disclosed to the plan's designated business associate (rather than the plan sponsor's designated business associate) and enacts new breach-notification obligations requiring plan sponsors and their designated business associates to immediately notify the administrator or PBM upon discovery of any unauthorized disclosure or security breach of protected information received pursuant to an audit.	4/13/2026	4/13/2026
Nebraska	L.B. 967 establishes a \$100-per-day fine for a PBM's failure to submit a required license renewal application and fee by the applicable deadline, which is 30 days prior to the license anniversary date, and provides for suspension of the license if the failure extends beyond the anniversary date. The director of insurance may grant a 30-day extension for good cause without imposition of fine or suspension. The law imposes a new requirement on PBMs to immediately notify the director of insurance of any material change in the	4/7/2026	7/17/2026

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	PBM's ownership or control or other circumstance affecting its qualification for a PBM license. Finally, the law amends the Unfair Insurance Trade Practices Act to expressly include PBMs within the definition of "insurer."		
New Mexico	S.B. 20 extends certain prior authorization requirements, previously applicable to health insurers, to PBMs that contract with entities subject to the Health Care Purchasing Act, which governs the purchase of health insurance for public employees and retirees. Among other things, a covered PBM must maintain an electronic prior authorization portal, assign a tracking number to prior authorization requests, and adjudicate requests within prescribed time frames. In addition, the law prohibits both health insurers and PBMs from requiring subsequent prior authorization for a previously approved treatment more than once every three years, unless specified conditions are met. Finally, the law adds serious mental illnesses to the list of conditions for which prior authorization or step therapy may not be required.	3/6/2026	Applies to contracts and policies issued on or after January 1, 2027
Ohio	H.B. 229 creates a separate licensure framework for PBMs under a new Chapter 3957 of the Ohio Revised Code. PBMs were previously regulated as third-party administrators. As of July 1, 2027, PBMs will need to be licensed under the new law. The new law also contains enhanced transparency and disclosure requirements for pharmacy benefit services agreements that are entered into, amended, or renewed on or after July 1, 2027, and more robust audit and enforcement powers for the superintendent of insurance. Certain existing sections of the TPA law governing PBMs are moved to the new chapter.	3/31/2026	7/1/2027 (PBM license required and provisions applicable to new, amended, or renewed contracts)
Oklahoma	S.B. 2184 revises pharmacy audit and reimbursement appeal procedures. Under the amended law, an auditing entity must allow a pharmacy to validate dispensing using drug purchase records from any date or source, provided the purchase was done in accordance with state or federal law. The law also provides that an audit recoupment may not include the dispensing fee amount or the actual invoice cost of the	5/6/2026	5/6/2026

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	prescription dispensed unless the prescription was not actually dispensed or the physician denied authorization. When a PBM denies a below-cost reimbursement appeal, it must provide a reason for the denial, along with documented proof from those wholesalers showing availability at that price. If the drug is not available below the acquisition cost obtained from the pharmacy's wholesaler, the PBM must immediately adjust the reimbursement amount and permit the pharmacy to reverse and rebill the claim retroactively. Separately, any appeal that results in an increase in reimbursement that continues to be below the pharmacy's acquisition cost is deemed a denial, subject to the same proof requirements. Additionally, a PBM may not require the pharmacy to collect additional monies from third parties other than the PBM who adjudicated the drug claim, after the pharmacy prevails on a below-cost reimbursement appeal.		
Rhode Island	H.B. 7127 adds a new PBM transparency reporting chapter to Rhode Island insurance law requiring each PBM to submit a transparency report to the health insurance commissioner annually beginning March 1, 2027. The report must include: (1) the aggregate amount of rebates received from all pharmaceutical manufacturers; (2) the aggregate administrative fees received from all manufacturers; (3) the aggregate retained rebates that the PBM did not pass through to health carriers; (4) the aggregate retained rebate percentage; (5) the highest, lowest, and mean aggregate rebate percentage for all health carrier clients; and (6) responses to standard questions regarding business practices. The insurance commissioner must publish each PBM's transparency report on the commissioner's website within 60 days, subject to the PBM's ability to request trade secret protection for qualifying material.	6/12/2026	7/1/2026 (reporting requirements begin 3/1/2027)
	H.B. 8579 / S.B. 3060 establishes a new chapter of law governing PBMs. It requires any person, firm, association, corporation, or other entity acting as a PBM to hold a certificate of authority as a PBM issued by the health insurance commissioner. It provides for a provisional PBM certificate of authority for up to two	6/22/2026	1/1/2027

