



# 2026

## STATE WINS FOR COMMUNITY PHARMACY

*From promoting comprehensive state-level PBM regulation and Medicaid managed care reform to supporting compounding and pharmacists' ability to practice at the top of their license, the National Community Pharmacists Association is working to change the pharmacy payment model and make it easier for independent and long-term care pharmacies to serve their communities. We are pleased by our 2026 state advocacy priority successes that bring transparency, accountability, and fairness and allow patient access to timely, quality pharmacy care.*

### PBM REFORM

**Florida HB 697:** Prohibits PBMs in the Program of All-Inclusive Care for the Elderly from reimbursing their owned or affiliated pharmacies more than others and allows pharmacies to decline to dispense medications below actual acquisition cost.

**Hawaii HB 1643:** Requires PBMs to have a registered pharmacist as consultant when the audit involves clinical judgment. Limits circumstances for recoupment, requires the same audit standards and parameters as other similarly situated pharmacies that are audited, prohibits audits within the first seven calendar days of the month unless consented to by the pharmacy, allows the pharmacy to reverse and rebill within the correction time frame of the audit, and prohibits the use of extrapolation.

**Kansas SB 20:** Creates a commercial market reimbursement floor of NADAC plus the greater of either \$10.50 or the state Medicaid professional dispensing fee for plans not subject to ERISA preemption. Strengthens audit protections by adding parameters for process timelines and recoupments, and limits audit periods to no more than 24 months and 250 prescriptions for clinical audits. Broadens and strengthens oversight and enforcement authority in the Department of Insurance.

**Louisiana HB 1236:** Creates a commercial market reimbursement floor of NADAC plus the Medicaid professional dispensing fee of \$11.81.

**Louisiana SB 387:** Strengthens appeals procedures and audit protections, assigns fiduciary responsibility to PBMs, requires PBMs to pass rebates through to insurers, and delinks PBM income from fees.

**Maine SP821/LD 2005:** Allows mail-order prescriptions to be filled at network pharmacies in certain instances of delay and/or unusable condition.

**New Hampshire HB 544:** Requires documentation of formulary changes and transparency of MAC pricing lists in managed care.

**Ohio HB 229:** Creates a PBM-specific regulatory framework with oversight by the superintendent of insurance effective July 1, 2027. Requires PBMs to disclose financial transactions, rebates, ownership interests, and contractual details, as well as to retain detailed records for at least 10 years.

**Oklahoma SB 1447:** Mandates disclosures, formulary and network management, rebate pass-through, impact analyses, operational data handling, and certification requirements for PBM contracting with the Oklahoma Employees Insurance Plan. Establishes reporting obligations for PBMs and pharmacies, including payment and billing information, and sets criteria for evaluating requests for proposals for PBM services.

**Rhode Island H 8579:** Establishes a new regulatory framework, including requirements for PBMs to obtain a certificate of authority from the Office of the Health Insurance Commissioner to operate in the state, sets data reporting obligations, and gives the commissioner stronger enforcement authority.

**Rhode Island H 8582:** Requires PBMs to have reimbursement appeals processes, prohibits gag clauses, and strengthens PBM obligations of "good faith and dealing" with patients, pharmacies, and insurers. The bill assigns to PBMs the cost of enforcement, with specifications that include 150 percent of salaries and benefits of utilized personnel in the Office of the Health Insurance Commissioner.

**Tennessee SB 2040/HB 1959:** Beginning July 1, 2028, a person or entity may not directly or indirectly own, operate, control, or direct the operation of a whole or any part of a pharmacy, and may not directly or indirectly own, operate, control, or direct the operation of a health insurance issuer or a PBM, when the ownership interest exceeds 5 percent. Enforcement is authorized for the attorney general. The board of pharmacy is required to refer potential violations and violations are subject to civil penalties up to \$10,000 per violation, with each day continuing constituting a separate violation. It requires rulemaking by the board to effectuate the act.

**Utah HB 527:** Improves transparency of maximum allowable cost (MAC) pricing, and strengthens the MAC appeals process. Creates fines for violations.

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**Virginia HB 830:** Requires carriers and contracted PBMs to use a pass-through pricing model and to offer at least one option for limiting PBM fees and compensation to services provided. Prohibits retroactive claims adjustments and reductions of any payment, directly or indirectly through a reconciliation process, including generic or brand effective rates.

**West Virginia HB 5430:** Prohibits spread pricing, authorizes oversight of the Public Employment Insurance Agency plan to the Office of the Insurance Commissioner (OIC), addresses rebate concerns from offshore group purchasing organizations, and requires a Medicaid cost of dispensing survey every three years starting in 2026. Establishes and strengthens pharmacy cost and audit integrity requirements.

