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Date: November 13, 2025

To: Matthew Weaver
Montana Economic Development Interim Committee

From: Colleen Becker, NCSL

Topic: Lowering drug costs and consumer access

Dear Matthew,

Thank you for inviting NCSL to present information on state initiatives to lower drug costs and address consumer access. Below you will find relevant information, state examples and legislation, and outside resources.

Please note, NCSL takes no position on state legislation or laws mentioned in linked material, nor does NCSL endorse any third-party publications; resources are cited for informational purposes only.

NCSL Resources:

- Toolkit, Prescription Drug Resource Center
- Database, Prescription Drug Legislation Database
- Web Resource, Copayment Adjustment Programs
- Web Resource, State Policy Options and Pharmacy Benefit Managers

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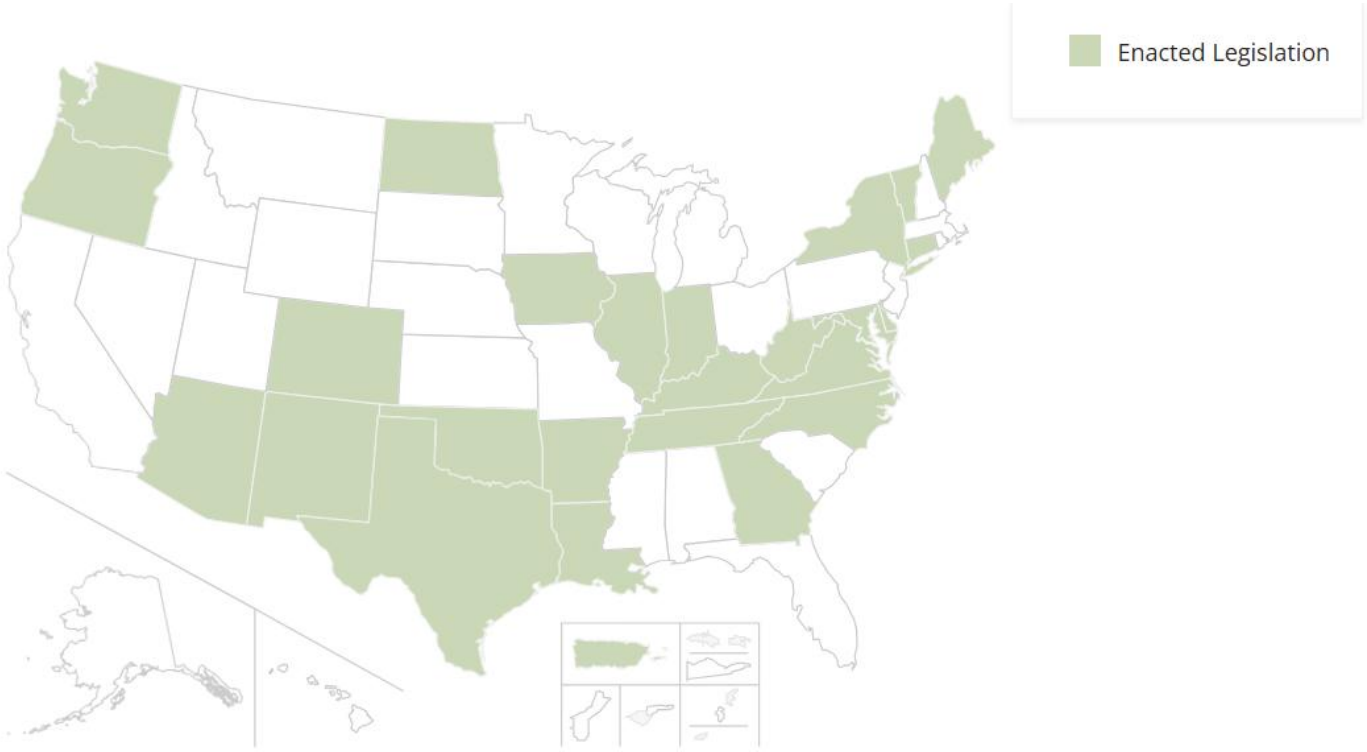
Copay Adjustment Programs

Payers use various utilization management tools to encourage patients to choose lower cost drug options, among them copay adjustment programs. A copay adjustment program, sometimes known as copay accumulator or maximizer programs, restricts a manufacturer's assistance coupon from counting toward a patient's annual out-of-pocket maximums and deductible. When the value of the coupon is exhausted at the pharmacy counter, the patient must then cover the full amount of his or her annual cost-sharing requirement until a deductible or out-of-pocket maximum is reached.

While copay adjustment programs may motivate patients to seek lower-cost treatment options before turning to more expensive ones, they may pose challenges for those with health plans that include high cost-sharing or coinsurance. Additionally, individuals with complex conditions like cancer, rheumatoid arthritis or diabetes, which often require costly medications, may have limited alternative treatment options.

As of 2025, laws in at least 25 states, the District of Columbia and Puerto Rico address the use of copay adjustment programs by insurers or PBMs by requiring any payment or discount made by or on behalf of the patient be applied to a consumer's annual out-of-pocket cost-sharing requirement.



Additional External Resources:

- Oct. 2023, Pharmaceutical Care Management Association (PCMA), **Response to NY Dept. of Financial Services' Proposed Rule**.
  Key point: Although some of the provisions are subject to interpretation, enactment of the provisions discussed below would alone cost New Yorkers over $3.1 billion in excess drug spending in the first year, and over $40 billion over the next 10 years.
  - PCMA transparency suggestions that lower drug costs:
    Information for patients:
    - Premiums, cost sharing for drugs in their health plan, and their out-of-pocket maximum cost
    - What drugs are covered and on what formulary tier.
    - What pharmacies are in the network.
    - Expected annual out-of-pocket costs for their prescription.

    Information for employers, unions, and other health plan sponsors:
    - Financial information about rebates, fees and payments, as outlined in the PBM-plan sponsor contract.
    - Whether the PBM is living up to its contract, through audits by the health plan.
    - How much they will pay for each prescription filled by an enrollee in their plan.
    - Aggregate data on drug utilization by plan enrollees.
    - Drug safety information.

    Information for physicians:

        - The plan's utilization management requirements, including for prior authorization and step therapy, and how to meet them.
        - The patient's formulary and cost sharing in real time.

- NORC Experience with Pharmacy Drug Benefits and Pharmaceutical Benefit Managers (PBMs)
    - Key highlight: 85% of employers were satisfied with the services their PBMs were providing.

- Oct. 2024, NY Dept. of Health, Transition of the Pharmacy Benefit from Managed Care (MC) to Medicaid NYRx Pharmacy Program FAQ
  Main Objectives:
  Transitioning pharmacy services from MC to NYRx will, among other things:
    - Provide the State with full visibility into prescription drug costs.
    - Centralize and leverage negotiation power.
    - Provide a single drug formulary with standardized utilization management protocols.
    - Address the growth of the 340B program and associated reductions in State rebate revenue.

