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PHARMACY BENEFIT MANAGERS (PBMs):
POLICY LANDSCAPE AND POTENTIAL REFORMS

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BACKGROUND

Pharmacy Benefit Managers (PBMs) have grown and developed alongside the pharmaceutical manufacturing and health insurance industries, with the earliest versions of PBMs being founded by local groups of pharmacists. In 1958, Canada saw the creation of a prescription prepayment plan called Prescription Services, Inc. In the United States, PAID Prescriptions was established in 1965. Initially, PAID reimbursed pharmacies based on their usual and customary cash prices, which were set by the pharmacies themselves. By 1968, however, PAID began determining its own reimbursement rates for pharmacies that joined their networks. In 1969, the Pharmaceutical Card System (PCS) was launched to handle claims processing and was funded by small fees imposed on each transaction. These early pharmacist-driven initiatives sparked controversy, with pharmacy trade groups raising concerns over administrative burdens, inconsistent coverage, and payment rates.

The landscape of these industries shifted in 1974 with the passage of the ***Employee Retirement Income Security Act (ERISA)***, which established federal guidelines for employer-sponsored retirement and health benefit plans. ERISA enabled large employers to implement cost-control strategies for their employee benefit plans, including the use of PBMs to oversee prescription drug benefits. The law has created barriers for states in their attempts to regulate employer-based health plans or to introduce reforms related to such plans. In recent years, state laws intended to regulate PBMs have often been met with legal challenges and been preempted by federal law.

Since its inception, the PBM sector has become increasingly consolidated through both ***horizontal and vertical integration***, leading to just three PBMs administering approximately 80% of all prescriptions in the United States. As this consolidation has occurred and PBMs influence has grown, so has concern over their increasing concentration of control over the prescription drug market. Critics of the industry frequently point to concerns regarding limited competition, opaque pricing practices, conflicts of interest, and a general lack of transparency[1].

As a result, both the federal and state governments have taken an interest in regulating the practices of PBMs, and the Federal Trade Commission (FTC) filed a lawsuit against the largest PBMs for monopolistic practices, alleging that the companies artificially inflated the cost of insulin – a life-saving treatment for diabetes that millions of Americans depend on[2]. Many states across the country have begun passing their own legislation to regulate these entities[3]. This policy brief explores key concerns associated with PBMs for payers, patients, and state governments, and discusses potential solutions based on legislation that has been proposed by Congress or passed and successfully implemented by state governments.

PHARMACY BENEFIT MANAGERS AND THEIR ROLE IN HEALTHCARE

While PBM operations have changed over time, they have continued to primarily serve five main roles[4]:

Formulary Design

Formularies list covered medications and their associated costs. Created by committees of pharmacists and physicians, formularies are based on clinical evidence, safety, efficacy, costs, and plan sponsor preferences, and are updated to account for new drugs, price changes, or new clinical evidence. Formularies can be open (broad access) or closed (limited access), with drugs placed in tiers, such as preferred or nonpreferred, that all affect the cost-sharing associated with that specific drug. PBMs often maintain multiple formularies tailored to plan sponsor preferences, which impact patient access and out-of-pocket costs.

Utilization Management

Utilization management involves several common practices, such as prior authorizations, step therapy requirements, and various financial incentives like co-payments or deductibles. ***Prior authorizations*** evaluate the appropriateness of a drug or treatment regimen and often require physicians to submit information justifying the treatment prior to the PBM approving any payment. As it relates to formulary design, PBMs have preferred and nonpreferred drugs, and ***step therapy*** is the process in which a patient is required to try the effectiveness of preferred drugs and experience "treatment failure" before the PBM approves payment for the nonpreferred drug that was originally prescribed by the physician. PBMs may also limit the dose or quantity of drugs for acute conditions that a patient can receive from a retail pharmacy and often require patients to obtain maintenance medications for chronic conditions from a mail-order pharmacy that is affiliated with the PBM. By establishing these limits and restrictions, PBMs' utilization management practices may have unintended consequences on patients' access to prescription drugs.

Price Negotiation

Price negotiation is the process in which PBMs work with drug manufacturers, wholesalers, and pharmacies to establish drug costs on behalf of the health plans they represent. Manufacturers often provide rebates or discounts to have their brand-name drugs included in a formulary or placed on a preferred tier, while the pharmacies negotiate payment terms for both brand-name and generic drugs to be included in a plan's network. These negotiations can significantly reduce the price paid by the plan sponsor

compared to standard list prices, currently though the exact net prices are disclosed only to the plan sponsor through contracts and are not made available to the public.