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	years after the health insurance commissioner issues guidance on the application process. The law establishes certificate application and renewal requirements, authorizes application fees, identifies grounds for suspension or revocation, and authorizes penalties for violations. The law also requires annual reporting by each PBM holding a certificate of authority on or before July 1 to the health insurance commissioner. The report must include, among other things: (1) any pricing discounts, rebates, inflationary payments, credits, clawbacks, fees, grants, chargebacks, reimbursements, incentives, inducements, refunds, or other benefit received by the PBM; (2) the terms and conditions of any contracts between the PBM and any other party relating to PBM services provided to an insurer; (3) certain information about patient utilization of prescription drugs covered by insurers in the state; (4) a response to a standard set of questions developed by the commissioner regarding business practices; (5) the rebate percentage and dollar amount retained by the PBM for every rebate, discount, price concession, or other consideration under each rebate contract; and (6) the dollar amount of any other compensation paid by a drug manufacturer to the PBM for services.		
	H.B. 8582 / S.B. 3059 amends existing law governing pharmacy freedom of choice. The new provisions prohibit a PBM from causing or requiring a pharmacy to substitute one prescription drug for another without the approval of the prescriber or as explicitly required or permitted by law. It also prohibits a PBM from prohibiting or penalizing a pharmacist or pharmacy for disclosing information to an individual purchasing a prescription, such as the cost of the medication and the availability of any therapeutically equivalent alternative medications or methods of purchasing the prescription. It prohibits a PBM from charging or collecting a copayment that exceeds the total submitted charges by the pharmacy. The law also requires PBMs to provide a reasonable appeal process for pharmacies and specifies certain features, including timelines for appeal response and	6/22/2026	1/1/2027

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	information to be provided to the pharmacy if the appeal is denied. The bill also imposes certain duties on PBMs, including a duty to perform PBM services with care, skill, prudence, diligence, and professionalism and a duty of good faith and fair dealing with all parties with whom the PBM interacts in the performance of PBM services. When interacting with a covered individual, the PBM has the same duty to the covered individual as the insurer for whom it is performing PBM services. The law establishes that all funds and fees received by the PBM in relation to PBM services are received in trust and can be used or distributed only pursuant to the PBM's contract with the insurer or applicable law. Beginning August 1, 2027, the PBM must provide or disclose to its insurer clients: (1) any pricing discounts, rebates, inflationary payments, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other benefits received by the PBM, and all financial and utilization information related to services provided to the insurer; (2) the terms and conditions of any contract between the PBM and any party related to PBM services provided to the insurer; and (3) any activity, policy, practice, contract, or arrangement that presents a conflict of interest with the PBM's relationship with or obligation to the insurer. Beginning August 1, 2028, reports provided under the CAA 2026 will be sufficient to comply with these requirements.		
Tennessee	S.B. 2040, known as the Fair Rx Act, prohibits any person or entity, on or after July 1, 2028, from directly or indirectly owning, operating, controlling, or directing the operation of both a pharmacy and either a health insurance issuer or a pharmacy benefits manager. The law defines "control" broadly to encompass direct or indirect power to direct, manage, or influence the operations or policies of a pharmacy, whether through ownership, contract, shared governance, overlapping management, audit authority, exclusive provider agreement, formulary management clause, or other arrangement conferring material influence over pharmacy operations and applies when any ownership interest exceeds five	5/22/2026	5/22/2026