- 2024, United States Government Accountability Office, **Selected States' Regulation of Pharmacy Benefit Managers**
  Each of the five states selected for review—Arkansas, California, Louisiana, Maine, and New York—enacted a variety of laws to regulate PBMs.
  Summary of key points:
    - **Private health plans contract with pharmacy benefit managers (PBM) to administer their prescription drug benefits and help control costs.** Each of the five states selected for review—Arkansas, California, Louisiana, Maine, and New York—enacted a variety of laws to regulate PBMs.
    - **Fiduciary or other "duty of care" requirements.** Four of the five states (California, Louisiana, Maine, and New York) enacted laws to impose a duty of care on PBMs. The laws varied from imposing a fiduciary duty—that is, a requirement to act in the best interest of the health plan or other entity to which the duty is owed—to what state regulators described as "lesser" standards such as a requirement to act in "good faith and fair dealing."
    - **Drug pricing and pharmacy reimbursement requirements.** The five states enacted a variety of laws relating to drug pricing and pharmacy payments, such as laws limiting PBMs' use of manufacturer rebates and their ability to pay pharmacies less than they charge health plans—a practice referred to as "spread pricing."
    - **Transparency, including licensure and reporting requirements.** To increase the transparency of PBM operations, the five states enacted laws that require PBMs to be licensed by or registered with the state, or both, and to report certain information such as drug pricing, fees charged, and the amounts of rebates received and retained.
    - **Pharmacy network and access requirements.** The five states also enacted laws regarding pharmacy networks and patient access. Examples include laws prohibiting discrimination against unaffiliated pharmacies and limiting patient co-pays charged by PBMs. The regulators GAO interviewed from selected states described lessons learned regarding PBM regulation. Examples include the following.
    - **Regulators in four states said that providing regulators with broad regulatory authority was more effective than enacting specific statutory provisions.** Doing so allowed regulators to address emerging issues without new legislation, according to regulators from one state.
    - **Some regulators also stressed the need for robust enforcement of PBM laws and effective penalties to enforce them**. Two pharmacy associations GAO interviewed concurred with these views, while a health plan association said that monitoring is needed to ensure compliance with PBM requirements. Three regulators also said that clear reporting requirements and definitions helped ensure consistent enforcement.

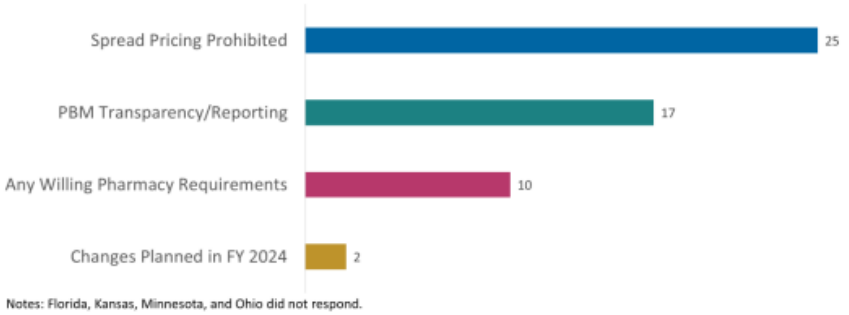
- 2024, U.S. Department of Health and Human Services Office of Inspector General, **Medicaid Managed Care: States Do Not Consistently Define or Validate Paid Amount Data for Drug Claims (*Full Report Here*, *Report in Brief Here*)**
  Summary of key points:
  - **In Medicaid managed care, consistent and accurate data on the amount pharmacies were reimbursed for filling prescriptions are critical for CMS and States to administer the program and oversee drug spending.** Such data are particularly important in light of concerns that pharmacy benefit managers' (PBMs') use of spread pricing could inflate Medicaid drug costs.
  - **State requirements varied for how plans should report the paid amount for drug claims.** Of the 36 States that covered outpatient prescription drugs for Medicaid through managed care in January 2022, 28 States required Medicaid managed care plans to report the paid amount for drug claims as the amount the plan or its PBM reimbursed to the pharmacy; 2 States required plans to report the amount the plan paid to its PBM; and 6 States had no reporting requirements.
  - **For 37 of 252 managed care drug claims in our review, the T-MSIS paid amount did not equal pharmacy-reported reimbursement, raising concerns about the accuracy or consistency of the paid amounts on these claims.** Twenty-two non-matching claims in our sample were from States where the T-MSIS paid amounts should have equaled pharmacy-reported reimbursement amounts for all claims according to States' requirements and practices.
  - **Although all States relied on drug claim paid amounts to safeguard and administer the Medicaid program, many States did not conduct certain activities to validate these data.** Most States relied on these data to develop capitation rates and identify fraud, waste, and abuse. Ten States did not validate these data by comparing them to another data source—a recommended, but not required, activity.

- 2024, Health Management Associates, Gifford, Lashbrook, Payne, **State Approaches to Managing the Medicaid Pharmacy Benefit**

  Spread pricing: More than half of MCO states that carve in pharmacy benefits (17 of 30 responding MCO states) reported having PBM transparency reporting requirements in place as of July 1, 2023, and 25 MCO states prohibit spread pricing in MCO PBM contracts altogether. This is more than double the number of states reporting prohibitions on spread pricing in 2019.

  As MCO/PBM contracting arrangements have become more common, so have concerns about transparency, access, and inflated Medicaid drug costs. In particular, the practice of spread pricing— that is, when a PBM charges the MCO more for the drug than the amount the PBM pays to a pharmacy and retains the difference—has resulted in closer scrutiny of PBM arrangements and more state and federal oversight. In the May 2023 Misclassification of Drugs proposed rule (not yet finalized at the time of this report), CMS sought to address select issues in support of PBM transparency. The proposed rule requires PBMs that contract with MCOs to separately report incurred claims for drugs, dispensing fees, and administrative fees to help MCOs capture information necessary for accurate medical loss ratio (MLR) calculations.

FIGURE 3
MCO PBM Contract Requirements as of July 1, 2023



Notes: Florida, Kansas, Minnesota, and Ohio did not respond.

Meanwhile, many states have already sought to promote PBM transparency and/or prevent or monitor spread pricing within MCO/PBM contracts. Of the survey respondents, MCO states that carve in pharmacy responded to survey questions about PBM transparency and spread pricing requirements. Of these states, 17 (including DC) reported having PBM transparency reporting requirements in place as of July 1, 2023, and 25 states (including DC) prohibit spread pricing in MCO PBM contracts altogether—more than double the number of states reporting prohibitions on spread pricing in 2019 (see Figure 3 *above* and Appendix Table 3 in the linked report). In addition, 10 MCO states with pharmacy carve ins reported having "any willing" pharmacy requirements in place for FY 2024. Any willing pharmacy provisions require MCOs and their contracted PBMs, if applicable, to permit any pharmacies willing to accept the contract's standard terms and conditions to participate in the network.

Uniform PDL: Nearly all responding states (44) reported having a preferred drug list (PDL) in place for FFS prescriptions as of July 1, 2023. A PDL is a list of "preferred" medications typically having a lower net cost to the state (after rebates) that providers are encouraged to select from when prescribing. The number of MCO states adopting a uniform PDL that requires all MCOs to cover the same drugs as the state continues to grow.

