EXAMPLE LEGISLATION OF PRICE AND SALES TRANSPARENCY

State Law	Law Addresses	Price Increases Triggering Reporting Requirements	Price Data	Effectiveness Information	Company Pricing Considerations	Production Cost Information	Sales Information	Profit Information	Rebate/Pharmacy Benefit Manager Information	Patient Assistance Programs and Coupon Information	Other Information Required	Enforcement
California (SB 17/Chapter 603) - 2017	All drugs with a wholesale acquisition cost (WAC) exceeding $40 over a course of a treatment with a WAC increase of more than 16%	Drugs with a wholesale acquisition cost (WAC) exceeding $40 over a course of treatment and have an increase of more than 16%, including the proposed and cumulative increases that occurred over the previous two calendar years	– Wholesale acquisition cost (WAC) – If manufactured by the company, a schedule of WAC increases for the past five years – If the drug was acquired from another company within the past five years: WAC at acquisition – Name of company – Year the drug was introduced to the market and – WAC at the time of introduction – Patent expiration date	Explanation of the change or improvement and if that necessitates a price increase	Financial and non-financial factors in price increase	NA	United States unit sales volume in prior calendar year	NA	NA	NA	NA	Civil fine of $1,000 per day for late submission of a required report
Connecticut (HB 5384/ Public Act 18-41) - 2018	A list of 10 outpatient prescription drugs determined by the executive director of the Office of Health Strategy as: -A substantial cost to the state or -Critical to public health	If wholesale acquisition cost (WAC), less all rebates: - Increased by at least 20% during the previous year or by 50% over the past three years and -Was more than $60 per month over the course of treatment	NA	NA	All factors that caused the increase in the wholesale acquisition cost (WAC) in a written, narrative description suitable for public release	Aggregate company level research and development costs and other such capital expenditures that the executive director deems relevant	NA	NA	NA	NA	NA	No more than $7,500 per violation
Florida (SB 1550/Chapter No. 2023-29) - 2023	Any prescription drug with a wholesale acquisition cost (WAC) of at least $100 for a course of therapy	–An increase of 15% or more of the WAC in the preceding year –Any cumulative increase of 30% or more of the WAC during the preceding 3 calendar years (calculated by comparing the WAC at the beginning and end of the 3-year period)	For a price increase: –Propriety and nonproprietary names of the drug –WAC before the increase –Dollar amount of the increase –Percentage increase from initial WAC –Intended uses of drug For the annual report: –List of all prescription drugs affected by a reportable price increase (proprietary and non-proprietary names) –Dollar amount and percentage of each increase relative to initial WAC, including total increase over the year if multiple forms have been previously filed for one drug –Intended uses and whether the manufacturer benefits from market exclusivity for each drug –Length of time each drug has been available for purchase –List of factors contributing to each increase, with description of justification for each factor and estimated percentage of influence of each factor adding up to 100% –Any action that the manufacturer has filed to extend a patent report after the first extension has been granted	Explanation of any change or improvement and if that necessitates a price increase	List of factors contributing to each reportable drug price increase	Annual report requires list of factors contributing to each reportable drug price increase, which can include research and development and manufacturing costs	Annual report requires list of factors contributing to each reportable drug price increase, which can include advertising and marketing costs	Annual report requires list of factors contributing to each reportable drug price increase, which can include profit information	Annual report requires list of factors contributing to each reportable drug price increase, which can include any rebate increase requested by a pharmacy benefit manager	Annual report requires list of factors contributing to each reportable drug price increase, which can include operating patient assistance and educational programs	NA	Not Specified
Louisiana (SB 283 / Act No. 371) - 2018	All prescription drugs with a wholesale acquisition cost (WAC) of $100 or more for a thirty-day supply	Wholesale acquisition cost (WAC) increase of 50% or greater	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Maine (LD 1162 /Chapter 470) - 2019	Per 2021 program updates, - on February 15 of each year, the Maine Health Data Organization (MHDO) will release a list of drugs that require reporting from manufacturers, wholesale distributors, and pharmacy benefit managers. In addition to the drugs that meet the specific price thresholds, MHDO may include drugs from the lists of the 25 costliest drugs, the 25 most frequently prescribed drugs in the state, and the 25 drugs with the highest year-over-year cost increases	Manufacturers must notify the state if their drugs had a price increase in the prior year, including: - Brand-name drugs with a wholesale acquisition cost (WAC) increase of more than 20% and - Generic drugs with a WAC of at least $10 and increases of more than 20%. Beginning January 30, 2022 instead of manufacturers reporting to the Maine Health Data Organization (MHDO), MHDO will post a list of prescription drugs from the prior calendar year that meet the price increase thresholds on its website.	NA	NA	NA	NA	NA	NA	NA	NA	NA	Civil fine of $30,000 for each day of violation; Maine can also audit the the submitted data at the manufacturer's expense
Minnesota (SF 1098 / Session Law Chapter 78) - 2020	Beginning January 1, 2024, the Commissioner must post on the Minnesota Department of Health website a list of up to 500 prescription drugs that the Commissioner determines to represent a substantial public interest. Substantial public interest will be determined by considering drugs that have previously triggered reporting, drugs for which average claims exceeded 125% of the drug price at the claim date, and drugs identified by the public through public comment.	- Brand-name drugs (including newly-acquired drugs) with a wholesale acquisition cost (WAC) increase of 10% or more in a year or 16% in 24 months - Generic drugs (including newly acquired drugs) with a WAC increase of 50% or more in a year	–The name, description and price of the drug and the net increase, expressed as a percentage, with the following listed separately: –The national drug code, the product name, the dosage form, the strength, and the package size –The name of any generic version of the prescription drug available on the market –The introductory price and the net yearly increase in price during the previous five years and the price of the drug on the last day of each of the five calendar years preceding the price increase –If the prescription drug was acquired by the manufacturer during the previous 12-month period: –Price at acquisition, price in the calendar year prior to acquisition, name of the company from which the drug was acquired, date of acquisition, and acquisition price.	NA	Factors that contributed to the price increase	Listed separately: – Manufacturing costs – Marketing/advertising costs – Distribution costs	Total sales revenue for the drug during the previous 12-month period	Manufacturer's net profit attributable to the drug during the previous 12-month period	NA	Total amount of financial assistance the manufacturer has provided through PAPs	– The name of any generic version of the drug available on the market – If a brand drug, the 10 highest prices paid for the drug in any country other than the U.S. – Any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the drug – The patent expiration date if under patent – The name and location of the company that manufactured the drug	Civil fine up to $10,000 per day of violation