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	percent. A pharmacy affiliated with both a PBM and a health insurance issuer in violation of the law has a limited wind-down period through December 31, 2028, contingent on demonstrating to the board of pharmacy that it is actively pursuing a bona fide sale to an unaffiliated entity. The board may grant a single extension not to exceed six months upon proof of substantial progress toward completion of the sale. Violations carry civil penalties of up to \$10,000 per day, enforceable by the Tennessee attorney general. The law provides that a hospital or health-system pharmacy is not a PBM for purposes of the prohibition, does not limit the ability of independently owned or unaffiliated pharmacies to provide mail-order, specialty, or delivery services, and does not prohibit an employer from administering pharmacy benefits solely for its own employees under a self-funded employee benefit plan. The law also does not apply to pharmacy services provided pursuant to a contract with the Department of Defense for the administration of the federal TRICARE program.		
Utah	H.B. 527 requires PBMs to make available to network pharmacies an electronic, searchable list identifying all drugs subject to maximum allowable cost (MAC) reimbursement along with each drug's national drug code and the MAC amount. The law also requires PBMs to provide pharmacies with dedicated contact channels (phone, email, and website) for submitting MAC appeals, either directly or through a pharmacy services administrative organization, and PBMs must accept supporting documentation in both paper and electronic form. Finally, when a pharmacy's MAC appeal is denied, PBMs must now disclose the specific basis on which the PBM can demonstrate the drug is available for purchase at or below the MAC and must take certain actions if the appeal is upheld.	3/19/2026	5/6/2026
Vermont	H.B. 577 prohibits insurers or PBMs from excluding amounts paid by or on behalf of a covered individual through the Vermont Prescription Drug Discount Card Program or another discount card when calculating the individual's cost-sharing contribution, including when the individual purchased the drug without using a health insurance plan coverage. The law adds	6/15/2026	7/1/2026

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	discount cards to the types of payments that must be included in the cost-sharing contribution. To facilitate appropriate attribution of such payments, the insurer or PBM must make available a downloadable proof of payment form for a covered individual to submit proof of payment and must provide notice to all covered individuals at least annually that they are responsible for providing proof of payment to have their spending properly attributed.		
	S.B. 197 amends Vermont law to require a health insurer to provide 60 days' notice to all covered individuals who filled a prescription within the previous 12 months for a drug that is being removed from the insurer's formulary or a formulary maintained by the insurer's PBM that coverage for the drug will be discontinued and the date the coverage will end.	6/18/2026	6/18/2026
Virginia	S.B. 669 expands Virginia's regulation of PBMs by adding new prohibited practices (including charging electronic claim processing fees, reversing claims without prior written notice or just cause, reducing payments to effective reimbursement rates not agreed to in a provider agreement, and retroactively denying or reducing claims except in limited circumstances) and by codifying specific acts that constitute prohibited retaliation against pharmacies. Building on the existing spread pricing ban, the law now mandates pass-through pricing, requires PBMs to offer fee-only compensation arrangements upon plan sponsor request, and requires PBMs to direct 100% of manufacturer rebates to the carrier or plan (to offset cost sharing and reduce premiums) or to the covered individual at the point of sale.	3/31/2026	7/1/2027
	H.B. 830 is identical to S.B. 669 ; see summary above.	4/13/2026	7/1/2027
	H.B. 1214 reduces the existing cost-sharing cap for prescription insulin from \$50 to \$35 in aggregate per 30-day supply, regardless of the amount or type of insulin needed to fill the covered person's prescription. The law also sets an aggregate cost-sharing cap of \$35 per 30-day supply of diabetes equipment and supplies — including blood glucose meters and strips, urine-testing strips, syringes, continuous glucose monitors and supplies, and insulin	4/13/2026	Applies to contracts and policies issued, reissued, amended, or extended on or after January 1, 2027

State	Description of Measure(s)	Date(s) Enacted	Effective Date(s)
	pump supplies, regardless of the amount or type of equipment or supplies needed to fill the covered person's prescription.		
	H.B. 1450 revises existing law requiring an insurer to provide medical claims and cost information to the employer that is the policyholder. The new law applies the existing requirements to PBMs with respect to pharmacy claims.	4/22/2026	Applies to employee welfare benefit plans delivered, issued, reissued, or extended on or after January 1, 2027
West Virginia	H.B. 5430 , expanding on existing law regulating PBMs, prohibits a PBM from charging a health care payor or health benefit plan an amount greater than the national average drug acquisition cost (NADAC), if available, or an amount greater than the amount paid to the pharmacy if NADAC is not available. The law also clarifies that existing rebate pass-through requirements apply to rebates received through GPOs and other vendors and prohibits a PBM from using, participating in, or owning any part of a GPO for purposes of avoiding the requirements of the Pharmacy Audit Integrity Act that governs PBMs.	4/1/2026	4/1/2026

Pending State Legislation

State legislators introduced over 75 bills between mid-February 2026 and June 2026. View [our table of pending state PBM legislation](#) by topic.