Nearly two-thirds of responding MCO states that do not carve out the pharmacy benefit (19 of 30 states) reported having a uniform PDL for some or all classes as of July 1, 2023. One state reported that it intends to implement a single PDL effective July 1, 2024, and two states reported plans to expand a uniform PDL to additional classes. Though states commonly use prior authorization (PA) to manage drug utilization, more than three-fifths of responding states (29 of 46 states and DC) reported statutory limitation(s) on the ability of the Medicaid agency to apply utilization controls to certain drugs or drug classes in the FFS pharmacy benefit.

States also play an active role in managing MCO clinical protocols or medical necessity criteria, with 22 out of 30 responding MCO pharmacy carve-in states reporting that they require uniform clinical protocols for some or all drugs with clinical criteria. Approximately one-half of responding MCO carve-in states also require review and approval of MCOs' PA criteria (15 of 30 states) and step therapy criteria (14 of 30 states).

FIGURE 4
State Uniform Preferred Drug List (PDL) Requirements, 2023

Note: Responses as of July 1, 2023. SC reported plans to implement a uniform PDL for all classes effective July 1, 2024. FL, KS, MN, OH did not respond to the survey. Publicly available data used to document outpatient Rx carve out in OH.

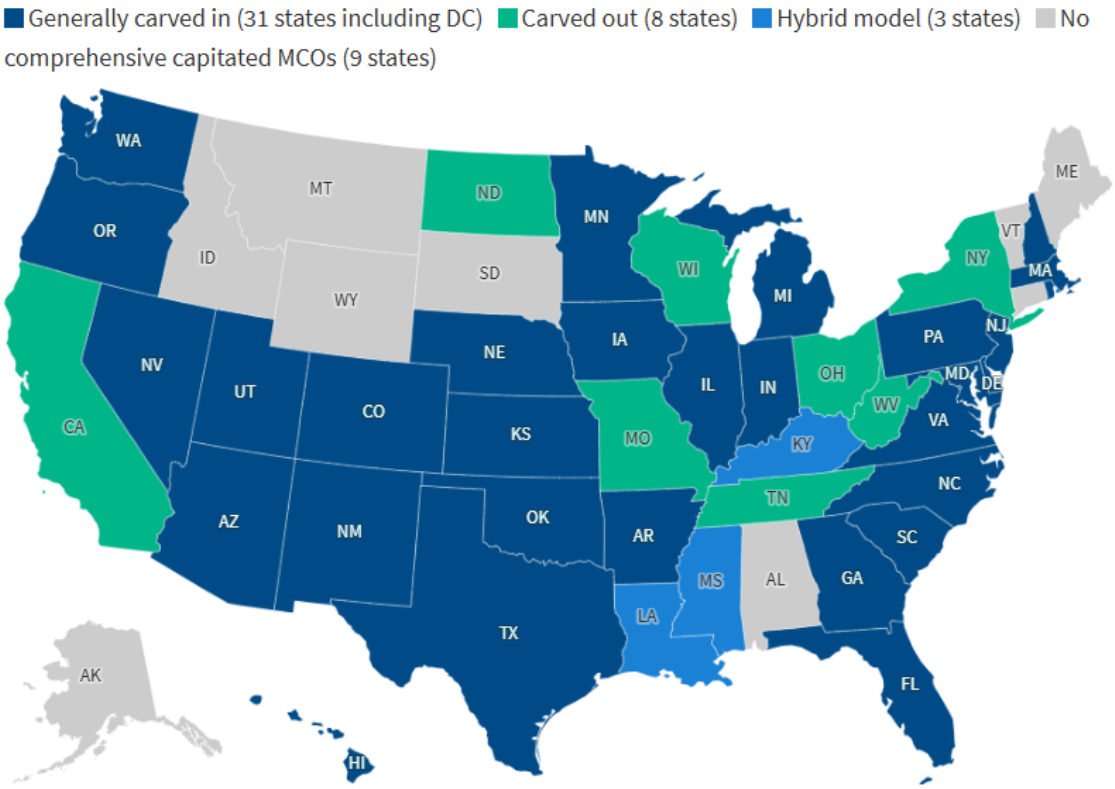
- 2024, KFF/HMA Medicaid Budget Survey, Hinton et. al, **Results from an Annual Medicaid Budget Survey for State Fiscal Years 2024 and 2025**

  Managed Care's Role in Administering Pharmacy Benefits

  Most states that contract with MCOs include Medicaid pharmacy benefits in their MCO contracts, but eight states "carve out" prescription drug coverage from managed care. While the majority of states that contract with MCOs report that the outpatient prescription drug benefit is carved in to managed care (31 of 42 states that contract with MCOs), eight states (California, Missouri, New York, North Dakota, Ohio, Tennessee, Wisconsin, and West Virginia) report that pharmacy benefits are carved out of MCO contracts as of July 1, 2024 (Figure 17). This count is unchanged from last year's survey, though Utah noted considering future pharmacy delivery model changes such as carving out the pharmacy benefit from MCO contracts following a legislature-initiated study. There has been an increase from one-state (Kentucky) to three states (Kentucky, Louisiana, and Mississippi) that now contract with a single PBM for the managed care population instead of implementing a traditional carve-out of pharmacy from managed care. Under this "hybrid" model, MCOs remain at risk for the pharmacy benefit but must contract with the state's PBM to process pharmacy claims and pharmacy prior authorizations according to a single formulary and PDL.

Figure 17

State Coverage of Pharmacy Benefits in MCO Contracts as of July 1, 2024



Note: MCO = managed care organization. ID's Medicaid-Medicare Coordinated Plan has been recategorized by CMS as an MCO but is not counted here as such since it is secondary to Medicare. FL did not respond to the 2024 survey, publicly available data used to verify status. KY, LA, MS implemented a "hybrid" model where MCOs remain at risk for the pharmacy benefit but have contracted with the state's PBM to process claims and prior authorizations (according to single formulary and PDL).

Source: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2024 • Get the data • Download PNG

KFF

Spread Pricing Restrictions

Health plans may choose reimbursement contracts with PBMs that use either a spread pricing model, pass-through pricing model or some other reimbursement mechanism. In most spread pricing arrangements, a PBM keeps a percentage of the difference between what the health plan pays the PBM for pharmacy benefit services, and the amount the PBM reimburses the pharmacy for a patient's prescription.

With a pass-through contract, the PBM passes through the full amount collected by the pharmacy, typically either to the health insurer or directly to the consumer at the point of sale. Since no difference is collected, PBMs might assess an administrative fee instead.

Citing concerns about containing prescription drug costs, several states have conducted audits of their Medicaid Managed Care Organization (MCO) prescription drug benefit contracts. These contracts may or may not be outsourced through a PBM. According to KFF's annual Medicaid Budget Survey for Fiscal Years 2024-2025, most states that administer the Medicaid program through MCOs (31 out of 42) carve the prescription drug benefit into the agreement. KFF also notes that in this study, two states—Hawaii and Rhode Island—reported new initiatives to prohibit PBM spread pricing. New Jersey has an added a requirement that MCOs have pass-through PBM contracts.