Nevada (SB 539/Chapter 592) - 2018 (SB 380/Chapter 547) - 2021	All prescription drugs (Until 2021, NV's law required reporting on essential diabetes and asthma medicines only)	Asthma drugs with wholesale acquisition cost (WAC) increases of a % equal to or greater than: – Percentage increase of the Medical care component of the medical consumer price index during the past year or – Twice the percentage increase in the medical consumer price index during the past two years All other drugs with a wholsale acquisition cost (WAC) of. at least $40 for a course of therapy and have a WAC increase of a percentage equal or greater than: – 10% during the preceding calendar year, or – 20% druing the preceding two calendar years	– Wholesale acquisition cost (WAC) – WAC price over the previous five years (amount of each increase expressed as a % of total WAC) – National Drug Code for the drug – Name, strength, dosage form, and strength of the drug	NA	– A list of each factor that has contributed to the increase – Percent of the total increase that is attributable to each factor – An explanation of the role of each factor in the increase	– Production costs – Administrative costs including marketing If the manufacturer acquired the intellectual property in the last five years, they must provide: – Name of the entity the property was acquired from; – Date of acquisition and purchase price – Wholesale acquisition cost (WAC) at the time of acquisition – WAC one year before acquisition – Year the drug was first made available for sale	List of pharmaceutical sales reps. who market the drug	– Profit earned – Profit earned as a percent of the total profit for the period the drug has been on the market	Aggregate amount of rebates that the manufacturer has provided to PBMs for sales of the drug	– Total amount of financial assistance that the manufacturer has provided – Cost associated with coupons provided to consumers	NA	$5,000 per day for failure to report
New Jersey (S 1615 / P.L.2023, c. 106)	All prescription drugs	Brand-name drugs with wholesale acquisition cost (WAC) increase of more than 10% per pricing unit in a year -Generic drugs priced between $10-$100 per unit with WAC increase of more than 40% in a year -Generic drugs priced at greater than $100 per unit with WAC increase of more than 10% in a year	–Name of drug –National drug code –WAC and related information for the drug or drug group as specified by the division, which may include but shall not be limited to the year of market introduction, WAC at market introduction, WAC in the previous calendar year, and current WAC	NA	Reasons for price increase	–Manufacturer costs associated with sales of the drug in the state as specified by the division in the previous calendar year and projected for the current calendar year; –Current year projections or incurred cost year to date, as the division may indicate, related directly or allocated specifically to sales of this drug or drug group in the State	–Sales volume in previous year and projected for coming year	–Revenue from previous year and projected revenue for coming year	NA	NA	–If a manufacturer certifies that it does not have access to the State-specific data required to be reported and has no way of obtaining the data, the division may permit the manufacturer to report the data on a national level upon proof satisfactory to the division that State-specific data is unavailable to the manufacturer	Director of the Division of Consumer Affairs may impose a civil fine of $20,000 for first day of violation and for subsequent days an amount starting at $21,000 and increasing by $1,000 for each day of non-compliance, not exceeding $100,000
New Mexico (HB33) 2023	All prescription drugs	Wholesale acquisition cost of $400 or more for a 30-day supply or for a course of treatment that is less than 30 days and is: -a brand name drug that has increased in wholesale acquisition cost by ten percent or more in the previous calendar year; -brand name drug that has increased in wholesale acquisition cost by sixteen percent or more over the course of the previous two calendar years; or -generic drug or biosimilar product that has increased in wholesale acquisition cost by thirty percent or more in the previous calendar year	For price increase: -Date of the increase -The current wholesale acquisition cost of the prescription drug -The dollar amount of the future increase in the wholesale acquisition cost of the prescription drug For annual report: -Introductory wholesale acquisition cost of the prescription drug product -Annual increase in the prescription drug product's wholesale acquisition cost over the previous five calendar years -Direct costs associated with manufacturing, marketing and distributing the prescription drug product -Total revenue from the prescription drug product over the previous calendar year -Net profit attributable to the prescription drug product over the previous calendar year -Patent expiration date for the prescription drug product -10 highest government-negotiated prices of the prescription drug product in European Union countries and the United Kingdom -Any agreement between the manufacturer and another entity that involves a delay in marketing a generic version of the prescription drug product -Names and prices of any generic equivalents of the prescription drug product -Total amount of manufacturersupported financial assistance provided to consumers of the prescription drug product	Explanation of any change or improvement and if that necessitates a price increase								May be subject to a penalty for failing to submit information or data; failing to submit information or data on time; or providing inaccurate or incomplete information or data. The entity that submitted the data shall pay all costs associated with the audit
New York (A 1707) - 2023	All prescription drugs with a wholesale acquisition cost of more than $40 for a course of therapy	If increase in the wholesale acquisition cost of such prescription drug is more than 16%, including the proposed increase and the cumulative increases that occurred within the previous 24 months prior to the planned effective date of the increase	-Date of the increase -The current wholesale acquisition cost of the prescription drug -The dollar amount of the future increase in the wholesale acquisition cost of the prescription drug -Proposed increase and the cumulative increases that occurred within the previous 24 months.	Explanation of any change or improvement and if that necessitates a price increase								Up to $5,000 per day for every day after the reporting period described in this section that the required information is not reported.
North Dakota (HB 1032) - 2021	All prescription drugs	Drugs with a wholesale acquisition cost (WAC) of $70 or more and a WAC increase of 40% or greater of the preceding five years or 10% or greater in the preceding 12 months	– Name of drug – Whether the drug is brand or generic – Effective date of price increase – Name of each of manufacturer's drug approved by FDA in last five years – Name of drugs that lost patent exclusivity in the previous five years	NA	NA		NA	NA	Aggregate rebate amounts paid to each PBM for the previous calendar year	NA	NA	Civil penalty not to exceed $10,000 for each violation. The attorney general may waive or reduce a fine.