Legal Challenges to State PBM Laws

Eighth Circuit Finds Arkansas Network Geographic Requirements Preempted by ERISA.

In *Flowers v. Caremark PCS Health, LLC*, the US Court of Appeals for the Eighth Circuit held that certain Arkansas requirements governing PBM pharmacy networks were preempted by ERISA. Specifically, provisions requiring PBMs to maintain pharmacy networks according to certain geographic requirements (e.g., a certain percentage of individuals in a plan residing within a set number of miles of a pharmacy) were determined to encroach upon ERISA by effectively dictating how PBMs

structure and manage their networks. (A separate legal decision, which had preliminarily enjoined the Arkansas law based upon the provisions governing pharmacy ownership, is currently under review by the Eighth Circuit.)

PBMs and PCMA Challenge Tennessee's Fair RX Act; Sixth Circuit Decides *McKee Foods Corp. v. BFP, Inc.* Tennessee's recently enacted Fair RX Act, which seeks to limit PBM ownership and control of pharmacies, has become the target of three separate federal lawsuits filed by CVS, Express



Scripts, and the Pharmaceutical Care Management Association (PCMA). The plaintiffs argue that the statute is preempted by federal programs, including ERISA, Medicare Part D, and TRICARE, and that requiring PBMs to divest long-standing pharmacy operations constitutes an unconstitutional taking of property. The lawsuits also allege that the law disproportionately burdens large national and specialty pharmacies that are located out of state. (These legal challenges have been brought despite the efforts of Tennessee lawmakers to adjust the Fair RX Act to account for legal issues identified in the prior lawsuits against the Arkansas law, including enacting certain exemptions for federal and military contracts.) These lawsuits remain pending.

Separately, in April, the [Sixth Circuit decided in *McKee Foods Corp. v. BFP, Inc.*](#) that Tennessee's any-willing-provider and anti-steering rules attempted to govern a matter of plan administration, and thus the regulations were preempted by ERISA.

PCMA Challenges Illinois' PDAA Reporting and Anti-Steering Requirements. Illinois' Prescription Drug Affordability Act (PDAA) faces a similar challenge in federal court in Illinois in *PCMA v. Gillespie*. The PDAA requires PBMs to submit annual reports detailing the PBM's drug pricing and dispensing practices to the state Department of Insurance and to payor customers. The PDAA also seeks to prevent PBMs from steering patients to pharmacies owned by the PBM and prohibits PBMs from designing networks to favor certain pharmacies. Here, PCMA argues that the state statute is preempted by ERISA.

State PBM Enforcement Actions

Florida Launches Antitrust Investigation of CVS's Ownership of PBM Caremark. Florida's attorney general is investigating CVS's ownership of Caremark along with hundreds of retail pharmacies in Florida. On June 23, 2026, Attorney General James Uthmeier [issued a Civil Investigative Demand \(CID\)](#)

probing CVS/Caremark's practices with respect to patient steering, reimbursement, audits, pharmacy contracts, rebates, and future expansion plans. According to the attorney general, compliance with the CID is required by July 28, 2026 — though it would not be unusual for this deadline to be extended. [We have previously written](#) on state and federal legislation targeting vertical integration, and Florida's investigation is another example of state-level enforcement action focused on the theory that vertically integrated PBM-pharmacy models harm competition and limit choices for consumers.

Discovery to Proceed in Michigan Antitrust Suit Against PBMs Pending Motion to Dismiss. In *Michigan v. Express Scripts, Inc. et al.*, No. 2:25-cv-11215 (E.D. Mich.), the PBMs moved to dismiss an [April 2025 complaint](#) filed by the Michigan attorney general. The complaint alleged that Express Scripts and Prime Therapeutics engaged in an unlawful agreement to suppress pharmacy reimbursement rates and harm competition. The PBMs argue that the state's horizontal price-fixing claims are legally deficient and time-barred. Despite the PBMs' request that discovery be stayed while the motion is pending, on April 20, 2026, Judge Jonathan J.C. Grey ordered discovery to proceed. This means that, notwithstanding the chance of dismissal, Michigan could obtain internal documents that shed light on how the PBMs set reimbursement rates and negotiate pharmacy contracts.