#### **PBM REGULATION ENFORCEMENT**

**Alabama:** The Department of Insurance's new PBM oversight division issued several enforcement actions against Express Scripts (ESI), alleging that it charged pharmacies a wide array of illegal fees, did not reimburse pharmacies serving patients in the commercial market at the Medicaid reimbursement rate per state law, and was unresponsive to requests from the department. The department requested the OIC to schedule an administrative hearing. If found in violation of the law, ESI's license could be suspended until it shows willingness to comply with the regulatory regimen. The OIC can also issue civil penalties or seek other forms of relief.

**Arkansas:** The Arkansas Insurance Division (AID) issued a report outlining its PBM enforcement actions pertaining to "fair and reasonable" reimbursement per Rule 128. In addition to an array of small fines issued to several PBMs, AID issued the expectation that generic medications be reimbursed at NADAC plus the state Medicaid professional dispensing fee of \$10.50 until the Department of Human Services completes its next cost of dispensing survey. An enforcement proceeding is also ongoing with Navitus.

**Louisiana:** ESI entered into an agreement with the Department of Insurance (LDI) to begin reimbursing local pharmacies in line with the "fair and reasonable" standard outlined in Directive 257. In the directive, LDI indicated reimbursement below NADAC plus a \$9 professional dispensing fee would be out of compliance with "fair and reasonable." This reimbursement will be replaced by NADAC plus the Medicaid professional dispensing fee per HB 1236 (see above) effective June 12, 2026.

**North Carolina:** The offices of the insurance commissioner and attorney general co-authored a letter to the 23 PBMs licensed in the state with their intention to oversee and enforce the Script Act, enacted last year as SB 479.

**Oklahoma:** CVS Caremark will pay \$32.1 million to the state as part of a settlement over its handling of discounts and rebates. Requires Caremark to report and remit rebates every quarter, providing transparency into the PBM's future payments to the plan.

**Oklahoma:** CVS Caremark will also pay over \$5 million in a settlement over allegations it under-reimbursed pharmacies. The state will distribute 75 percent of the funds to eligible pharmacies that filled over 68,000 prescriptions between January 2024 and August 2025 and were paid less than what the drugs cost. The Office of the Attorney General will keep the other 25 percent. Caremark also agreed to various reforms including reviewing pharmacy payment disputes against national cost benchmarks, allowing pharmacies to use documentation of actual costs when challenging payments.

**Rhode Island:** The Office of the Attorney General intervened to enforce audit protections against Prime Therapeutics. A consent order documents how Prime failed to provide the required 14 days' written notice ahead of the audits, asked for records beyond the two-year period statutorily allowed, and did not provide the range of prescription numbers which would be inspected nor an opportunity to reschedule the in-person visit. Although no penalties were assessed, Prime was ordered to cease the auditing practice leading to the complaints filed with the Office of the Attorney General.

**Tennessee:** The Department of Commerce and Insurance (DCI) has issued five consent orders for failure to comply with PBM laws. DCI issued two fines of \$250,000 each to Caremark entities for withholding self-funded ERISA claims data, not paying professional dispensing fees per the state's tier structure, spread pricing, improper appeals processes with no instructions for reverse and rebill, not meeting prompt pay requirements, and reimbursing their owned/affiliated pharmacies more than others. DCI also issued two fines of \$250,000 to OptumRx for not cooperating during the PBM audit process and many violations of state law regarding pharmacy appeals. Additionally, DCI fined RxAdvance \$250,000 for not being properly licensed.

**West Virginia:** The OIC issued a \$1.4 million fine to CVS Caremark based on 2,871 violations of the 2021 Pharmacy Audit Integrity Act. CVS Caremark improperly applied the definition of rebate when withholding rebate payments and fees from the health plan; recouped excessive funds from pharmacy claims relative to the financial harm associated with the dispensed products; exceeded the maximum number of prescriptions covered in a pharmacy audit; delivered contracts and communications to providers that cited fees associated with the cost of pharmacy audits in excess of those allowed by law; and unreasonably designated 65 covered prescription medications as specialty drugs. The OIC ordered CVS Caremark to file a plan to address the violations within 30 days and is allowing 90 days to implement it.

**West Virginia:** The OIC issued a \$800,000 penalty on Navitus for violations of the state's pharmacy audit, pharmacy reimbursement, and rebate pass-through laws between Jan. 1, 2023, and June 1, 2024. Navitus did not allow audited pharmacies 30 days to respond to preliminary reports and rejected documents to validate pharmacy records. Rebates totaling \$540,000 were kept by the PBM rather than passed through as required by law. Navitus did not reimburse West Virginia pharmacies at the required rate of NADAC plus a \$10.49 professional dispensing fee.