Oregon (SB 192 / Chapter 466) - 2023	Requires pharmacy benefit managers to annually report to Department of Consumer and Business Services information about certain rebates, fees, price protection payments and other payments received from prescription drug manufacturers. Requires department to publish aggregated information received from pharmacy benefit managers on department's website.										Requires Prescription Drug Affordability Board to develop, and to report on to interim committees of Legislative Assembly related to health by September 15, 2024, plan for establishing upper payment limits on certain drugs. Provides that plan must include analysis of how upper payment limits could be implemented by Public Employees' Benefit Board, Oregon Educators Benefit Board, other state-administered health benefits and insurance. Provides that report must include analysis of potential savings or costs for state, insurers, hospitals, pharmacies and consumers.	
Oregon (HB 4005/Chapter 7) - 2018	All prescription drugs costings $100 per month or more over the course of treatment and All drugs with a net price increase of 10% or more	Drugs with a cost of more than $100 a month that increase greater than 10% in prior calendar year	– Wholesale acquisition cost (WAC) – WAC price over the previous five years – Price Increase as percent of drug's price – 10 highest prices paid for drug outside of U.S. – Time on market – Price at launch – Price increases by calendar year since launch	Whether drug is more effective than predicted	Financial and non-financial factors in price increase	– Manufacturing costs – Marketing Costs – Distribution Costs – Ongoing Research	Total sales revenue for the drug during the previous year	Profit attributable to the drug during the previous year	Amount of rebates to PBM; PBM rebates by insurance market segment	– Number of program participants – Total value of the coupons, discounts, or copay assistance – Number of regills that qualify – Program expiration date – Eligbility Requirements	NA	Up to $10,000 per day for failure to report complete and accurate data
Texas (HB 2536) - 2019	All prescription drugs	Wholesale acquisition cost (WAC) of more than $100 over a course of treatment or a 30-day supply with a WAC increase of: - 15% over previous year or - 40% over the previous three years	– Name of drug – Whether the drug is brand or generic – Effective date of price increase – Name of each of manufacturer's drug approved by FDA in last three years – Name of drugs that lost patent exclusivity in the previous three years	NA	Description of the factors that caused the increase and an explanation of the role of each factor in the cost	Aggregate, company level research and development costs for the most recent year	NA	NA	NA	NA	NA	Not Specified
Utah (SB 272) - 2020	All prescription drugs that cost $100 or more for a 30-day supply	Wholesale acquisition cost (WAC) increase greater than 16% in two years or 10% in one year	– Name, dosage form, and strength of the drug – Whether the drug is brand or generic – Effective day of the wholesale acquisition cost (WAC) – Names of drugs manufactured by the manufacturer that lost patent exclusivity during the preceding three calendar years	NA	Written description of the factors that led to the increase and the significance of each factor	Aggregate, company-wide research and development costs for the most recent year	NA	NA	NA	NA	NA	Not specified
Vermont (S 92 / Act 193) - 2018	Fifteen drugs with price increases listed as sources of significant spending (generic and brand-name drugs), determined by the Attorney General's office based on submissions from the Department of Health Access and health insurers	Drugs to be included in the list of 15 drugs will have wholesale acquisition cost (WAC) increases of 50% or more in past five years, or 15% or more in previous year	NA	NA	Each factor that caused the net cost increase; percent of the total cost increase attributable to each factor; and an explanation of the role of each factor in the cost increase	NA	NA	NA	NA	NA	NA	$1,000 per day for failure to report
Virginia (HB 2007/Assembly Chapter 304) - 2021	All prescription drugs	- Brand-name drugs (including biologics) with a wholesale acquisition cost (WAC) of more than $100 over a course of treatment or a 30-day supply with a WAC increase of 15% or more over the preceding calendar year - Generic drugs with a WAC of at least $100 for a 30-day supply and a WAC increase of 200% or more during the preceding 12-month period	– Name of drug – Whether the drug is brand or generic – Effective date of price increase – Name of each of manufacturer's drug approved by FDA in last three years – Name of drugs that became subject to generic competition and for which there is a therapetutically equivalent version available	NA	Concise statement regarding the factors that caused the increase in wholesale acquisition cost (WAC)	Aggregate, company level research and development costs for the most recent year	NA	NA		NA	NA	Civil penalty not to exceed $2,500 per day (Commissioner may reduce or waive the penalty)
Washington (HB 1224/ Chapter 334) - 2019	All prescription drugs	Wholesale acquisition cost (WAC) of more than $100 over a course of treatment or 30-day supply with a WAC increase of: - 20% over previous year or - 50% over the previous three years	N/A	Statement regarding whether a change or improvement in the drug necessitates the price increase	– A description of financial & nonfinancial factors used to make the decision to set or increase the wholesale acquisition cost (WAC) – Explanation of how these factors explain the increase in WAC	Itemized cost for prodution and sales including: - Annual manufacturing costs - Annual marketing and adversiting costs - Total research and development costs - Total costs of clinical trials and regulation - Total cost for acquisition of the drug		NA	NA	Total financial assistance given by the manufacturer through assistance programs, rebates, and coupons	NA	WA Health Care Authority may assess a fine up to $1,000 per day for failure to comply
West Virginia (SB 689) - 2020	All prescription drugs that cost $100 or more for a 30-day supply	Generic, brand-name, or specialty drugs with a wholesale acquisition cost (WAC) of at least $100 for a 30-day supply; and a WAC increase of: - 40% or greater over the preceding three calendar years, or -15% or greater in the previous calendar year	– Name of drug – Whether the drug is brand or generic – Effective date of price increase – Introductory price of the drug when it was approved by the FDA	NA	Statement regarding the factor or factors that caused the WAC increase	Aggregate, company level research and development costs for the most recent year with final audit data	Name and annual U.S. sales/revenue of each drug manufacturer's prescription drugs that lost patent exclusivity in the United States in the previous three calendar years	NA	NA	NA	NA	State Auditorwill publish the identity of any drug manufacturer who fails to comply with the requirements or who submits false or inaccurate information

https://nashp.org/state-tracker/prescription-drug-pricing-transparency-law-comparison-chart/
Accessed: 12/24/2025
Note: Removed columns extraneous to the main substance of the bills, such as "amendments to state law," and "use of public funds"

EXAMPLE LEGISLATION OF SPECIALTY PHARMACEUTICALS (BROWN/WHITE BAGGING)