PBMs Seek Dismissal as Ohio Antitrust Action Proceeds in Federal Court. We previously [covered](#) the Sixth Circuit's [decision](#) to keep Ohio's lawsuit against several PBMs in federal court. Ohio brought the case under state antitrust and deceptive trade practices laws, accusing the PBMs of working together to inflate drug prices. The court found the PBMs were "acting under" federal officers, which allowed the case to stay in federal court.

The PBMs have since [moved](#) to dismiss the state's complaint, arguing that Ohio has not shown a "conspiracy," an unreasonable restraint of trade, or

antitrust injury. The PBMs also argue that Ohio lacks standing — meaning it is not legally authorized — to bring these claims. Ohio opposed the motion, challenging the PBMs' reliance on federal legal doctrines and defending the strength of its allegations. The parties finished briefing in late June and are now awaiting the judge's decision. The appellate case is *Ohio ex rel. Dave Yost v. Ascent Health Services, LLC et al.*, No. 24-3033 in the US Court of Appeals for the Sixth Circuit.

State Prescription Drug Boards

Colorado PDAB Litigation Update. In our [Spring 2026 PBM Update](#), we reported on the pending legal challenges to the Colorado [PDAB's](#) upper payment limit (UPL) on prescription drugs (scheduled to take effect on January 1, 2027). On July 1, the US District Court for the District of Colorado granted a [preliminary injunction](#) preventing enforcement of the UPL. The court held that the manufacturer was likely to succeed on the merits of its federal patent law challenge.

Update Since Publication: The Colorado PDAB voted to appeal the [injunction](#).

Maryland PDAB Proposed Its First UPLs. The Maryland PDAB [proposed rules](#) to implement UPLs on two prescription drugs. If finalized, the rules will be implemented in two phases. Phase 1 will go into effect in January 2027 and will apply to state and local government employee health plans. Phase 2 will go into effect in January 2028 and will expand the UPL to commercial payors.

Virginia Governor Vetoed a Bill to Create a PDAB. Governor Spanberger [vetoed H.B. 483](#) and [S.B. 271](#) (the Affordable Medicine Act). Similar bills were vetoed in 2024 and 2025 by former Governor Glenn Youngkin. The bill would have created a PDAB to conduct data analyses and develop policy recommendations on lowering drug prices. In her

veto, the governor focused on the PDAB's ability to establish UPLs, which, she argues, limit the availability of drugs based on cost, instead of medical necessity. She also asserts that UPLs in other states have not produced savings.

Louisiana Created a PDAB Without Authority to Set UPLs. On June 12, the governor signed [S.B. 401](#), which requires the new PDAB to (1) develop a list of prescription drugs sold in Louisiana for which there is a substantial public interest in understanding pricing, (2) identify up to 10 prescription drugs on which the state spends significant health care dollars and require manufacturers to report on them, and (3) publish a report on the PDAB website of its findings. The Act also requires manufacturers to annually report their current wholesale acquisition cost (WAC) for drugs sold in Louisiana and to report more detailed pricing information on drugs that meet certain price increase thresholds. These manufacturer reports will be published on the Department of Insurance website.

Separately, on June 29, the National Academy for State Health Policy [published](#) revised model legislation intended for states that want to use Medicare maximum fair prices as UPLs without establishing a PDAB.

OTHER INDUSTRY NEWS

Insulin Pricing Litigation

Additional Plaintiffs Joined the Insulin MDL. As reported in our [Spring 2026 PBM Update](#), the multi-district litigation (MDL) in the District Court of New Jersey is comprised of over 500 cases spanning plaintiffs from various entities including state and local governments, self-funded payors, unions, and private companies. The claims, combined under the MDL, allege that consumers were deceived by PBMs and manufacturers through a pricing scheme whereby manufacturers conspired to artificially raise prices and paid PBMs secret rebates for placement on the PBMs formularies. Since our last update, the following plaintiffs have joined the MDL or filed suits in their respective states:

- [The Commonwealth of Virginia](#);
- Chester County, Pennsylvania; and
- Aramark Services, Inc.