**West Virginia:** The OIC has issued a series of penalties, including a \$1.5 million fine, to ESI for multiple violations identified in an examination report that reviewed claims between Jan. 1, 2023, and June 1, 2024. Among the violations, ESI audits recouped more money from pharmacies than the harm associated with the dispensed product. ESI also did not reimburse pharmacies at the required rate of NADAC plus \$10.49 while reimbursing their owned or affiliated pharmacies more than others. ESI continued to designate specialty drugs in an unreasonable manner. Among the provisions of the agreed order were a \$1.5 million administrative penalty, corrected reimbursement with interest, and a corrective action plan.

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**MEDICAID REFORM**

**Illinois HR 746:** This resolution urges the Illinois Department of Healthcare and Family Services to ensure that Medicaid managed care networks are reimbursing pharmacies no less than the fee-for-service rate, including both the ingredient cost and the professional dispensing fee.

**Maryland SB 839/HB 1470:** Requires the Maryland Department of Health to conduct a Medicaid cost of dispensing survey at least once every three years.

**Minnesota:** The Centers for Medicare & Medicaid Services approved Minnesota's State Plan Amendment for a Directed Pharmacy Payment Program (DPPP). The DPPP provides additional reimbursement of \$4.50 per Medicaid prescription (on top of the MCO contracted rate) to eligible pharmacies in rural and underserved areas as a bridge until the single PBM program is implemented on Jan. 1, 2028, with the reimbursement floor of NADAC plus the Medicaid professional dispensing fee of \$11.55 (see below). DPPP-eligible pharmacies are those with 13 or fewer independently owned locations or in Health Resources and Services Administration-designated underserved geographic areas and not owned or affiliated with a PBM. designated underserved geographic areas and not owned or affiliated with a PBM.

**Minnesota SF 4612:** Requires Medicaid managed care organizations to reimburse pharmacies at or above NADAC plus the state Medicaid professional dispensing fee of \$11.55 when the state implements its single PBM policy on Jan. 1, 2028.

**West Virginia HB 5430:** In addition to PBM reform provisions, the law requires Medicaid cost of dispensing survey every three years starting in 2026.

**SCOPE OF PRACTICE AND PAYMENT FOR SERVICES**

States enacted numerous laws in 2026 advancing pharmacist scope of practice and payment for services. The examples below highlight several of the year's most significant legislative wins and are not intended to be a comprehensive list of all enacted scope and payment legislation.

**Alaska HB 195:** Expands pharmacists' independent prescriptive authority, allowing pharmacists to prescribe and administer medications for conditions that do not require a new diagnosis or that have a test to guide diagnosis in accordance with the standard of care.

**Colorado HB 1336:** Requires health benefit plans to provide coverage for health care services provided by a pharmacist if the service is within the pharmacists' scope of practice and would otherwise be covered by another provider. Expands pharmacists' independent prescriptive authority, allowing pharmacists to prescribe medications to individuals five years of age or older for conditions that do not require a new diagnosis, are generally minor and self-limiting, or have a CLIA-waived test for flu, COVID, strep, or RSV. Allows pharmacy technicians to perform final product verification for non-controlled substances.

**Connecticut HB 5375:** Requires reimbursement for pharmacist-provided clinical services if the service is provided within the pharmacists' scope of practice and would otherwise be eligible for reimbursement if provided by a physician, physician assistant, or advanced practice registered nurse.

**Wyoming SF 121:** Allows pharmacists to assess patients prescribe medications pursuant to board of pharmacy rules.

**COMPOUNDING**

NCPA worked with state and national partners to defeat legislation targeting GLP-1 compounding that would have unnecessarily restricted pharmacists' ability to compound a broad range of medications. These bills, introduced in 10 states, sought to impose additional requirements beyond federal law, including burdensome active pharmaceutical ingredient sourcing and supplier validation standards that would significantly limit pharmacies' ability to compound legally permissible medications. Several of these bills also included excessive civil penalties for violations, creating significant legal and financial risks for pharmacies and threatening patient access to necessary compounded therapies. NCPA continues to advocate for policies that protect patient safety without imposing unnecessary barriers to safe and legitimate pharmacy compounding.

**Indiana SB 282:** The only GLP-1 compounding bill to pass in 2026, this legislation was significantly amended from its original language to better align with existing federal compounding requirements rather than impose new and unnecessary restrictions. The final law establishes much-needed oversight and regulation of medical spas.

**DRUG PRICING**

**Maximum Fair Price (MFP):** Virginia Gov. Abigail Spanberger (D) vetoed SB 481/HB 271, legislation that would have enacted a first-of-its-kind MFP policy at the state level. An additional MFP bill, SB 2384, was also defeated in Rhode Island. NCPA worked in coalition with industry partners to express concern about the pharmacy reimbursement provisions of these bills.

**Upper Payment Limits (UPLs) via Prescription Drug Affordability Boards (PDABs):** Bills to create PDABs were defeated in nine states, five of which would have been empowered to create UPLs. NCPA worked in coalition with industry partners to express concern about the pharmacy reimbursement provisions of these bills.