Examples of State Audit Reports:

- California
- Florida (MCO report)
- Louisiana
- New York
- Ohio (MCO report)
- West Virginia (MCO carve out report)

Outside Resources:

- 2023, Fiedler, Adler and Frank, A Brief Look at Current Debates About Pharmacy Benefit Managers. Brookings researchers suggest that policies restricting spread pricing and passing rebates back to consumers at the point of sale may not have the intended effect that lawmakers are aiming for. K*ey Points:*
  - Much recent discussion related to PBMs has focused on PBMs' retention of rebates paid by drug manufacturers and use of so-called pharmacy "spread" pricing. However, restricting these specific practices, as some of the bills currently under consideration in Congress would do, is unlikely to save much money for payers since PBMs could likely extract revenue from payers in other ways. It might even backfire by weakening PBMs' incentives to aggressively negotiate prices.
  - Cost-sharing for prescription drugs can cause patients to forgo necessary drugs and partially unravels the financial protection that health insurance aims to provide. But contrary to common arguments, the fact that cost-sharing is often calculated using point-of-sale prices that exclude some PBM-negotiated discounts (especially rebates) may not meaningfully increase patients' overall cost-sharing burdens since consumers and employers can generally choose among plans with more and less generous cost-sharing designs. Rather, where patients face excessive cost-sharing, the main cause is likely deeper market or regulatory failures, such as consumer difficulties in choosing insurance plans and adverse selection. Addressing those issues is likely to require solutions targeted at those broader problems—such as directly regulating how much cost-sharing insurance plans can impose, subsidizing more generous coverage, or improving risk adjustment systems—not solutions specific to rebates or PBMs.
- 2023, Mattingly, Kenechukwu, Bai, et al., Pharmacy Benefit Manager Pricing and Spread Pricing for High-Utilization Generic Drugs. *Key Points:*
  - In 2021, all but 29.9% of Medicare Part D dollars spent on 45 high-utilization generic drugs went to intermediary gross profit.
  - This study was limited by the lack of information on direct and indirect remuneration offered by manufacturers or pharmacies.
  - Without data on operating expenses the authors were unable to estimate net profits generated.
  - Additionally, without access to the proprietary agreements between the Centers for Medicare & Medicaid Services (CMS) and PBMs or plan sponsors, the authors were unable to determine what proportion of gross profits earned on these generic drug transactions was returned to CMS or used to reduce premiums.
  - To the extent that the FUL exceeds actual pharmacy revenue for certain drugs in Medicare Part D, our estimated PBM spread pricing may be underestimated.
  - Policy efforts prohibiting spread pricing practices of PBMs may lower claim-level revenue retained by PBMs for generic drugs. However, absent sufficient market competition, PBMs may raise administrative fees to sustain revenue.
  - Therefore, it remains unclear how much spread pricing reform focused on PBMs alone would lower drug spending or strengthen the generic pharmaceutical supply chain.

A study by KFF on the Implications of Policy Changes in Medicaid Drug Purchasing showed these additional points:

- **Estimates of spread pricing or the effect of bans on it vary widely, making the scale of the cost savings to Medicaid difficult to predict.** Overall, limiting spread pricing would likely decrease net federal and state spending through lower payments to MCOs or PBMs. If PBMs and MCOs were required to pass through any savings, states spending for prescription drugs could decline by the spread price amount. Further, the federal

government may indirectly share in savings because Medicaid drug costs are jointly financed by state and federal funds. A number of states have conducted analyses finding high amounts of spread on generic drugs and estimating state savings in the millions if spread pricing is eliminated, but it is not clear to what extent these findings are generalizable to other states. An analysis by CBO of federal legislation to ban spread pricing estimated federal savings of $929 million nationwide between 2021-2030.

- **The overall effect of limiting PBM spread pricing on manufacturers is uncertain, as PBMs retain some incentives to negotiate discounts**. PBMs generally use leverage and PDL management to negotiate lower prices from manufacturers and generally incentivize use of generic drugs. While PBMs would no longer retain these savings as spread pricing, they may still have an incentive to negotiate lower manufacturer prices due to the need to compete for contracts. Because research has shown that PBMs generate higher spread on generic drugs than brand drugs, elimination of spread pricing may mean PBMs may have less of an incentive to prioritize generic drugs. Manufacturers could see an increase in revenue due to increased brand drug usage but also would likely pay more in rebates to Medicaid.
- **Eliminating or limiting spread pricing could lead to increased reimbursement to pharmacies, depending on how PBMs change their negotiating tactics with pharmacies.** PBMs often negotiate with pharmacies to create "network" pharmacies, driving business to pharmacies and allowing PBMs to negotiate lower payment rates to pharmacies (and thus increase their spread). Pharmacy reimbursement to network pharmacies may increase without PBM incentive to create spread, and other pharmacies may see increased business due to decreased PBM incentives to create pharmacy networks.

Reverse Auctions

At least eight states are pursuing a reverse auction strategy for their prescription drug procurement contracts. In a reverse auction, a third-party vendor administers an anonymous platform through which the state solicits contracts for PBM services. A single PBM administrator offering the lowest bid is awarded the contract.

Examples of reporting and analysis:

- April 2025, Delaware Pharmacy Benefit Manager (PBM) Report and Analysis
- January 2024, Maryland Reverse Auction Status Update
- March 2025, Minnesota Pharmacy Benefit Manager Reverse Auction Report

State	Bill	Summary
Colorado	(2021) CO H 1237	Provides for a process for a reverse auction. The department is required to repurpose the technology platform used to conduct the reverse auction over the duration of the PBM services contract to perform reviews of all invoiced PBM prescription drug claims, and to identify all deviations from the specific terms of the PBM services contract.
Delaware	(2025) DE S 134	Allows for the use of reverse auctions in the procurement of professional services for or related to pharmaceuticals or pharmacy benefits management services.
Louisiana	(2021) LA S 180	Provides for the use of a reverse auction by a political subdivision to purchase materials, supplies, or equipment when the procurement officer determines that the best interests of the political subdivision would be served and that electronic online bidding is more advantageous than other procurement methods, adds pharmacy benefit manger services as an example of a consulting service under the Louisiana Procurement Code, provides for the use of reverse auction technology.

Maryland	(2021) MD H 607	Requires the Department of Budget and Management to use a reverse auction to select a pharmacy benefits manager to administer the State Rx Program, requires the Department to procure a certain platform and associated services in a certain period of time before a reverse auction is scheduled to be completed, requires that the platform have certain capabilities, prohibits a responsive offeror from proposing to subcontract certain services.
Maryland	(2020) MD H 1150	Requires that the terms of a certain participant bidding agreement for participation in a reverse auction for the selection of a pharmacy benefits manager for the Maryland Rx Program include a requirement that the bidder, if selected as a pharmacy benefits manager for the Program through the auction, pay a fee-for-service professional dispensing fee to certain pharmacists.
Minnesota	(2025) MN S 1574 *Pending* note: several companion bills pending	The commissioner must, through a competitive procurement process, select a single pharmacy benefit manager. The commissioner must approve or disapprove all utilization review limitations, requirements, and strategies imposed by managed care plans on prescription drug coverage. The commissioner must approve all reimbursement rates, fees and remuneration. Relates to a reverse auction. The state PBM must disclose all source of payment it receives including rebates, discounts and credits. The state PBM must provide a written quarterly report. Relates to price transparency. Establishes program authority to adopt a preferred drug list.