Opioid Cases Against PBMs

Michigan's Opioid Suit Against Express Scripts and Optum Rx Remains in Federal Court. On March 31, 2026, a federal judge denied Michigan's request to remand its [lawsuit against PBMs Express Scripts and Optum Rx](#) and their affiliates back to state court, meaning the case will continue in [federal court](#). Michigan sued the two PBMs in state court, alleging that their business practices helped fuel the opioid addiction crisis. Because the PBMs handle drug benefits for federal workers and the US Department of Defense as well as for private clients, the judge found they were acting under federal direction, and that their federal and nonfederal work could not be separated. Michigan tried to keep the case in state court by carving out the work done for federal clients, but the federal judge agreed with the companies that their negotiations on behalf of all clients are too intertwined to divide.

On May 15, 2026, the PBMs moved to dismiss the case, arguing they are not to blame for opioid abuse because they have no control over prescription drugs once those medications reach patients. The companies said their role is limited to negotiating drug prices and deciding which medications insurance will cover, and that they cannot be held responsible simply for being part of the supply chain for a legal, heavily regulated product. Citing the decision by the First Circuit Court of Appeals in a similar case earlier this year (discussed in our [Spring 2026 PBM Update](#)), the PBMs also contended that the state waited too long to sue, arguing the case is barred by a three-year statute of limitations because Michigan should have known of its claims back in 2019. Finally, the PBMs argued the lawsuit must additionally be dismissed on the grounds that federal law (ERISA) preempts the state's claims.

Separately, Optum Rx and its parent company, UnitedHealth Group, asked to be dropped from the case, saying the court has no authority over them because they are not based in Michigan. We are tracking additional court activity related to these motions.

Philadelphia Defends Opioid Suit Against CVS and Other PBMs. On February 24, 2026, the City of Philadelphia urged a Pennsylvania federal judge to reject arguments from CVS and other PBMs that they should be released from the city's lawsuit accusing them of helping fuel the opioid crisis. Responding to the PBM-defendants' motion to dismiss, the city argued that its claims were both filed on time and strong enough to move forward, contending that the PBMs worked with drug manufacturers to flood the market with opioids and expand access to the drugs in exchange for financial rewards, rather than protecting the health plans and patients who relied on them. As noted in our [Spring 2026 PBM Update](#), the companies had argued the city waited too long to sue; in this pleading, Philadelphia countered that it did not

learn the PBMs were a source of its harm until 2022 because of their alleged secret collusion, keeping the 2025 suit within the four-year filing deadline.

The city also defended the substance of its claims, asserting that it spent heavily on public services to fight the epidemic, including purchasing the overdose-reversal drug naloxone, while suffering falling property values, lost tax revenue, and a shrinking population. Philadelphia maintained that the opioid crisis harmed the community as a whole and not just individual users, pointing to widespread effects such as increased crime, discarded needles, and other public health and safety dangers that reach even residents who never used opioids.

Fourth Circuit Holds Express Scripts Entitled to Jury Trial in West Virginia Opioid Abatement Suit. On May 15, 2026, the US Court of Appeals for the Fourth Circuit ruled that Express Scripts is entitled to a jury trial in a lawsuit brought by 120 cities, towns, and counties across West Virginia alleging that Express Scripts contributed to excess opioids in these areas. These local governments had asked for an “abatement fund” to pay for removing the excess opioids as well as for addiction treatment, public education, and community rehabilitation. The trial court had planned to decide those claims itself in a bench trial rather than before a jury. The Fourth Circuit disagreed, concluding that because part of the relief sought (the abatement fund) is a legal remedy and not an equitable one, the Seventh Amendment guarantees the right to a jury.

Express Scripts had separately argued the district court’s order for “statewide” abatement was inappropriately broad because it risked adjudicating the rights of communities that were not parties to the litigation. Although the Fourth Circuit declined to order relief on this issue, the court expressly recognized Express Scripts’ ability to later challenge any order the district court may issue that is overbroad in this respect.

