



# 2025

## STATE WINS FOR COMMUNITY PHARMACY

### DRUG PRICING AND REIMBURSEMENT

**Massachusetts and Maine:** NCPA worked with stakeholders to defeat pharmacy taxes proposed in the respective states' budget plans. The Maine proposal sought a \$0.70 tax per prescription and the Massachusetts plan sought a \$2 tax per prescription. Neither proposal contemplated the implications for pharmacy owners, including administrative and operational burden and cash flow concerns. The taxes were intended to draw down additional matching federal dollars and there was vague talk of higher dispensing fees.

**Nevada:** As part of two broad-based coalitions, NCPA worked to defeat maximum fair price legislation AB 259 for the second consecutive year, securing a veto from Gov. Joe Lombardo (R). Several states have tried to introduce Inflation Reduction Act policies at the state level, Nevada receiving the most traction.

**Ohio:** The Department of Medicaid published a report evaluating the single PBM reform program mandated by HB 166 from 2019 and implemented on Oct. 1, 2022. The single PBM uses the state Medicaid program's fee-for-service reimbursement methodology. The report found a total savings of \$140 million during the first two years of the single PBM program, even after the average professional dispensing fee shifted from \$0.73 to around \$9 per the fee-for-service methodology. The report found these changes stabilized the Medicaid marketplace, preserving and even expanding patient access.

### MEDICAID REFORM LEGISLATION

**Minnesota HF 2:** Requires the state Medicaid program to utilize a single PBM to administer the pharmacy benefit starting Jan. 1, 2027. The single PBM will have to reimburse pharmacies with the lesser of NADAC or actual acquisition cost plus the professional dispensing fee used in the state's fee-for-service program. Creates a "directed pharmacy dispensing payment" of \$4.50 per prescription for Minnesota pharmacies not owned or affiliated with a PBM and with 13 or less locations, and those non-owned/affiliated pharmacies serving rural and/or underserved areas as defined by the Health Resources and Services Administration, taking effect July 1, 2025 and expiring on Dec. 31, 2026.

**Nevada SB 389:** Requires the state Medicaid program to utilize a single PBM to administer its pharmacy benefit on or before Jan 1, 2030. Establishes criteria for selecting the PBM, such as prohibiting the use of spread pricing.

**Virginia SB 875/HB 2610:** Create a single PBM to administer the state's Medicaid pharmacy program by July 1, 2026. Establish fiduciary responsibility for the PBM, require pass-through pricing, and prohibit spread pricing.

### PAYMENT FOR NON-DISPENSING SERVICES

**Hawaii SB 1245:** Recognizes pharmacists as providers and mandates Medicaid and commercial coverage and payment parity for all services within a pharmacist's scope of practice.

**Kentucky SJR 26:** Directs the Department of Medicaid Services to provide a report detailing the cost associated with pharmacists' payment parity.

**Oregon SB 2942:** Requires the Oregon Health Authority and coordinated care organizations to pay pharmacists for HIV care and associated services as other health providers.

**Tennessee SB 569:** Allows pharmacists to charge an administrative fee when dispensing hormonal contraceptives and ensures fair reimbursement from commercial payers by banning discrimination.

**Utah SB 312:** Mandates private health insurance coverage for all drugs and devices prescribed by a pharmacist within their scope of practice, and mandates coverage for consultations for certain devices.

**Vermont S 30:** Mandates coverage for pharmacist-prescribed self-administered hormonal contraceptives in both commercial and Medicaid plans.

### PBM REFORM LEGISLATION

**Alabama SB 252:** Ties commercial reimbursement for independent pharmacies to the state's Medicaid reimbursement methodology: state-based average acquisition cost benchmark plus a professional dispensing fee of \$10.64, effective Oct. 1, 2025. Prohibits PBMs from requiring mail order, prohibits patient steering, requires reporting of spread pricing, and permits pharmacist to decline to dispense if reimbursement is below cost.

**Alaska SB 132:** Creates PBM licensure requirements (previously registration) and includes \$20,000 licensure and renewal fees.

**Arkansas HB 1150:** Prohibits state permits to pharmacies owned by PBMs effective Jan. 1, 2026.

**Arkansas HB 1602:** Strengthens PBM licensure and reporting requirements and establishes initial PBM licensure and renewal fees of \$20,000.

**Arkansas HB 1620:** Creates PBM prompt payment guidelines. PBMs are to issue, mail, or otherwise transmit payments for clean claims within seven to 14 days after the date of the receipt of a claim for an electronic claim; or within 30 days after the date of the receipt of a claim for any other paper or manually submitted claim. Processes are outlined for claims not considered clean. Establishes a penalty of 12 percent per month for late payment of claims to the contracted pharmacist or pharmacy.