Date: December 17, 2025

To: Matthew Weaver

Montana Economic Development Interim Committee

From: Colleen Becker, NCSL

Topic: State Approaches to PBMs and Fiduciary Responsibility

Marcus C. Evans Jr.
President, NCSL
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Dear Matthew,

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- Database, Prescription Drug Legislation Database

Background

The concept of fiduciary responsibility in health insurance goes back to the 1974 Employee Retirement Income Security Act (ERISA). The U.S. Department of Labor define plan fiduciaries as, for example, plan trustees, plan administrators, and members of a plan's investment committee. The Department further defines the responsibility of fiduciaries is to:

"Run the plan solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits and paying plan expenses. Fiduciaries must act prudently and must diversify the plan's investments in order to minimize the risk of large losses. In addition, they must follow the terms of plan documents to the extent that the plan terms are consistent with ERISA. They also must avoid conflicts of interest. In other words, they may not engage in transactions on behalf of the plan that benefit parties related to the plan, such as other fiduciaries, services providers or the plan sponsor."

PBMs, ERISA and State Regulation

ERISA requires health plans to act as fiduciaries, but in *Rutledge v PCMA (2020)* the U.S. Supreme Court ruled that pharmacy benefit managers (PBM) are not protected by ERISA, allowing state lawmakers latitude to regulate on PBM practices. Several states have enacted legislation to fiduciary responsibilities and specifying which entities they apply to.

State Examples

Year	State	Citation	Summary
2025	Connecticut	H 7192	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.
2025	Indiana	S 3	Provides that the fiduciary duty includes the duty to act with loyalty and care in the best interest of the plan sponsor, ensure that all fees, costs, and commissions are reasonably and fully disclosed, avoid self-dealing and conflicts of interest, and maintain transparency in all financial and contractual arrangements related to the plan sponsor's health insurance coverage, including prescription drug benefits.
2024	Iowa	H 2099	Amends current law. This bill relates to the regulation of pharmacy

Year	State	Citation	Summary
			benefits managers (PBMs). Under current law, a PBM owes a duty of good faith and fair dealing to third-party payors. The bill expands that duty to pharmacies. The bill prohibits retaliation by a PBM against a pharmacy based on the pharmacies exercise of any right or remedy, or on the pharmacy's cooperation with the commissioner. Prohibited retaliation includes terminating or refusing to renew a contract with a pharmacy, subjecting a pharmacy to increased audits, or withholding or failing to promptly pay the pharmacy any money owed by the PBM.
2022	Iowa	H 2384	PBMs owe a fiduciary duty to each health carrier for whom the PBM manages a prescription drug benefit provided by the carrier and shall discharge its duties in accordance with applicable state and federal law. Carriers shall owe a fiduciary duty to each covered person participating in a health benefit plan offered or issued by the carrier. PBMs, carriers, or benefit plans are prohibited from discriminating against a pharmacy or pharmacist with respect to participation, referral, reimbursement of a covered service, or indemnification if a pharmacist is acting within the scope of the pharmacist's license. PBMs are required to allow a pharmacy located in the state to participate in a pharmacy network provided that the pharmacy accepts the same terms and conditions as the PBM imposes on the pharmacies in the network. PBMs are prohibited from assessing, charging, or collecting any form of remuneration that passes from a pharmacy in the network to the PBM including but not limited to claim processing fees, performance-based fees, network participation fees, or accreditation fees. A covered person is not required to make a cost-sharing payment at the point-of-sale for a prescription drug (drug) in an amount that exceeds the maximum allowable cost (MAC) for that drug. A PBM cannot prohibit a pharmacy from disclosing the availability of a lower-cost drug option to a covered person, or from selling a lower-cost drug option to a covered person. Any amount paid by a covered person for a drug must be applied to any deductible imposed by the covered person's health benefit plan in accordance with the plan's coverage documents. A covered person cannot be prohibited from filling a drug order at any pharmacy located in the state if the pharmacy accepts the same terms and conditions as the covered person's benefit plan. A PBM cannot impose different cost-sharing or additional fees on a covered person based on the pharmacy at which a covered person fills their prescription. A PBM cannot require a covered person, as a condition of payment or reimbursement, to purchase pharmacy services, including drugs, exclusively through a mail-order pharmacy. Relates to patient steering. The bill requires that a covered person's cost-sharing for a drug shall be calculated at the point-of-sale based on a price that is reduced by an amount equal to at least 100% of all rebates that have been received, or that will be received, by the health carrier or a PBM in connection with the dispensing or administration of the drug. A health carrier may

Year	State	Citation	Summary
			decrease a covered person's cost-sharing by a greater amount. A PBM shall include any amount paid by a covered person, or by any other person on behalf of a covered person, when calculating the covered person's total contribution toward the covered person's cost-sharing. Relates to copay accumulator programs. Allows a pharmacy to decline to dispense a drug to a covered person if, because of the maximum allowable cost list (MACL) to which the pharmacy is subject, the pharmacy will be reimbursed less than the pharmacy's acquisition cost. A PBM shall not reimburse a pharmacy or pharmacist for a drug in an amount less than the NADAC for the drug on the date that the drug is administered or dispensed. In addition to the reimbursement, a PBM shall reimburse the pharmacy or pharmacist a professional dispensing fee that is no less than the pharmacy dispensing fee published in the Iowa Medicaid enterprise provider fee schedule on the date that the drug is administered or dispensed. A PBM is prohibited from reimbursing a pharmacy located in the state in an amount less than the amount that the PBM reimburses a PBM affiliate for dispensing the same drug as the pharmacy. After the date of receipt of a clean claim submitted by a pharmacy, a PBM cannot retroactively reduce payment on the claim, either directly or indirectly, except if the claim is found not to be a clean claim while a routine audit. The requirements for the appeal process are detailed in the bill. The commissioner of insurance is required to take any enforcement action under the commissioner's authority to enforce compliance with the bill. A PBM is subject to the commissioner's authority to conduct an examination. If the commissioner conducts an examination, a proceeding, an audit, or an inspection, all information received from the PBM, and all documents related to the examination, proceeding, audit, or inspection are confidential records. The bill requires the commissioner to adopt rules to administer the bill.
2019	Louisiana	S 41	Louisiana Board of Pharmacy, authority to regulate pharmacy benefit managers (PBMs). The board shall promulgate rules and regulations to implement the provisions of this Part and the applicable provisions of the Pharmacy Benefit Manager Licensing Law. A PBM shall be prohibited from changing or substituting any prescription generated by a prescribing practitioner for a patient in Louisiana. No PBM shall operate in Louisiana without having a license in good standing with the Louisiana Department of Insurance. A PBM shall be a fiduciary to the beneficiaries of any PBM plan administered by the PBM and to the pharmacists and pharmacies who provide pharmacy services to those beneficiaries. The fiduciary duties shall include the duties of good faith, trust, confidence, and candor. Every PBM that does business in this state or pays for benefits to a beneficiary through a PBM plan shall be licensed. No license or permit shall be issued to a PBM who has not registered with the Louisiana secretary of state to conduct business within the state. Every PBM licensed by the commissioner of