State	Bill #	Year	Short Summary	Status	Date of Last Action	Topics	Summary
Alaska	AK H 226	2024	Board of Pharmacy	Enacted - Act No. 2024-61	09/23/2024 - Enacted	Pharmacy Benefit Managers (PBM)	For a prescription drug that the FDA or the prescription drug's manufacturer has not approved for self-administration, the Pharmacy Board has the power to prohibit, limit, or provide conditions relating to the dispensing of the prescription drug, including establishing specifications to ensure the effectiveness and security of a prescription drug to be administered by infusion or otherwise administered in a clinical setting. Relates to white bagging.
Arkansas	AR S 104	2025	State Pharmacy Benefits Manager Licensure Act	Enacted - Act No. 514	04/10/2025 - Enacted	Cost Sharing and Deductibles - Consumers, Pharmacy Benefit Managers (PBM)	A healthcare payer, pharmacy benefits manager (PBM), or PBM affiliate shall not engage in unfair or deceptive trade practices in the administration of pharmacy benefits. Defines that unfair trade practices includes a policy or protocol that unreasonably restricts an enrollee's choice of pharmacy within the PBM network, so long as a pharmacy meets the PBM network participation requirements. This include a pharmacy that has existing approval to dispense one (1) or more self-administered prescription drugs in the pharmacy benefits manager network or one (1) or more networks for the underlying health benefit plan, (white-bagging), coercing enrollees, either through penalties or adjustment through cost-sharing responsibilities, or failing to disclose other options, to use PBM-affiliate pharmacies (steering). A PBM or healthcare payer is prohibited from restricting a pharmacy or pharmacist from discussing a health benefit plan, including prescription drug benefits, with an enrollee (gag-clause). Allows for rulemaking. Prohibition of carve-out networks or ghost networks. A healthcare payor or PBM shall ensure that its PBM network of participating pharmacists and pharmacies is not solely serviced by a mail-order and PBM-affiliated. Add public health emergency clause.
Arkansas	AR H 1907	2021	Patients Best Interest Billing	Enacted - Act No. 1105	05/03/2021 - Enacted	Access, Insurance/Coverage - Rx Drugs, Specialty Pharmaceuticals, Cost Sharing and Deductibles - Consumers	Enables healthcare providers to make appropriate billing decisions that are in the best interest of patients, establishes the Billing In the Best Interest of Patients Act. Relates to white bagging policies.
Idaho	ID H 596	2024	Pharmacy Benefit Managers	Enacted - Act No. 247	04/01/2024 - Enacted	Cost Sharing and Deductibles - Consumers, Pharmacy Benefit Managers (PBM)	A pharmacy benefit manager shall not directly or indirectly charge a pharmacy benefits plan or program a different amount for a prescription drug's ingredient cost or dispensing fee than the amount the pharmacy benefit manager reimburses a pharmacy for the prescription drug's ingredient cost or dispensing fee where the pharmacy benefit manager retains the amount of any such difference. The pharmacy benefit manager shall pass along or return one hundred percent (100%) of any manufacturer rebate to a pharmacy benefits plan or program, including any payment, discount, incentive, fee, price concession, or other remuneration. No later than January 1, 2025, and each year thereafter, each licensed pharmacy benefit manager shall report to the director of the department of insurance the following information: (i) The aggregate amount of the difference between the amount the pharmacy benefit manager paid each pharmacy on behalf of the health plan for prescription drugs, and (ii) If at any time during the reporting year the pharmacy benefit manager moved or reassigned a prescription drug to a formulary tier that has a higher cost, higher copayment, higher coinsurance, higher deductible to a consumer, or lower reimbursement to a pharmacy, an explanation of the reason why the drug was moved or reassigned, including whether the move or reassignment was determined or requested by a prescription drug manufacturer or other entity. Any pharmacy benefit manager that owns, controls, or is affiliated with a pharmacy shall also report any difference in reimbursement rates or practices, direct and indirect remuneration fees or other price concessions, and clawbacks between a pharmacy that is owned, controlled, or affiliated with the pharmacy benefit manager and any other pharmacy. In addition to any other requirements in this title, all contractual arrangements executed, amended, adjusted, or renewed between a pharmacy benefit manager and a pharmacy benefits plan or program must include, in substantial form, requirements, to the extent allowable by law, to: (a) Use a pass-through pricing model, (b) Exclude terms that allow for the direct or indirect engagement in the practice of spread pricing, (c) Ensure that funds received in relation to providing services for a pharmacy benefits plan or program or a pharmacy are used or distributed only pursuant to the pharmacy benefit manager's contract with the pharmacy benefits plan or program or with the pharmacy or as otherwise required by applicable law, (d) Require the pharmacy benefit manager to pass one hundred percent (100%) of all prescription drug manufacturer rebates, including nonresident prescription drug manufacturer rebates, received to the pharmacy benefits plan or program, if the contractual arrangement delegates the negotiation of rebates to the pharmacy benefit manager, for the sole purpose of offsetting defined cost-sharing and reducing premiums of covered persons. Rebates include any payment, discount, incentive, fee, price concession, or other remuneration. Any excess rebate revenue after the pharmacy benefit manager and the pharmacy benefits plan or program have taken all actions required pursuant to this section must be used for the sole purpose of offsetting copayments and deductibles of covered persons, (e) Include network adequacy requirements that meet or exceed medicare part D program standards for convenient access to the network pharmacies and that: (i) Do not limit a network to solely include affiliated pharmacies, (ii) Do not require a covered person to receive a prescription drug by United States mail, common carrier, local courier, third-party company or delivery service, or pharmacy direct delivery unless the prescription drug cannot be acquired at any retail pharmacy in the pharmacy benefit manager's network for the covered person's pharmacy benefits plan or program. (iii) For the in-person administration of covered prescription drugs, prohibit requiring a covered person to receive pharmacist services from an affiliated pharmacy or an affiliated health care provider, and (iv) Prohibit offering or implementing pharmacy networks that r equire or provide a promotional item or an incentive to a covered person to use an affiliated pharmacy or an affiliated health care provider for the in-person administration of covered prescription drugs or advertising, marketing, or promoting an affiliated pharmacy to covered persons. Relates to white bagging policies. At a minimum, require the pharmacy benefit manager or pharmacy benefits plan or program to, upon revising its formulary of covered prescription drugs during a plan year, provide a sixty (60) day continuity-of-care period in which the covered prescription drug that is being revised from the formulary continues to be provided at the same cost for the patient for a period of sixty (60) days. Relates to pharmacy contracts, networks and reimbursement from PBMs.
Maryland	MD H 1243	2025	Specialty Drugs Insurance Coverage	Enacted - Act No. 729	05/20/2025 - Enacted	Insurance/Coverage - Rx Drugs, Cost Sharing and Deductibles - Consumers, Pharmacy Benefit Managers (PBM); Crossfiled with MD S975	An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for prescription drugs through a pharmacy benefits manager may not exclude coverage for a covered specialty drug administered or dispensed by a provider. Relates to white bagging.
Missouri	MO S 751	2024	Insurance Coverage of Pharmacy Services	Enacted - Became Law Without Governor's Signature	07/09/2024 - Enacted	Pricing and Payment - Industry, Other Prescription Drug Measures	A pharmaceutical manufacturer, third-party logistics provider, or an agent or affiliate of such pharmaceutical manufacturer or third-party logistics provider, shall not deny, restrict, or prohibit, either directly or indirectly, the acquisition of a 340B drug by, or delivery of a 340B drug to, a pharmacy that is under contract with, or otherwise authorized by, a covered entity to receive 340B drugs on behalf of the covered entity unless such receipt is prohibited by the United States Department of Health and Human Services. he state board of pharmacy may promulgate rules to implement the provisions of this section. The state board of pharmacy is authorized to investigate any complaint of a violation of this section.