**Arkansas HB 1703:** Establishes appeals process, including reimbursement at 110 percent of acquisition cost if upheld.

**Arkansas SB 103:** Clarifies and strengthens any willing provider statute.

**Arkansas SB 104:** Defines and addresses unfair or deceptive trade practices, including steering and prohibition of ghost pharmacy networks.

**Arkansas SB 544:** Prohibits use of national contracts unless amended for Arkansas law, addresses opt-out contracts, and strengthens enforcement and penalties for underpayment.

**Arkansas SB 583:** Establishes private right of action for MAC appeals process, including recovery of damages and losses.

**California AB 116:** Creates PBM licensure requirements under the Department of Managed Health Care effective Jan. 1, 2027, and adds enforcement provisions, including the creation of funds to collect licensure fees and penalties.

**Connecticut HB 7192:** Requires PBMs to offer pass-through pricing options to payers.

**Colorado HB 25-1094:** Limits PBMs to earning income through flat-dollar service fees and requires PBMs to reimburse pharmacies with NADAC plus a reasonable and adequate dispensing fee.

**Colorado HB 25-1222:** Creates a reimbursement floor in the commercial market for independent pharmacies effective Jan. 1, 2026, using NADAC plus the state's Medicaid dispensing fee for rural independent pharmacies (currently \$14.14) plus a 1 percent increase annually. Also contains audit protections and ensures that rural independent pharmacies can deliver drugs to underserved communities.

**Georgia HB 196:** Creates a pharmacy reimbursement floor in state health plans serving state employees, teachers and public school employees, and current and retired employees of the University System of Georgia. The floor uses NADAC plus a professional dispensing fee of \$11.50 for independent pharmacies and \$10.50 for chain pharmacies. Closes discount card loopholes.

**Illinois HB 1697:** Eliminates spread pricing and patient steering, and mandates 100 percent rebate pass-through. Institutes an oversight structure for PBMs and requires annual transparency reports, plan audits, and market conduct

examinations. Allocates tens of millions of dollars a year to critical access pharmacies.

**Indiana SB 140:** Establishes reimbursement floors in the commercial market for independent pharmacies effective Jan. 1, 2026. Requires reimbursement not less than the greater of 1) the reimbursement level paid to PBM-owned or affiliated pharmacies or 2) one of the following reimbursement schemes dependent on whether pharmacies hold permits to sell liquor: For pharmacies not holding permits to sell liquor (typically independent), the reimbursement floor is NADAC plus the professional dispensing fee from the Medicaid fee-for-service program, and for pharmacies holding permits to sell liquor, the floor will be actual acquisition cost plus a "fair and reasonable" dispensing fee.

**Iowa SF 383:** Requires reimbursement not less than NADAC plus a professional dispensing fee of \$10.68 in the commercial market, requires the use of pass-through pricing, includes any willing provider provisions, and prohibits arbitrary accreditation requirements. Addresses rebates and bolsters oversight and enforcement authority.

**Louisiana HB 264:** Prohibits patient steering without the patient's consent; creates a stringent definition for "specialty drugs;" requires an acquisition-based reimbursement, including a dispensing fee for local pharmacies and a pathway to challenge the reimbursement; bans all fees charged to pharmacists; bans spread pricing; and prohibits PBMs from retaining rebates.

**Louisiana SR 209:** Requires the Department of Health to study impact of prohibiting PBMs from owning pharmacies.

**Maine HP 1038/LD 1580:** Prohibits spread pricing.

**Montana HB 740:** Requires independent pharmacies to be reimbursed in the commercial market at the rate of NADAC plus a professional dispensing fee of \$15, plus increases every Jan. 1 to reflect the consumer price index. The legislation takes effect on Oct. 1, 2025, and has a sunset provision of June 30, 2029.

**Nebraska LB 198:** Prohibits PBMs from requiring mail order, creates any willing provider provisions, and allows pharmacists to decline to dispense drugs reimbursed below cost.

**New Mexico HB 174:** Establishes NADAC plus a professional dispensing fee based on Medicaid fee-for-service program methodology for independent pharmacies serving the health plan for state employees, public school employees, and their respective retirees.

**North Carolina SB 479:** Requires networks to accept any willing provider and prohibits multiple accreditations to enter specialty pharmacy networks; requires PBMs to report on their use of spread pricing, strengthens audit protections, and addresses patient steering; assigns fiduciary duty to PBMs; prohibits PBMs from reimbursing their owned or affiliated pharmacies more than other pharmacies; and requires most rebate savings be passed along to patients. Defines pharmacy deserts, and tasks the Board of Pharmacy with tracking pharmacy openings and closures. PBMs contracts are prohibited from requiring an independent

pharmacy or any pharmacy in a pharmacy desert to accept reimbursement for providing a covered prescription drug, device, or service at a rate less than the acquisition cost for the covered drug, device, or service. Extends the state's current policy of reimbursing pharmacies in the Medicaid managed care program with the fee-for-service methodology through June 2031.