Pharmacy Networks

PBMs create and manage networks of pharmacies, including retail, specialty, and mail-order options, where a plan sponsor's members can fill prescriptions. By limiting which pharmacies are in the network, PBMs increase competition and encourage pharmacies to offer lower prices in exchange for access to the PBM's patients. In some cases, PBMs own the pharmacies and promote the use of their affiliated locations, while potentially discouraging the use of independent, unaffiliated pharmacies.

Mail Order Pharmacy Services

Mail order pharmacy deliveries were pioneered by the Veteran's Administration in the 1940s. As PBMs began vertically integrating with their own pharmacies to provide mail order delivery, they contributed to massive growth in mail order sales – from $100 million in 1981 to $1.5 billion in 1989. This expansion raised concerns about conflicts of interest and variances in the dispensing rates of generic drugs and ultimately led to Congressional reviews and inquiries. Today, mail order pharmacies are typically closely associated with PBMs, though they are not necessarily synonymous with one another.

To generate profits, PBMs mainly utilize two strategies for contracting with health plan sponsors[5]:

Rebate Retention Contracting

In some cases, employers and health plan sponsors may choose to allow the PBM to keep a portion or all of the rebates or discounts the PBM negotiated with the drug manufacturer. The intent of this model is to incentivize PBMs to negotiate deeper discounts and derive greater cost savings. However, the amount of savings from rebates or discounts that are either retained by the PBM or passed along to patients varies and is not widely available information. Any potential savings associated with rebates and discounts that could be passed along to patients could be even greater with enhanced transparency and regulatory mechanisms.

Risk Mitigation Contracting

This contracting strategy involves the use of ***spread pricing***. In spread pricing, the plan sponsor pays a set price for each drug regardless of what the PBM actually pays the pharmacy. The difference between these amounts determines whether the PBM takes a loss or earns a margin on that specific claim. Another approach is for the plan sponsor to cover the exact cost of the dispensed prescription (after all rebates) and pay the PBM a separate administrative fee for its negotiation and administrative services.

These PBM contracting strategies and the execution of their five main roles have had varying implications on the financial interests of relevant stakeholders, including patients and pharmacies, that have drawn criticisms and led to legislative reform efforts that often fall within four interrelated categories[6]:

- Pricing Practices
- Market Consolidation
- Lack of Competition
- Lack of Transparency

FEDERAL ACTION

Existing federal laws and regulations pertaining to PBMs are limited and do not broadly apply to their business practices overall. While PBMs are subject to the commerce clause and general consumer protections, the only statutory regulations or limitations specific to the business practices of PBMs apply to only a few types of health plans. For example, statutes enacted upon passage of the Affordable Care Act require PBMs contracted with a Medicare Part D drug plan or Qualified Health Plans on state-based exchanges to disclose financial information to the U.S. Department of Health and Human Services (HHS) (see table 1). Additionally, federal law prohibits PBMs from enforcing gag clauses that restrict pharmacists from discussing drug cost information with patients[7,8]. In June 2022, the Federal Trade Commission (FTC) launched a probe into the largest PBM companies and issued orders for the companies to produce information related to their operations. Since the beginning of this inquiry, the FTC released an interim report on July 9, 2024, detailing industry practices, filed a formal lawsuit against those companies in September 2024, and released a second interim report on January 14, 2025, that detailed PBM's impact on specialty generic drugs for HIV, cancer, and other chronic conditions like diabetes. The United States Congress has advanced and continues to propose legislation that enhances oversight and regulations of PBMs and their business practices. This section summarizes findings of the FTC's investigations as well as PBM legislation introduced since the beginning of the 119th Congress on January 3, 2025.

TABLE 1: PBM Reporting Required by Sect. 1150a of the Social Security Act (42 U.S.C. 1320b-23)

Total Number of Prescriptions Dispensed, including:

- Percent filled through retail pharmacies compared to mail order pharmacies
- Percent of generic drug prescriptions available and dispensed

Aggregate Amount of Rebates, Discounts, or Price Concessions that are:

- Attributable to patient utilization
- Passed through to health plan sponsor

Aggregate amount of Difference between what a health plan pays a PBM and what the PBM pays both retail and mail-order pharmacies.