Mississippi	MS H 17	2025	Patient Access to Physician Administered Drugs Act	Enacted - Became Law Without Governor's Signature	03/21/2025 - Enacted	Insurance/Coverage - Rx Drugs, Cost Sharing and Deductibles - Consumers, Pharmacy Benefit Managers (PBM)	A health insurance issuer, pharmacy benefit manager (PBM), or the agent of either shall not: Refuse to authorize, approve, or pay a participating provider for providing covered physician-administered drugs and related covered services to covered persons, or Require a covered person to pay any penalty or additional fee not otherwise applicable to cost-sharing amounts payable by the covered person as designated within the benefit plan to obtain the physician-administered drug when provided by a participating provider. Relates to white-bagging.
North Dakota	ND S 2378	2023	Clinician-Administered	Enacted - Act No. 208	04/04/2023 - Enacted	Biologics and Biosimilars, Pharmacy Benefit Managers	Regulates pharmacy benefit managers by prohibiting any pharmacy benefit manager, third-party payer, or other related parties from requiring a patient, as a condition of payment or reimbursement, to purchase pharmacy services exclusively through mail-order pharmacy or pharmacy benefit manager affiliate, or combination of both. Relates to white bagging policies.
Oklahoma	OK H 1713	2024	Pharmacy Provisions	Enacted - Act No. 185	04/29/2024 - Enacted	Biologics and Biosimilars, Pharmacy Benefit Managers (PBM)	All health benefit plans and pharmacy benefits managers in this state shall not refuse to authorize, approve, or pay a participating provider for providing covered physician-administered drugs to covered persons. A health benefit plan or a pharmacy benefits manager of a plan shall not require a covered patient to self-administer an injectable drug against a health care provider's recommendation in accordance with the manufacturer's approved guidelines. Health benefit plans shall not require a covered patient to pay additional fees for white bagged drugs beyond cost-sharing obligations as outlined in the individual's plan. Providers and health care facilities shall be permitted to dispense and administer a covered physician-administered drug based on a patient's best interest, provided that the health care facility or provider that administers the drug shall agree to the terms and conditions of network participation and accept, as payment in full, reimbursement for the drug at the health insurer's negotiated contracted rate. The health care facility or provider is prohibited from billing or collecting from the patient any amount in excess of or in addition to the patient's cost sharing obligations as outlined in the individual's plan. Relates to white-bagging.
Oregon	OR H 4012	2024	Clinician Administered Prescription Drugs	Enacted - Act No. 024	03/27/2024 - Enacted	Cost Sharing and Deductibles - Consumers, Pharmacy Benefit Managers (PBM)	Relates to white bagging policies.
Texas	TX H 1647	2023	Health Benefit Plan Coverage of Administered Drugs	Enacted - Act No. 417	06/09/2023 - Enacted	Biologics and Biosimilars, Insurance/Coverage - Rx Drugs, Pharmacy Benefit Managers (PBM); TX S 1138 - Very similar	Sec. 1369.764. CERTAIN LIMITATIONS ON COVERAGE OF CLINICIAN-ADMINISTERED DRUGS PROHIBITED. (a) A health benefit plan issuer may not, for an enrollee with a chronic, complex, rare, or life-threatening medical condition: (1) require clinician-administered drugs to be dispensed only by certain pharmacies or only by pharmacies participating in the health benefit plan issuer's network, (2) if a clinician-administered drug is otherwise covered, limit or exclude coverage for such drugs based on the enrollee's choice of pharmacy, or because the drug was not dispensed by a pharmacy that participates in the health benefit plan issuer's network, (3) reimburse at a lesser amount clinician-administered drugs based on the enrollee's choice of pharmacy, or because the drug was dispensed by a pharmacy that does not participate in the health benefit plan issuer's network, or (4) require that an enrollee pay an additional fee, higher copay, higher coinsurance, second copay, second coinsurance, or any other price increase for clinician-administered drugs based on the enrollee's choice of pharmacy, or because the drug was not dispensed by a pharmacy that participates in the health benefit plan issuer's network. (b) Nothing in this section may be construed to: (1) authorize a person to administer a drug when otherwise prohibited under the laws of this state or federal law, or (2) modify drug administration requirements under the laws of this state, including any requirements related to delegation and supervision of drug administration. Relates to white bagging policies.
Utah	UT S 193	2023	Pharmaceutical Amendments	Enacted - Signed by Governor	03/15/2023 - Enacted	Biologics and Biosimilars	A health insurer may not require a pharmacy to dispense a clinician-administered drug directly to an enrollee with the intention that the enrollee will transport the drug to a health care provider for administering. Relates to white bagging policies.

https://www.ncsl.org/health/prescription-drug-legislation-database

Accessed: 12/24/2025

Note: Excludes most legislation that is either not enacted or focused solely on one component of the Rx drug supply chain vice general brown/white bagging policies

EXAMPLE LEGISLATION OF COPAY ADJUSTMENT PROGRAMS

State	Bill #	Year	Summary
Arizona	HB 2166	2019	This measure requires that when calculating an insured's contribution to any applicable cost-sharing requirement, an insurer or pharmacy benefit manager must include any cost sharing amount paid by either the enrollee or another person on behalf of the enrollee for a drug that is without a generic equivalent.
Arkansas	H 1569	2021	When calculating an enrollee's contribution to any applicable cost-sharing requirement, a healthcare insurer shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. Relates to copay accumulator programs.
California	A 948	2023	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law, until January 1, 2024, prohibits the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription from exceeding $250 for a supply of up to 30 days, except as specified. Existing law, until January 1, 2024, requires a nongrandfathered individual or small group plan contract or policy to use specified definitions for each tier of a drug formulary. This bill would delete the January 1, 2024, repeal date of those provisions, thus making them operative indefinitely. Because extension of the bill's requirements relative to health care service plans would extend the existence of a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.
California	AB 265	2017	This bill prohibits the distribution of manufacturer-sponsored drug coupons when other US Food and Drug Administration-approved lower cost generic drugs are available, are covered under the individual’s health plan, and are not otherwise contraindicated for the condition for which the prescription drug is approved.
Colorado	S 195	2023	The bill requires a health insurer of pharmacy benefit manager to include in the calculation of a covered person's contributions toward cost-sharing 5requirements, including any annual limitation on a covered person's out-of-pocket costs, any payments made by or on behalf of the covered person. Relates to copay accumulator policies.