Market Developments

PBM Litigation Trends: The Fight Over Value in the Drug Supply Chain. Recent PBM litigation centers on a common theme: lack of transparency. These cases characterize PBMs not merely as intermediaries, but as gatekeepers whose complex pricing structures allegedly shift costs to plan sponsors, patients, and pharmacies. For example, labor unions are suing PBMs for alleged pricing and rebate schemes that inflate drug costs. In two class actions — [one in Illinois](#) against Express Scripts and [one in Rhode Island](#) against CVS — plaintiffs allege that PBMs charge drug manufacturers “exorbitant” fees to secure favorable formulary placement. This raises the concern that formulary access may be driven by rebate economics rather than patient cost or clinical value. The cases, brought under the Racketeer Influenced and Corrupt Organizations (RICO) Act, accuse PBMs of diverting billions in drug manufacturer rebates to offshore entities, breaching fiduciary duties, and inflating the costs of life-saving medications. *Plumbers’ Welfare Fund, Local 130 U.A. v. Express Scripts et al.*, No. 1:26-cv-01718 (N.D. Ill.); *Roofers’ Unions Welfare Trust Fund v. CaremarkPCS Health LLC et al.*, No. 1:26-cv-00162 (D.R.I.).

Direct-to-Employer Platforms Emerge as Alternatives to Traditional PBM-Managed Benefits. In early-to-mid 2026, several companies launched pharmacy benefit platforms that allow employers to offer workers access to high-cost drugs without routing those benefits through a traditional PBM. Rising GLP-1 costs and coverage gaps drove this trend. Multiple platforms now enable employers to offer transparent, cash-pay or subsidized pricing arrangements that operate alongside — not within — their traditional pharmacy benefits.

- In February 2026, GoodRx [launched](#) “Employer Direct,” a platform that enables employers to select high-impact brand medications (with an initial focus on GLP-1s)

and directly subsidize manufacturer-sponsored cash-pay prices available through GoodRx. The employer's contribution is applied at the pharmacy counter, reducing the employee's out-of-pocket cost without adding the medication to the insurance formulary.

- In March 2026, Eli Lilly formally [launched](#) “Employer Connect,” a direct-to-employer platform offering Zepbound at a list price of \$449 per month (applicable to all doses) through a dedicated pharmacy network that includes HealthDyne and Humana's CenterWell. The platform pairs employers with more than 15 independent program administrators — including Calibrate Health, Teladoc Health, GoodRx, and Mark Cuban's Cost Plus Drugs — to structure obesity benefits outside traditional plan designs.
- Omada Health also entered this space, offering a GLP-1 cash-pay option for employers that integrates clinical prescribing, behavioral support, and medication fulfillment.

These direct-to-employer models reflect several converging pressures: employer demand for more predictable and transparent pricing from PBMs; employee demand for GLP-1 access; manufacturers' desire to reach patients who lack formulary coverage; and a broader market shift toward transparency and consumer choice in pharmacy benefits.

Optum Rx Unveils Transparent, Fee-Based Pharmacy Care Model. On May 11, 2026, Optum Rx [announced](#) a new pharmacy care model described as the industry's first fully transparent pricing structure. As noted in our [Spring 2026 PBM Update](#), Optum Rx previously announced a shift to cost-based pharmacy reimbursement and reduced prior authorization requirements. The new model goes further — it replaces traditional pricing approaches

tied to manufacturer list prices or prescription volume with monthly, clearly defined per-member fees that are independent of drug pricing. The model also eliminates spread pricing and provides full transparency into Optum Rx's fees, including those charged by its group purchasing arm, and discloses all payments received from drug manufacturers. By the end of 2027, Optum Rx plans to fully transition its group purchasing to flat service fees.

Optum Rx's announcement follows similar commitments from competitors. As noted in our [Spring 2026 PBM Update](#), Express Scripts announced a shift to a rebate-free, pass-through model (to be standard for all clients by 2028), and CVS has signaled movement toward cost-plus pharmacy reimbursement. Each of the Big Three PBMs has now announced pricing models that emphasize transparency, though the scope and timing of implementation vary.

PCMA's Path to Patient Affordability. On June 9, 2026, PCMA [released](#) “The Path to Patient Affordability,” a six-part policy platform urging federal and state policymakers to take action to lower drug costs. The platform focuses on competition-enhancing policies, including encouraging prescribers to use electronic tools showing patients their lowest-cost options, accelerating biosimilar adoption, and promoting transparency in manufacturer pricing. PCMA has framed the initiative as building on the PBM reform enacted in the CAA 2026, positioning the industry as aligned with — rather than resistant to — reform objectives.