FEDERAL TRADE COMMISSION

Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs & Squeezing Main Street Pharmacies – Interim Staff Report, July 2024

This report detailed how vertical integration has led to a highly concentrated market for PBM services in which the three largest PBMs processed almost 80% of the 6.6 billion prescriptions filled in the United States in 2023, and where pharmacies affiliated with those three PBMs accounted for almost 70% of all specialty drug revenues. The high degree of consolidation among PBMs has given them significant power over American's access to medications and specifically impacts which drugs are covered, how much they cost, and which pharmacies patients can use to fill their prescriptions. The report found that vertically integrated PBMs may prioritize their affiliated businesses, steering patients away from independent pharmacies and capturing significant revenue beyond drug acquisition costs. At the same time, their market concentration allows them to impose contract terms that obscure reimbursement rates and disadvantage smaller, unaffiliated pharmacies. Additionally, rebate agreements between PBMs and brand manufacturers can restrict coverage of lower-cost generics and biosimilars, limiting patient access to more affordable medications[9].

Specialty Generic Drugs: A Growing Profit Center for Vertically Integrated Pharmacy Benefit Managers – Second Interim Staff Report, January 2025

This analysis found that throughout the FTC's study period from 2017 through 2022, the three largest PBMs applied extreme markups – often hundreds or thousands of percent – on many specialty generics, with the steepest increases concentrated in drugs dispensed by their own affiliated pharmacies. These included medications critical for patients with serious illnesses such as cancer, multiple sclerosis, HIV, and pulmonary hypertension.

Because of high reimbursement rates and large dispensing volumes, pharmacies affiliated with the three largest PBMs earned substantial and growing levels of revenue far above their estimated acquisition costs for the marked-up specialty generics, and the PBMs themselves also profited from the associated spread pricing. These findings indicate that plan sponsors and their members may be paying significantly more than actual acquisition costs for essential medications and that patients are faced with significantly higher costs for these prescriptions to be filled[10].

119TH CONGRESS

S. 526: Pharmacy Benefit Manager Transparency Act of 2025 and S. 527: Prescription Pricing for the People Act of 2025

The Pharmacy Benefit Manager Transparency Act and the Prescription Pricing for the People Act were originally proposed during the 118th Congress. This legislation was reintroduced and intends to prohibit PBMs from abusive pricing practices, mandates transparency, and authorizes enforcement action. The legislation specifically prohibits PBMs from engaging in spread pricing, payment claw backs, or lowering reimbursement rates to offset reimbursement changes made by the federal government.

The bills would require annual reports be sent to FTC and HHS on the aggregate amount of spread retained by PBMs, as well as reports submitted to Congressional Committees by the Comptroller General on how the top 10 PBMs use rebates and fees. Additionally, the FTC would be directed to issue reports addressing whether PBMs are responsible of the following:

- Charging payors more than the PBM reimbursement rate to PBM affiliated pharmacies or unaffiliated pharmacies
- Steering patients to pharmacies for competitive advantage
- Audits of proprietary data of unaffiliate pharmacies to increase revenues or market share
- Use of formulary designs to increase market share of higher cost drugs or depress market share of lower cost drugs[11]

S. 882: The Patients Before Middlemen Act

The Patients Before Middlemen Act aims to ensure fair treatment of pharmacies by requiring Medicare Part D plans to contract with any willing pharmacy and introduces an "Essential Retail Pharmacy" designation to improve access in rural and underserved areas. The legislation seeks to enhance transparency and accountability to prevent PBMs from limiting patient access to available pharmacies, and would prohibit PBM compensation tied to drug prices, discounts, rebates, or other fees, ensuring service fees are independent of drug costs. The law would also establish an enforcement mechanism that would require PBMs to pay any excess amounts over the designated service fees to HHS[12].

- ***Essential Retail Pharmacy***: a retail pharmacy that is not affiliated with a PBM or managed care entity and is in either a medically underserved area, a rural area with no pharmacy within 10 miles, a suburban area with no other pharmacy within 2 miles, or an urban area with no other pharmacy within 1 mile[13].

S. 891: The Bipartisan Health Care Act

The Bipartisan Health Care Act includes the PBM reforms that were removed from the final version of the December 2024 Continuing Resolution. This standalone bill would prohibit PBMs who are contracted with Medicare Part D plans from obtaining any income other than bona fide service fees, would prohibit spread pricing by requiring contracts between PBMs and state Medicaid programs or Medicaid managed care organizations (MCOs) to be based on ***pass-through pricing models***, and would require 100% of rebates, fees, or other compensation received by PBMs from specified entities to be passed through group health plans or insurers offering group coverage[14].