Colorado	H 1370	2022	Beginning in 2023, the bill requires each health insurance carrier (carrier) that offers an individual or small group health benefit plan in this state to offer at least 25% of its health benefit plans on the Colorado health benefit exchange (exchange) and at least 25% of its plans not on the exchange in each bronze, silver, gold, and platinum benefit level in each service area as copayment-only payment structures for all prescription drug cost tiers. Starting in 2024, a carrier or, if a carrier uses a pharmacy benefit manager (PBM) for claims processing services or other prescription drug or device services under a health benefit plan offered by the carrier, the PBM, or a representative of the carrier or the PBM, is prohibited from modifying or applying a modification to the current prescription drug formulary during the current plan year. The bill repeals and reenacts the current requirements for step therapy and requires a carrier to use clinical review criteria to establish the step-therapy protocol. For each health benefit plan issued or renewed on or after January 1, 2024, the bill requires each carrier or PBM to demonstrate to the division of insurance that: ! 100% of the estimated rebates received or to be received in connection with dispensing or administering prescription drugs included in the carrier's prescription drug formulary are used to reduce costs for the employer or individual purchasing the plan, ! For small group and large employer health benefit plans, all rebates are used to reduce employer and individual employee costs, and ! For individual health benefit plans, all rebates are used to reduce consumers' premiums and out-of-pocket costs for prescription drugs to the extent practicable. The bill requires the commissioner of insurance (commissioner) to promulgate rules to implement prescription drug pass-through requirements for carriers. Each carrier or PBM is required to report annually specified prescription drug rebate information to the commissioner. Beginning in 2023, the bill requires the department of health care policy and financing, in collaboration with the administrator of the all-payer claims database, to conduct an annual analysis of the prescription drug rebates received in the previous calendar year, by carrier and prescription drug tier, and make the analysis available to the public.
Connecticut	H 7192	2025	Any pharmacy benefits manager (PBM) shall exercise good faith and fair dealing in the performance of such PBM's contractual duties to any health carrier or other health benefit plan sponsor. Relates to fiduciary obligations. The Insurance Commissioner may adopt regulations. Provides pharmacy protections against certain PBM business practices including clawbacks, cost disclosures to consumers, and sustaining penalties for non-compliance. Adds additional reporting requirements for PBMs. The Commissioner will compile a report on pricing and profit generated between health carriers and PBMs and mail-order pharmacies. Creates a task force to address prescription drug shortages. State agencies may utilize bond proceeds to support prescription drug production capacity in the states. Health carriers shall,when calculating an insured's or enrollee's in-network liability for such insured's or enrollee's annual coinsurance, copayment, deductible or other in-network out-of-pocket expense, give credit for any out-of-pocket expense such insured or enrollee pays directly to any pharmacy. Allows patients to receive credit for prescription drugs purchased out-of-network for a lower amount than the average paid by the carrier. A consultant will study the feasibility of a Canadian prescription drug importation program. Allows for the establishment of such program. State agencies shall negotiate bulk purchasing contracts with the goal of lowering prices for single agencies. A drug purchasing agency may incorporate as a guiding price in the negotiations with a pharmaceutical drug manufacturer, the maximum fair prices (MFN) in any negotiation with a pharmaceutical drug manufacturer to supply prescription drugs for health care programs subsidized by the state. Establishes an Advisory Council on Pharmaceutical Procurement. Petitions federal DHHS to authorize generic, lower cost forms of GLP-1 drugs approved by the FDA to treat obesity or diabetes. Upon approval, the commissioner may enter into a contract with any manufacturer of generic forms of such drugs, and to supply such drugs to the state for use. The commissioner may enter into a consortium with official in other states in contracting with such manufacturers.
Connecticut	S 1003	2021	Prohibits certain health carriers and pharmacy benefits managers from employing copay accumulator programs, requires certain health carriers and pharmacy benefits managers to give credit for payments made by third parties for the amount of, or any portion of the amount of an insured's or enrollee's cost sharing liability for a covered benefit.
Connecticut	HB 6622	2021	This measure prohibits a health carrier from removing a prescription drug from the drug formulary or list of covered drugs during a plan year, or moving a prescription drug from a lower cost-sharing tier that imposes a lesser cost-sharing tier to a higher cost-sharing tier.

Delaware	SB 267	2022	This measure requires a carrier, pharmacy benefit manager, or health insurance plan to include any cost-sharing amounts paid by or on behalf of the enrollee when calculating a covered person's contribution to any applicable cost sharing requirement. The measure also prohibits any entity providing health insurance in the state from imposing a copayment or coinsurance requirement for a covered prescription drug that exceeds the lesser of one of the following: the coypayment or coinsurance amount that would apply for the drug in the absence of the corresponding section of the bill; the amount an individual would pay if they were paying the usual and customary price; or the contract price for the drug.
D.C.	B 141	2023	Amends the Specialty Drug Copayment Limitation Act to require health insurers to apply discounts, financial assistance payments, product vouchers, or other reductions in out-of-pocket expenses made by or on behalf of a member when calculating the member's coinsurance, copayment, cost-sharing responsibility, deductible, or out-of-pocket maximum for prescription drugs.
Georgia	HB 946	2020	Provides extensive revisions regarding pharmacy benefits managers, revises definitions, revises provisions relating to license requirements and filing fees, revises a provision regarding the prohibition on the practice of medicine by a pharmacy benefits manager, provides additional authority for the Insurance Commissioner to regulate pharmacy benefits managers, revises provisions relating to rebates from pharmaceutical manufacturers, revises provisions relating to administration of claims.
Illinois	H 1745	2021	Notwithstanding any other provision of law, on and after January 1, 2022, every health insurance carrier that provides coverage for prescription drugs shall ensure that no fewer than 50% of individual and group plans offered within each service area and at each level of coverage as defined in 42 U.S.C. 18022, if applicable, that are delivered, issued for delivery, renewed, amended, or continued by the health insurance carrier meet one or more of the following criteria: (1) apply a pre-deductible and flat-dollar copayment structure to the entire drug benefit, including all tiers, the flat-dollar copayment tier structure for prescription drugs under this Section must be graduated and proportionate, (2) limit a beneficiary's monthly out-of-pocket financial responsibility, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug, the out-of-pocket limit established under this Section shall apply pre-deductible, if applicable, or (3) limit a beneficiary's annual out-of-pocket financial responsibility for prescription drugs, including specialty drugs, to no more than the minimum per year dollar amounts in effect under Section 223(c)(2)(A)(i) of the Internal Revenue Code for self-only coverage.
Illinois	H 465	2019	Amends the Insurance Code, provides that contracts between health insurers and pharmacy benefit managers must require the PBM to update maximum allowable cost pricing information every week, provide access to its cost list to each pharmacy or administrative organization, and provide a process by which a contracted pharmacy can appeal the provider's reimbursement, provides for generically equivalent drugs, provides for registration requirements of PBMs.
Indiana	SB 8	2023	This measure requires that a covered individual's cost-sharing for a prescription drug be calculated at the point of sale, based on a price reduced by an amount equal to at least 85% of all rebates received or estimated to be received by the insurer. An insurer must pass through to a plan sponsor of group plans 100% of all rebates received or estimated to be received. At the time of contracting, an insurer shall provide plan sponsors the option of calculating cost-sharing for covered individuals at the point of sale. An insurer shall disclose to a plan sponsor on an annual basis: the approximate amount of rebates expected to be received by the insurer, and an explanation that the plan sponsor may choose to: apply rebates to reduce premiums for all covered individuals, or calculate cost-sharing for a covered individual at the point of sale. This measure requires a pharmacy benefit manager (PBM) to report at least every six months including aggregate amounts charged to health plans and paid to pharmacies.