From the Desk of ML Strategies

Introducing [Traci L. Vitek](#)

Senior Vice President, ML Strategies

Mintz is pleased to welcome Traci L. Vitek, Senior Vice President at ML Strategies. Drawing on more than two decades of experience in federal health policy, on Capitol Hill and in the private sector, Traci brings valuable perspective on the forces reshaping the PBM industry.

Federal PBM policy has entered a consequential implementation phase. Following enactment of the CAA 2026, agency activity and congressional oversight are now focused less on whether PBM reform will occur and more on how new statutory requirements will be defined, operationalized, and enforced. The developments below highlight the policy choices that will shape PBM compensation, transparency, plan sponsor accountability, pharmacy access, and market conduct over the next several years.

Trump Administration Regulatory Activity

The Trump administration's PBM agenda is now centered on translating statutory reforms into administrable rules and compliance expectations. Recent activity points to several policy priorities:

- **Medicare Part D “delinking” is becoming an operational compliance issue.** Beginning in 2028, PBM compensation for Part D services must move away from list-price-, utilization-, or rebate-linked remuneration and toward bona fide, flat-dollar, fair-market-value service fees. The practical policy question is how CMS will distinguish permissible service fees from payments that function as continued price-linked compensation.
- **DOL transparency rulemaking remains central to the commercial-market policy framework.** The Department of Labor's PBM transparency rulemaking complements the CAA 2026's employer-plan reporting,

rebate pass-through, and audit provisions by increasing the information available to ERISA plan fiduciaries. This reflects a broader federal move toward treating PBM oversight as part of plan fiduciary governance and procurement accountability.

- **The federal policy trajectory is toward transparency,** auditability, and anti-circumvention. Agency activity since April suggests regulators are building the record needed to define covered entities, standardize reporting, identify compensation channels, and close potential loopholes before the 2028–2029 implementation window.

Congressional PBM Oversight and Legislation

On Capitol Hill, PBM reform has shifted from enactment to oversight, implementation pressure, and targeted follow-on legislation. With the CAA 2026 now serving as the federal baseline, lawmakers are focused on whether agencies implement the statute aggressively enough to address concerns about market consolidation, opaque compensation, pharmacy reimbursement, and employer access to pricing data.

Key policy themes include:

- **Oversight of CAA implementation.** Congressional committees — particularly Senate HELP and House committees with health jurisdiction — are monitoring whether CMS, DOL, and other agencies translate the CAA's PBM provisions into enforceable rules. Chairman Bill Cassidy's recent questioning of Department of Labor officials regarding PBM transparency regulations underscores continued interest in employer-sponsored plan oversight and fiduciary accountability.



From the Desk of ML Strategies (cont.)

- **Continued scrutiny of PBM market conduct.** Hearings this year have examined vertical integration, spread pricing, broker compensation arrangements, rebate incentives, and PBM-affiliated pharmacy networks. The policy concern is not only whether PBM practices increase costs, but whether current market structures limit plan sponsor visibility, pharmacy competition, and patient access.
- **Targeted follow-on reforms are emerging.** Lawmakers are beginning to consider narrower proposals that would build on the CAA by addressing specific gaps or unresolved policy questions, including:
 - i. Whether additional limits are needed on PBM vertical integration, ownership structures, and affiliated-pharmacy steering
 - ii. Whether PBM-broker compensation arrangements create conflicts of interest for employer plan sponsors
 - iii. How much claims, pricing, rebate, and reimbursement data employers and plan fiduciaries should be able to access and audit
 - iv. How direct-to-consumer purchasing models, alternative distribution channels, and pharmacy access protections may affect traditional PBM contracting models
- **Transparency and fiduciary accountability remain the unifying congressional themes.** Congress continues to press for employer-sponsored plans to receive complete and usable information regarding rebates, fees, spread pricing, pharmacy reimbursement, and other compensation arrangements. The implementation period will be a key test of whether statutory transparency rights translate into practical negotiating leverage for plan sponsors and meaningful accountability for PBMs.

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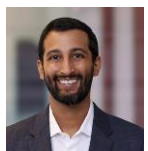
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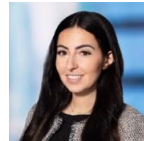
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