**North Dakota HB 1584:** Strengthens the PBM licensure program with clear authorities for oversight and enforcement by the Department of Insurance. Removes ERISA from statute, ensuring oversight of all PBMs serving all plans in the state.

**Oklahoma SB 789:** Prohibits PBM or third-party payers from entering into contracts that establish payment for services or medications based on an effective rate of reimbursement.

**Oklahoma SB 993:** Strengthens audit protections and clarifies the appeals process for below-cost reimbursement.

**Rhode Island HB 5248 and SB 314:** Limit pharmacy audits to once every 12 months unless fraud or misrepresentation is reasonably suspected, with enforcement authority granted to the Office of the Attorney General.

**Tennessee SB 881/HB 1244:** Create prompt payment standards with oversight and enforcement authority, including fines, to the Department of Commerce and Insurance.

**Texas HB 1236:** Prohibits retroactive claims adjustments and defines and regulates adverse material changes and other modifications to PBM contracts.

**Texas SB 493:** Prohibits PBMs from prohibiting or restricting pharmacies from informing patients about out-of-pocket costs with and without submitting a claim under their prescription drug benefit.

**Utah HB 257:** Requires PBMs to offer self-funded insurances an option without spread pricing.

**Vermont S 30:** Prohibits PBMs from requiring mail order.

## PBM ENFORCEMENT

The **Mississippi** Board of Pharmacy issued a memo with instructions and a \$200 payment opportunity for pharmacies to file appeals for CVS Caremark claims that were known to be below pharmacy acquisition cost since Jan. 1, 2023.

The **Tennessee** Department of Commerce and Insurance published its audit of Express Scripts for activity in 2023 and found many areas of noncompliance that harmed community pharmacies. It found that ESI reimbursements favored their own affiliated pharmacies over non-affiliated ones, paying higher rates for 568 of 2,318 medications sampled. Additionally, the audit found that ESI failed to pay the mandatory commercial dispensing fee to low volume pharmacies in 100 percent of the claims sampled.

The **Florida** Office of Insurance Regulation issued a memorandum with detailed information about its PBM examination regiment in the wake of the strong PBM reform legislation SB 1550 enacted in 2023.

**Oklahoma** Attorney General Gentner Drummond is suing CVS Caremark for repeated violations of state laws intended to protect pharmacies from below-cost reimbursement, taking the complaint to the Oklahoma Office of Administrative Hearings' new PBM Administrative Court.

**West Virginia's** Office of the Insurance Commissioner (OIC) issued a bulletin with analysis on the impact of rebate transparency and shared savings as required by HB 2263, the Pharmacy Audit Integrity Act, enacted in 2021. Analysis of the law's required 100 percent rebate pass-through policy showed that patient premiums either decreased or that the policy mitigated any increases in patient premiums. Patient cost-share at the point of sale was also reduced because that was required before the excess rebates were reported to the OIC. When PBMs are not allowed to pocket rebates, reform legislation can save money for patients and payers.

As part of its ongoing engagement of the National Association of Insurance Commissioners (NAIC), NCPA provided feedback to the Pharmacy Benefit Management Working Group as it began drafting a new chapter in its market conduct manual dedicated to auditing PBMs. NCPA had previously advocated successfully for PBM oversight and enforcement, including PBM examinations, to be included in the working group's 2025 charges.

## PREP ACT

**Maryland HB 1315:** Updates vaccine authority language to allow pharmacists to administer vaccines in compliance with the CDC's ACIP recommendations in effect on Dec. 31, 2024, or at a later date to account for any new vaccines recommended by ACIP pursuant to a physician protocol.

**New Jersey A 1899:** Authorizes pharmacists to administer the flu and COVID-19 vaccine for patients five (5) years and older.

**North Carolina HB 67:** Allows pharmacists to order and perform CLIA-waived tests for flu and initiate treatment based on results in accordance with statewide protocols.

**Oregon SB 295:** Authorizes pharmacists to assess and treat certain health conditions as defined by the state's Public Health and Pharmacy Formulary Advisory Committee.

**Rhode Island SB 166:** Allows pharmacists to administer flu and COVID-19 vaccines to patients three (3) years and older.

**West Virginia SB 526:** Allows pharmacists to test and treat for flu, COVID-19, and RSV.

## SCOPE OF PRACTICE

**New Hampshire SB 250:** Allows pharmacists to be reimbursed for administering medications though long-acting injectables.

**Rhode Island SB 476:** Allows pharmacists to prescribe and dispense all FDA-approved hormonal contraceptives and permits pharmacists to initially prescribe more than a three-month supply.