Indiana	HB 1604	2025	This measure requires insurers, administrators, and pharmacy benefit managers (PBMs) to apply the annual limitation on cost sharing set forth in the Affordable Care Act to drugs which: (1) are covered under a health plan administered by the pharmacy benefit manager; (2) are life-saving or intended to manage chronic pain; and (3) do not have an approved generic version. This measure also provides that an insurer, an administrator, or PBM may not alter the terms of health insurance coverage based on the availability or amount of financial assistance available for a drug. This measure also requires each insurer and administrator to certify to the insurance commissioner that the insurer or administrator has fully complied with the cost sharing requirements during the previous calendar year. This measure also requires a health plan to credit toward a covered individual's deductible and annual maximum out-of-pocket expenses any amount the covered individual pays directly to any health care provider for a medically necessary covered health care service if a claim for the health care service is not submitted to the health plan and the amount paid by the covered individual to the health care provider is less than the average discounted rate for the health care service paid to a health care provider in the health plan's network. This measure also requires a health plan to publish average discounted rates that the health plan has negotiated to pay health care providers for health care services.
Iowa	SB 383	2025	Relates to covered person's choice of pharmacy. A pharmacy benefits manager shall not restrict a covered person from selecting a pharmacy or pharmacist of their choice, or impose a monetary advantage or penalty that would affect a covered persons choice. A monetary advantage or penalty includes a higher copayment, a reduction in reimbursement for services, or promotion of one participating pharmacy over another. Relates to network adequacy standards and anti-steering. Relates to reimbursement standards. A covered persons cost-sharing for a prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to at least one hundred percent of all rebates that have been received, or that will be received, by the health carrier or a pharmacy benefits manager in connection with the dispensing or administration of the prescription drug. Any additional rebate in excess of the required cost sharing shall be passed on to the health benefit plan for the purpose of reducing premiums.A pharmacy benefits manager shall include any amount paid by a covered person, or on behalf of a covered person, when calculating the covered persons total contribution toward the covered persons cost-sharing. Relates to copay accumulator policies. Requires transparency reporting by PBMs to the commissioner. All contracts between a PBM and a a third-party payor shall use pass-through pricing. The PBM may use spread pricing in certain circumstances. Addresses appeals and disputes.
Kentucky	SB 45	2021	This measure prohibits an insurer or pharmacy benefit manager from excluding any cost-sharing amount paid by or on behalf of an insured when calculating the insured's contribution to any applicable cost-sharing requirement.
Louisiana	S 94	2021	Present law provides for regulations and definitions for third-party administrators, defining "pharmacy benefit manager" as a person, business, or other entity and any wholly or partially owned or controlled subsidiary of the entity that administers a pharmacy benefit management plan. Proposed law retains this provision but allows administrator either directly or through an intermediary manager. Proposed law retains present law and specifies that for the definition of "pharmacy benefit manager", the management or administration of a benefit plan may include review, processing of drug prior authorization requests, adjudication of appeals and grievances related to the prescription drug benefit, contracting with network pharmacies, and controlling the cost of covered prescription drugs. Proposed law provides for fairness in enrollee cost-sharing. Defines terms for purposes of proposed law, including "cost-sharing requirement", "enrollee", "health benefit plan", "health care services", "health insurance issuer", and "person". Proposed law provides that when calculating an enrollee's contribution to any applicable cost-sharing requirement, a health insurance issuer shall include any cost sharing amounts paid by the enrollee or on behalf of the enrollee by another person. Proposed law provides that in implementing the requirements of proposed law, the state shall regulate a health insurance issuer only to the extent permissible under applicable law. Allows the commissioner of insurance to promulgate rules and regulations necessary to implement proposed law. Effective upon signature of the governor or lapse of time for gubernatorial action. Relates to copay accumulator programs.

Maine	LD 1783 (SP 621)	2022	This measure requires health insurance carriers and their pharmacy benefits managers to include cost-sharing amounts paid on behalf of an insured when calculating the insured's contribution to any out-of-pocket maximum, deductible, or copayment when a drug does not have a generic equivalent or was obtained through prior authorization, a step therapy override exception or an exception or appeal process.
Maryland	SB 773	2025	This measure amends existing law to require insurers, health maintenance organizations (HMOs), and pharmacy benefits managers (PBM) to include any discount, financial assistance payment, product voucher, or other out–of–pocket expense made by or on behalf of the insured or enrollee for a prescription drug when calculating the insured person's contribution to their cost sharing amount. This measure prevents a PBM from directly or indirectly altering coverage based on the amount available financial or product assistance.
New Mexico	SB 51	2023	This measure requires an insurer, when calculating an enrollee's cost-sharing obligation for covered prescription drugs, to credit the enrollee for the full value of any discounts provided or payments made by third parties on behalf of the enrollee. An insurer shall not charge a different cost-sharing amount for prescription drugs or pharmacy services obtained at a non-affiliated pharmacy. An insurer shall not require an insured to make a payment at the point of sale for a covered drug in an amount greater than the lesser of: the applicable cost-sharing amount for a prescription; amount an insured would pay for the prescription drug without using insurance or any other source of benefits or discounts; total amount the pharamcy will be reimbursed for the drug by the insurer; or value of the rebate from the manufacturer provided to the insurer or pharmacy benefit manager (PBM) for the drug. If a drug rebate is more than the amount needed to reduce the insured's copayment to zero, the remainder shall be credited to the insurer, and any rebate amount shall be counted toward an insured's out-of-pocket prescription drug costs. An insurer shall not charge a different cost-sharing amount for: prescription drugs or pharmacy services obtained at a non-affiliated pharmacy, or administration of prescription drugs at different infusion sites.
New York	A 1741	2022	Any policy that provides coverage for prescription drugs shall apply any third-party payments, financial assistance, discount, voucher or other price reduction instrument for out-of-pocket expenses made on behalf of an insured individual for the cost of prescription drugs to the insured's deductible, copayment, coinsurance, out-of-pocket maximum, or any other cost-sharing requirement when calculating such insured individual's overall contribution to any out-of-pocket maximum or any cost-sharing requirement.
North Carolina	S 257	2021	Promotes pricing transparency for patients, establishes standards and criteria for the regulation and licensure of pharmacy benefits managers providing services for health benefit plans in the state, adds and amends definitions, provides that person or organization may not establish or operate as a pharmacy benefits manager for health benefit plans in the state without obtaining a license from the Commissioner of the Department of Insurance, requires disclosure of specified information before charging fees. Relates to copay accumulator programs.
North Dakota	SB 2140	2023	This measure caps the total amount that a health insurer can require an enrollee to pay for a 30-day supply of: prescription insulin drugs at $25, regardless of the quantity or type of insulin needed; and prescription medical supplies for insulin dosing and administration at $25, regardless of the quantity or manufacturer of supplies. A health insurance policy may not allow for the use of a formulary to determine coverage of an insulin drug or medical supplies.
North Dakota	HB 1216	2025	This measure requires that any insurer include any amount paid by an enrollee or another person on behalf of the enrollee for a prescription drug when calculating an enrollee's overall contribution to an out-of-pocket maximum or cost sharing requirement under the enrollee's health benefit plan. The health benefit plan may not vary the out-of-pocket maximum cost or cost sharing requirement, or otherwise design benefits in a manner that takes into account the availability of a cost-sharing assistance program for a prescription drug.
Oklahoma	HB 2678	2021	This measure expands the definition of an unfair claims settlement practice to include a pharmacy benefit manager's failure to include any amount paid for an enrollee or on behalf of another person when calculating the enrollee's total contribution to an out-of-pocket maximum or other cost-sharing requirements.