Year	State	Citation	Summary
			insurance shall abide by the provisions of the Louisiana Insurance Code and the rules and regulations of the insurance commissioner and the Department of Insurance regarding the PBM's business regulated by the commissioner of insurance. A PBM in Louisiana shall not: Participate in spread pricing, Directly or indirectly engage in patient steering, Penalize a beneficiary or provide an inducement to the beneficiary for the purpose of getting the beneficiary to use specific retail, mail order pharmacy, or another network pharmacy provider in which a PBM has an ownership interest, Retroactively denying or reducing a claim of a pharmacist or pharmacy for payment or demanding repayment of all or part of a claim, after the clam has been approved by the PBM.
2019	Minnesota	S 278	Beginning January 1, 2020, no person shall perform, act, or do business in this state as a pharmacy benefit manager (PBM) unless the person has a valid license issued under this chapter by the commissioner of commerce. A PBM seeking a license shall apply to the commissioner of commerce on a form prescribed by the commissioner. This license must be renewed annually. A PBM must exercise good faith and fair dealing in the performance of its contractual duties. A provision in a contract between a PBM and a health carrier or a network pharmacy that attempts to waive or limit this obligation is void. A PBM must provide an adequate and accessible pharmacy network for the provision of prescription drugs that meet the relevant requirements. Mail order pharmacies must not be included in the calculations of determining the adequacy of the PBM's pharmacy network. The PBM must disclose, upon the request of the plan sponsor, the certain information but not limited to: the aggregate wholesale acquisition costs from a drug manufacturer or wholesale drug distributor for each therapeutic category of prescription drugs, the aggregate amount of rebates received by the PBM, the aggregate amount of rebates must include any utilization discounts the PBM receives from a drug manufacturer or wholesale drug distributor, the amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive charges, any spread between the net amount paid to the pharmacy and the amount charged to the plan sponsor. This data must also be reported to the commissioner. This bill also address PBM ownership in pharmacies, including mail order and specialty. Sets limits on maximum allowable cost. Provides for procedures and processes for conducting and reporting a pharmacy audit. A contract between a PBM and a pharmacy must allow for synchronization of prescription drug refills for a patient on at least one occasion per year, if certain criteria are met. Prohibits 'gag-clauses'. When a pharmacist receives a prescription in which the prescriber has not expressly indicated that the prescription is to be dispensed as communicated and the drug prescribed is not covered under the purchaser's health plan or prescription drug plan, the pharmacist may dispense a therapeutically equivalent and

Year	State	Citation	Summary
			interchangeable prescribed drug or biological product that is covered under the purchaser's plan.
2025	Nebraska	L 198	Pharmacy benefit manager duty means a duty and obligation to perform PBM services with care, skill, prudence, diligence, fairness, transparency, and professionalism, and for the best interest of the covered person, the health benefit plan, and the provider. Relating to specialty pharmacies and clinician-administered drugs, to prohibit health benefit plans, health carriers, and pharmacy benefit managers from patient steering. Relates to white-bagging and brown-bagging policies. Provides for retail pharmacy services and delivery.
2022	New York	S 7837	A PBM interacting with a covered individual shall have the same duty to a covered individual as the health plan for whom it is performing PBM services. A PBM shall have a duty of good faith and fair dealing with all parties, including but not limited to covered individuals and pharmacies, with whom it interacts in the performance of PBM services.
2025	North Carolina	S 479	Relates to patient steering. Defines a pharmacy services administrative organization or PSAO and requires PSAOs to obtain licensure from the state. The department is authorized to regulate PSAOs, Provides PSAO disclosure requirements and outlines contractual obligations. PSAOs that have ownership ties to a manufacturer are prohibited from requiring independent pharmacies purchase drugs from a PSAO entity. Provides for appeals processes. The Commissioner of Insurance is authorized to adopt rules. Requires transparency reporting from PBMs. Provides reimbursement standards for pharmacies. Requires that PBMs have a fiduciary duty. A PBM has a fiduciary duty to act in good faith and fair dealing in the performance of all of its contractual duties, including all the following: 1) Acting in the best interest of the insurers and health benefit plans offered by the insurers with which the PBM has a contract. 2) Acting with prudence and passing through any rebates or discounts the PBM received related to covered benefits bought and paid for with the contracted insurer's assets or funds. 3) Avoiding self-dealing and conflicts of interest. A PBM is prohibited from engaging in spread pricing. Amends pharmacy audit practices by PBMs. Requires at point of sale that an enrollee's cost sharing be reduced by 90% of all rebates received for the drug. Requires price transparency from manufacturers. Requires the board of pharmacy to report on the number of pharmacies open and closed in the past 5 years. Outlines considerations for pharmacy benefit contract negotiations for state health plans.
2022	Vermont	H 353	A pharmacy benefit manager that provides PBM for a health plan has a fiduciary duty to its health insurer client that includes a duty to be fair and truthful toward the health insurer, to act in the health insurer’s best interests, and to perform its duties with care, skill, prudence, and diligence. A PBM contract with a health insurer shall not contain any provision purporting to reserve discretion to the

Year	State	Citation	Summary
			PBM to move a drug to a higher tier or remove a drug from its drug formulary any more frequently than two times per year. A PBM shall not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of: (A) the cost-sharing amount under the terms of the health benefit plan; (B) the maximum allowable cost for the drug; or (C) the amount the covered person would pay for the drug if the covered person were paying the cash price. Any amount paid by a covered shall be attributed toward any deductible and the annual out-of-pocket maximums under the covered person's health benefit plan. Relates to copay accumulator policies. A participation contract between a PBM and a pharmacist shall not prohibit, restrict, or penalize a pharmacy or pharmacist in any way from disclosing to any covered person any health care information that the pharmacy or pharmacist deems appropriate. A PBM shall not terminate a contract with or penalize a pharmacist or pharmacy due to the pharmacist or pharmacy: (1) disclosing information about PBM practices, except for information determined to be a trade secret under State law or by the Commissioner, (2) sharing any portion of the PBM contract with the Commissioner pursuant to a complaint or query regarding the contract's compliance with the provisions of this chapter. Establishes an appeal process for pharmacies. Amends pharmacy rights during an audit. A PBM or other third party that reimburses a 340B covered entity for drugs shall not reimburse the 340B covered entity for pharmacy-dispensed drugs at a rate lower than that paid for the same drug to pharmacies that are not 340B covered entities, and the PBM shall not assess any fee, charge-back, or other adjustment on the 340B covered entity. With respect to a patient who is eligible to receive 340B drugs, a PBM or other third party that makes payment for the drugs shall not discriminate against a 340B covered entity in a manner that prevents or interferes with the patient's choice to receive the drugs from the 340B covered entity. A PBM shall not reimburse a pharmacy or pharmacist in this State an amount less than the amount the PBM reimburses a PBM affiliate for providing the same pharmacist services. A PBM shall not restrict, limit, or impose requirements on a licensed pharmacy in excess of those set forth by the Vermont Board of Pharmacy or by other State or federal law, nor shall it withhold reimbursement for services on the basis of noncompliance with participation requirements. A PBM shall provide notice to all participating pharmacies prior to changing its drug formulary. Prohibits patient steering and establishes pharmacy benefit network requirements
2025	Virginia	H 2610	**Summary:** By December 31, 2025, the Department shall select and contract with a single third-party administrator to serve as the state pharmacy benefits manager (PBM) to administer all pharmacy benefits for Medicaid recipients, including those enrolled in a managed care organization with whom the Department contracts