Oklahoma	SB 1050	2025	This measure prohibits a pharmacy benefits manager from failing to include any amount paid by an enrollee or on behalf of an enrollee by another person when calculating the enrollee's total contribution to an out-of-pocket maximum, deductible, copayment, coinsurance or other cost-sharing requirement.
Oregon	HB 4113	2024	This measure requires a health plan or pharmacy benefit manager (PBM) to include any amounts paid by the enrollee or on behalf of the enrollee when calculating an enrollee's overall contribution to any cost-sharing requirements if the drug does not have a generic equivalent or the drug has a generic equivalent and the enrollee has obtained prior authorization from the insurer or PBM.
Rhode Island	SB 871	2023	This measure requires that every individual or group health insurance plan that provides prescription coverage shall not impose a copayment or coinsurance requirement on a covered specialty drug that exceeds $150 for up to a 30-day supply. Coverage for specialty drugs shall not be subject to any deductible unless prohibiting a deductible requirement would cause a health plan to not qualify as a high deductible health plan. Specialty drugs are defined as those drugs prescribed for an individual with a complex, chronic, or rare medical condition, with a wholesale acquisition cost or negotiated price exceeding the Medicare Part D specialty tier threshold.
Tennessee	HB 619	2021	This measure requires an insurer to include cost-sharing amounts paid by or on behalf of an enrollee when calculating an enrollee's contribution to an applicable cost-sharing requirement. This does not apply to a prescription drug for which there is a generic alternative unless the enrollee has obtained access to a brand name drug through prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process.
Texas	S 1076	2017	Relates to limiting the copayment amounts charged to an enrollee in a health benefit plan for prescription drugs covered by the plan, and not more than the claim amount or the purchase price without using "a health benefit plan or any other source of drug benefit or discount.
Texas	HB 999	2023	This measure requires an issuer of a health benefit plan or a pharmacy benefit manager to apply any third party payment, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on behalf of an enrollee for a prescription drug to the enrollee's deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum under the enrollee's plan.
Utah	HCR 2	2025	This measure directs the Public Employees' Benefit and Insurance Program (PEHP) to give state health plan members the estimated value of rebates at the point of sale in proportion to the member's cost sharing responsibility for the drug, less any confirmed payment assistance that is available for reducing the member's out-of-pocket costs. This measure requires that the costs of giving state members the estimated value of rebates remain cost neutral to the state by spreading such costs across all covered state members by increasing the member premium share or reducing the state's health savings account contribution. This measure also requires that PEHP optimize the total value of PEHP's pharmacy benefit manager contract through monitoring, updating, and rebidding.
Virginia	SB 1596 / HB 2515	2019	This measure requires any carrier issuing a health plan to count any payments made by another person on the enrollee's behalf, as well as payments made by the enrollee, when calculating the enrollee's overall contribution to any out-of-pocket cost-sharing requirement under the carrier's health plan.
Washington	SB 5610	2022	This measure requires a health carrier or health care benefit manager to include any cost-sharing amounts paid by or on behalf of an enrollee for a covered prescription drug when calculating an enrollee's contribution to any applicable cost-sharing or out-of-pocket maximum in full. This applies to a drug that is without a generic or therapeutic equivalent or with an equivalent, but for which the enrollee has obtained prior access to the brand name drug through prior authorization, step therapy, or a specific drug exception request process.
West Virginia	HB 2770	2019	This measure requires that when calculating an insured's contribution to any applicable cost-sharing requirement, including the annual limitation on cost sharing, a pharmacy benefit manager or insurer must include any cost-sharing amounts paid by the insured or on behalf of the insured by another person.

https://nashp.org/state-tracker/state-drug-pricing-laws-2017-2025/

Accessed: 12/29/2025

https://www.ncsl.org/health/prescription-drug-legislation-database

Accessed: 12/24/2025

https://allcopayscount.org/state-legislation-against-copay-accumulators/

Accessed: 12/24/2025

Note: Generally excludes bills that focus on a specific ailment or treatment, i.e. diabetes/insulin-focused vice broad copay policies

EXAMPLE LEGISLATION OF RX DRUG DISPOSAL PROGRAMS

State	Relevant Laws
Alabama	Ala Code. § 20-3-3
	Ala. Admin. Code r. 420-11-1-.01--.03
Arizona	Ariz. Rev. Stat. § 32-1909
	Ariz. Admin. Code R4-23-1208 (handling fee)
California	Cal. HSC Code § 150200-150208
Colorado	Colo. Rev. Stat. § 25.5-5-502
	Colo. Rev. Stat. §12-280-135
	https://leg.colorado.gov/sites/default/files/images/olls/crs2023-title-25.pdf
Florida	Fla. Stat. § 465.1902
	Fla. Admin. Code r. 64J-4
Georgia	O.C.G.A. §§ 31-8-301
	O.C.G.A. §§ 31-8-302
	Ga. Comp. R & Regs. 511-5-12
Illinois	410 ILCS 715
Iowa	Iowa Code § 135M
	Iowa Admin. Code r. 641.109
Kansas	Kan. Stat. Ann. §§ 65-1670
	Kan. Stat. Ann. §§ 65-1671
	Kan. Stat. Ann. §§ 65-1672
	Kan. Admin. Regs §§ 68-18-1-3
Kentucky	Ky. Rev. Stat. 315.450-460
	201 KAR 2:440
Louisiana	La. Stat. Ann. §§ 37:1226.2
	La. Stat. Ann. §§ 37:1226.3
Maryland	Md. Code Ann., Health General §15-601–609
	Md. Code Regs 10.34.33.01--.07
Michigan	Mich. Comp. Laws § 333.17775
	Mich. Admin. Code r. 338.3601--3643
Minnesota	Minn. Stat. § 151.555
Mississippi	Miss. Code Ann. § 43-13-501-509
Montana	Mont. Code. Ann. § 37-7-1401--1408
	Mont. Admin. R. 24.174.1141
Nebraska	Neb. Rev. Stat § 71-2422--2430
	Neb. Rev. Stat § 71-2436--2443
	Neb. Rev. Stat § 71-2496
New Jersey	Rules adopted 08/2024 N.J.A.C. 8:32
New Mexico	N.M. Stat. § 26-1-3.2
	N.M. Code. R. § 16-19-34
North Carolina	N.C. Gen. Stat. § 90-85.44
	21 N.C. Admin. Code 46.2513
North Dakota	N.D. Cent. Code § 43-15.2
Ohio	Ohio Rev. Code §§ 3715.87--.873
	Ohio Admin. Code 4729:5-10
Oklahoma	Okla. Stat. tit. 59, § 367.1-7
	Okla. Admin Code § 535:12-1-12
Oregon	Or. Rev. Stat § 689.770--.780
	Or. Admin. R. 855-044
Pennsylvania	49 Pa. Code § 27.501--506
South Dakota	S.D. Codified Laws § 34-20H
	S.D. Admin. R. 20:51:35
Tennessee	Tenn. Code Ann. § 63-10-501--507
Texas	Tex. Health & Safety Code § 442
	25 Tex. Admin. Code. § 95
Virginia	Va. Code. Ann. § 54.1-3411.1
	18 Va. Admin Code § 110-20-740--800
Washington	Wash. Rev. Code § 69.70
	WAC 246-945-488
Wisconsin	Wis. Stat. § 255.056
	Wis. Admin. Code. DHS § 148
Wyoming	Wyo. Stat. Ann. § 35-7-1601-1606

https://www.ncsl.org/health/state-prescription-drug-repository-programs

Accessed: 12/24/2025

Note: Removed columns regarding status, i.e. "operational" or "enacted law, not operational"