Year	State	Citation	Summary
			for the delivery of Medicaid services. Each managed care contract entered into or renewed by the Department for the delivery of Medicaid services by a managed care organization shall require the managed care organization to contract with and utilize the state PBM for the purpose of administering all pharmacy benefits for Medicaid recipients enrolled with the managed care organization. The Department's contract with the state PBM shall: Establish the state PBM's fiduciary duty owed to the Department, Require the use of pass-through pricing, Require the state PBM to use the common formulary, reimbursement methodologies, and dispensing fees established by the Department, Require transparency in drug costs, rebates collected and paid, dispensing fees paid, administrative fees, and all other charges, fees, costs, and holdbacks, and Prohibit the use of spread pricing.

Additional External Resources:

- **2020, Brown and McCuskey, The Implications of Rutledge v. PCMA for State Health Care Cost Regulation**
  Findings: The Supreme Court's unanimous decision in *Rutledge v. Pharmaceutical Care Management Association* (2020) significantly narrowed ERISA preemption and expanded states' authority to regulate health care costs. The Court held that ERISA does not preempt state laws that regulate PBMs or other intermediaries when such laws merely affect costs without dictating plan structure or coverage. This ruling strengthens the legal footing for state PBM regulations—such as transparency requirements, gag clause bans, and spread pricing prohibitions—and opens the door for broader state reforms, including provider rate regulation and consumer protections like surprise billing laws. While Rutledge provides meaningful latitude for states, ERISA's broad preemption language continues to create uncertainty, fueling litigation and limiting systemic reforms. Long-term solutions may require Congressional action to amend ERISA or add waiver mechanisms.

- **2023, Monahan, ERISA Fiduciary Duties: An Old Dog With New Tricks?**
  Findings: Employer-sponsored insurance is under pressure as health care costs rise and employers hesitate to shift more costs to workers. Transparency initiatives—such as federal price disclosure rules and the Consolidated Appropriations Act's ban on gag clauses—are giving new force to ERISA fiduciary duties, requiring employers to act as prudent purchasers. With greater access to claims data and vendor compensation, employers can identify waste, conflicts of interest, and excessive fees in contracts with brokers, TPAs, and PBMs. While cutting contractual waste is achievable, reducing provider prices remains challenging due to market consolidation and limited fiduciary reach over intermediaries. Long-term sustainability may require systemic reforms, including potential price regulation.

- **2024, United States Government Accountability Office, Selected States' Regulation of Pharmacy Benefit Managers**
  Key Points: Each of the five states selected for review—Arkansas, California, Louisiana, Maine, and New York—enacted a variety of laws to regulate PBMs
  - **Private health plans contract with PBMs to administer their prescription drug benefits and help control costs.** Each of the five states selected for review—Arkansas, California, Louisiana, Maine, and New York—enacted a variety of laws to regulate PBMs.

- **Fiduciary or other "duty of care" requirements.** Four of the five states (California, Louisiana, Maine, and New York) enacted laws to impose a duty of care on PBMs. The laws varied from imposing a fiduciary duty—that is, a requirement to act in the best interest of the health plan or other entity to which the duty is owed—to what state regulators described as "lesser" standards such as a requirement to act in "good faith and fair dealing."
- **Drug pricing and pharmacy reimbursement requirements.** The five states enacted a variety of laws relating to drug pricing and pharmacy payments, such as laws limiting PBMs' use of manufacturer rebates and their ability to pay pharmacies less than they charge health plans—a practice referred to as "spread pricing."
- **Transparency, including licensure and reporting requirements.** To increase the transparency of PBM operations, the five states enacted laws that require PBMs to be licensed by or registered with the state, or both, and to report certain information such as drug pricing, fees charged, and the amounts of rebates received and retained.
- **Pharmacy network and access requirements.** The five states also enacted laws regarding pharmacy networks and patient access. Examples include laws prohibiting discrimination against unaffiliated pharmacies and limiting patient co-pays charged by PBMs. The regulators GAO interviewed from selected states described lessons learned regarding PBM regulation. Examples include the following.
  - **Regulators in four states said that providing regulators with broad regulatory authority was more effective than enacting specific statutory provisions.** Doing so allowed regulators to address emerging issues without new legislation, according to regulators from one state.
  - **Some regulators also stressed the need for robust enforcement of PBM laws and effective penalties to enforce them**. Two pharmacy associations GAO interviewed concurred with these views, while a health plan association said that monitoring is needed to ensure compliance with PBM requirements. Three regulators also said that clear reporting requirements and definitions helped ensure consistent enforcement.

- **2024, U.S. Department of Health and Human Services Office of Inspector General**, **Medicaid Managed Care: States Do Not Consistently Define or Validate Paid Amount Data for Drug Claims** (*Full Report Here*, *Report in Brief Here*)
  Summary of key points:
  - ***In Medicaid Managed Care, consistent and accurate data on the amount pharmacies were reimbursed for filling prescriptions are critical for CMS and States to administer the program and oversee drug spending*.** Such data are particularly important in light of concerns that PBMs' use of spread pricing could inflate Medicaid drug costs.
  - ***State requirements varied for how plans should report the paid amount for drug claims*.** Of the 36 States that covered outpatient prescription drugs for Medicaid through managed care in January 2022, 28 States required Medicaid managed care plans to report the paid amount for drug claims as the amount the plan or its PBM reimbursed to the pharmacy; 2 States required plans to report the amount the plan paid to its PBM; and 6 States had no reporting requirements.
  - ***For 37 of 252 managed care drug claims in our review, the T-MSIS paid amount did not equal pharmacy-reported reimbursement, raising concerns about the accuracy or consistency of the paid amounts on these claims*.** Twenty-two non-matching claims in our sample were from States where the T-MSIS paid amounts should have equaled pharmacy-reported reimbursement amounts for all claims according to States' requirements and practices.
  - **Although all States relied on drug claim paid amounts to safeguard and administer the Medicaid program, many States did not conduct certain activities to validate these data.** Most States relied on these data to develop capitation rates and identify fraud, waste, and abuse. Ten States did not validate these data by comparing them to another data source—a recommended, but not required, activity.

- **Feb. 2025 Visante, Increased Costs Associated With Proposed State Legislation Impacting PBM Tools**

Visante was commissioned by the Pharmaceutical Care Management Association (PCMA) to estimate the potential cost impact of four types of state legislation impacting pharmacy benefit management (PBM) tools: PBM disclosure mandates, PBM fiduciary mandates, limits on prior authorization (PA) and step therapy (ST), and any willing specialty pharmacy requirements. As a general rule, such state legislation would affect only plan sponsors for commercial, fully insured plans. These plans provide prescription drug benefits to an estimated 85 million Americans.

To make our estimates, we conducted a comprehensive review of the published evidence on how much PBM tools save as they are currently used in the marketplace and created an economic model of the impact of legislative proposals on the use of these tools would be reduced and how projected drug expenditures might increase over the next 10 years as a result.

Major Findings:

- **PBM Disclosure Mandates**: Proposed disclosure mandates include legislative and regulatory measures that would require PBMs to divulge the contractual price concessions they have negotiated with drug manufacturers and pharmacies. According to the Federal Trade Commission (FTC), disclosure mandates could result in tacit collusion and standardization of contract terms. We predict that disclosure mandates would increase projected drug expenditures by an estimated 5.2% over the next 10 years.
- **PBM Fiduciary Mandates:** Fiduciary mandates are state proposals to designate PBMs as fiduciaries for their health plan/employer clients. Such mandates would reduce savings from many PBM tools, including PA, ST, and other PBM tools that improve formulary performance and manage drug utilization. Fiduciary mandates would also likely increase PBM costs for liability insurance. We predict that fiduciary mandates would increase projected drug expenditures by an estimated 6.4% over the next 10 years.
- **Limitations on Prior Authorization and Step Therapy:** Some states are considering proposals to limit or prohibit the ability of health plans and their PBMs to implement PA and ST protocols. We predict that prohibiting the use of PA and ST would increase projected drug expenditures by an estimated 6.75% over the next 10 years.
- **Any Willing Specialty Pharmacy Requirements:** Some states are considering proposals to restrict the ability of health plans and PBMs to selectively contract for the provision of specialty pharmacy services by imposing any willing pharmacy requirements on such contracts. Such proposals would likely reduce specialty pharmacy network discounts and negatively impact the use of PBM tools that improve formulary performance and manage drug utilization. We predict that any willing specialty pharmacy requirements would increase projected drug expenditures by an estimated 3% over the next 10 years.

- March 2024, GAO Selected States' Regulation of Pharmacy Benefit Managers, *Survey results:* Most stakeholders we interviewed told us they believed a duty of care requirement was appropriate for PBMs although some stakeholders we interviewed disagreed. Regulators from three states, officials from four pharmacy associations, and officials from three national advocacy organization told us that a duty of care should be imposed on PBMs. However, officials from four health plan associations, officials from one health plan, and officials from the PBM trade association told us that they did not think a duty of care should be imposed.

Marcus C. Evans Jr.
President, NCSL
Assistant Majority Leader, Illinois

Lonnie Edgar
Staff Chair, NCSL
Mississippi Joint Legislative PEER Committee

Tim Storey
Chief Executive Officer, NCSL

Date: December 16, 2025

To: Matthew Weaver
Montana Economic Development Interim Committee

From: Colleen Becker, NCSL

Topic: State Approaches to Bagging Policies

Dear Matthew,

Thank you for inviting NCSL to present information on state initiatives to lower drug costs and address consumer access. Below you will find relevant information, state examples and legislation, and outside resources.

Please note, NCSL takes no position on state legislation or laws mentioned in linked material, nor does NCSL endorse any third-party publications; resources are cited for informational purposes only.

NCSL Resources

- Toolkit, Prescription Drug Resource Center
- Database, Prescription Drug Legislation Database

Background

Specialty drugs are frequently prescribed for complex or chronic conditions like cancer, human immunodeficiency virus (HIV), rheumatoid arthritis, and many behavioral, physical, and developmental conditions, as well as rare diseases. According to a federal HHS study of state Medicaid programs, though often colloquially known to mean a small set of high-cost prescription drugs needing special handling, no standard definition exists.

Specialty drugs are often distributed via specialty pharmacies rather than retail outlets to the physician's office or outpatient clinic for administration. Providers may also purchase prescription drugs directly from distributors or manufacturers through a process known as "buy-and-bill." Here, the provider is responsible for the storage and handling of the medication, as well as billing the insurer.

Researchers looking at drug spending in Medicare Part D from 2010 to 2021 found an annual growth rate of 23.5%. They discovered that the share of specialty drug spending increased from 21.7% in 2012 to 71.1% in 2021, even though specialty drugs accounted for 6.2% of prescriptions.

One way health plans and pharmacy benefit managers (PBM) are trying to curb this rise in specialty drug costs is to shift from the buy-and-bill process to require patients to fill prescriptions at PBM-affiliated specialty pharmacies. For example:

- White-bagging—when a PBM requires a clinician-administered drug to be dispensed by an affiliated specialty pharmacy.
- Brown-bagging—When a patient receives a medication and is then responsible for transporting it to a clinic for administration.

Among drugs used in various care settings, one group of scholars learned that, although bagging policies may lower payments made by insurers, they increased patient out of pocket costs and created challenges for both patients and providers.

State Examples

Since 2020, at least 15 states have enacted legislation to limit or prohibit the use of "bagging" policies. States have addressed this issue using other strategies such as limits on patient steering, creating independent pharmacy protections, and establishing patient choice of pharmacy laws.

This list is not exhaustive.

Year	State	Citation	Summary
2025	Maryland	H 1243	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. R
2025	Mississippi	H 17	A health insurance issuer, 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.
2025	Nebraska	L 198	A PBM or health carrier shall not require a specialty pharmacy to dispense a covered clinician-administered drug directly to a covered person with the intention that the covered person will transport the clinician-administered drug to a health care provider for

Year	State	Citation	Summary
			administration; Refuse to authorize or reimburse a participating provider for dispensing a covered clinician-administered drug based on costs if the costs of the drug to the health benefit plan are substantially similar as compared to the costs of the drug if provided from a specialty pharmacy selected by the PBM or health carrier; Require a covered person to obtain a clinician-administered drug from a specialty pharmacy selected by the PBM or health carrier if a participating provider of the covered person's choice sources the drug and provides for administration at substantially similar costs.
2024	Oklahoma	H 1713	All health plans and PBMs 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 plan or a PBM 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 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.
2024	Oregon	H 4012	A health plan that reimburses the cost of hospital or medical expenses may not, for a covered clinician-administered drug for the treatment of cancer or a covered drug administered by an enrollee’s oncology clinic to treat a symptom, complication or consequence of cancer: Require a physician or health care provider participating in the health benefit plan issuer’s provider network to bill for or be reimbursed for the delivery and administration of the drugs as a pharmacy benefit instead of as a medical benefit under the plan; Limit or deny coverage of the drug based on the enrollee’s

Year	State	Citation	Summary
			choice of pharmacy or because the drug was not dispensed by a pharmacy that participates in the health benefit plan issuer's provider network.
2023	Texas	H 1647	A health benefit plan issuer may not, for an enrollee with a chronic, complex, rare, or life-threatening medical condition: require clinician-administered drugs to be dispensed only by certain pharmacies or only by pharmacies participating in the health benefit plan issuer's network; If a clinician-administered drug is otherwise covered, limit or exclude coverage for such drugs based on the enrollee's choice of pharmacy require a physician or health care provider participating in the health benefit plan issuer's network to bill for or be reimbursed for the delivery and administration of clinician-administered drugs under the pharmacy benefit instead of the medical benefit; 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.
2023	Utah	S 193	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.

External Resources