S. 927: Protecting Pharmacies in Medicaid Act

Like the Bipartisan Health Care Act, this legislation draws from the initial language of the December 2024 Continuing Resolution and would prohibit spread pricing by requiring PBM contracts with Medicaid MCOs or state Medicaid programs to be based on a pass-through pricing model. The Protecting Pharmacies in Medicaid Act would also direct the HHS Secretary to determine the National Average Drug Acquisition Cost (NADAC) benchmarks by surveying drug prices at both retail community pharmacies and applicable nonretail pharmacies. The legislation would require this survey information to be made public and include a list of the pharmacies that are not compliant with the reporting requirements[15].

H.R. 950: Saving Seniors Money on Prescription Drugs Act

The Saving Seniors Money on Prescription Drugs Act would mainly require PBMs that contract with Medicare Part D or Medicare Advantage plans to fully disclose all information regarding the PBM's pricing guarantees or similar cost performance measurements as it relates to rebates, discounts, price concessions, or net costs. The Act would also require PBMs to submit reports to health plan sponsors and the Centers for Medicare and Medicaid Services (CMS) with an itemized list of drugs dispensed and data on the cost of the drugs, claims and reimbursements, and the percentage of total drugs dispensed by affiliated pharmacies. Under this legislation, PBMs would be required to certify their compliance with the provisions of this law on an annual basis[16].

H.R. 2450: Prescription Drug Transparency and Affordability Act

The Prescription Drug Transparency and Affordability Act also draws on language initially proposed in the December 2024 Continuing Resolution to establish new and tougher reporting requirements for PBMs. This bill would authorize the HHS Secretary to enforce these requirements and impose up to $100,000 in civil monetary penalties for each violation of the reporting requirements or for reporting false information. The legislation would also require that these reports be made publicly available by HHS[17].

H.R. 4317: The PBM Reform Act of 2025

The PBM Reform Act of 2025 is bipartisan legislation that also includes the same reforms that were in the original December 2024 Continuing Resolution. This reintroduced legislation would ban spread pricing in Medicaid, establish a policy for PBMs under Medicare Part D to separate compensation from the cost of medications, as well as a requirement for CMS to define and implement Medicare Part D contract terms that are "reasonable and relevant." Additionally, the legislation would require biannual reports on formulary design, drug spending, and rebates to achieve greater transparency for health plan sponsors and their members[18].

STATE ACTION

All 50 states have at least one law regulating PBM business practices. The most common have required PBMs to be licensed or registered with the state and ban PBMs from enforcing gag clauses. Mississippi is among the 45 states that require some sort of licensure, as well as the 44 states that have enacted gag clause prohibitions. As the momentum has grown for states to pass laws to regulate PBMs, so have the instances in which federal laws that regulate and protect employee benefit plans, such as ERISA, have preempted and made null state PBM laws and regulations[19].

ARKANSAS

Arkansas has recently been recognized for passing some of the broadest PBM restrictions and reforms. House Bill 1150 was passed into law on April 16, 2025, as Act 624 (the Act), and intended to address issues associated with PBMs in their state. The Act was meant to directly address conflicts of interest by prohibiting PBMs from owning pharmacies or obtaining or holding pharmacy permits. Aiming to prevent PBMs from acting as both "price setter and price taker," Arkansas' law targets the issue of vertical integration by forcing companies to choose between running a PBM or pharmacies. This regulatory approach acknowledges the concern that vertically integrated PBMs favor their own pharmacy operations, potentially inflating drug prices and harming independent pharmacies.

The Act would establish a clear timeline for its ownership prohibition, including assessment by the Arkansas State Board of Pharmacy by July 1, 2025, notification of violations, and a January 1, 2026, effective date[20]. This structured approach to implementation can provide greater clarity for both PBMs and pharmacies and enhance the enforceability of the regulations – an area in which the Mississippi Board of Pharmacy has sought to strengthen over the years as well.

Arkansas' law faced strong opposition from the PBM industry even before being signed into law. CVS Health ran ads against the policy, arguing it would reduce pharmacy access and increase drug costs[21]. Just over a month after the Act was passed, two of the largest PBMs as well as the national trade association that represents the industry filed three federal lawsuits against the Arkansas State Board of Pharmacy. These complaints for declaratory and injunctive relief were filed to block implementation and enforcement of the Act on the grounds that the Act had multiple violations of the U.S. Constitution's Commerce and Supremacy clauses and was preempted by several federal statutes and regulations[22,23,24]. On July 28, 2025, a U.S. District Judge granted the preliminary injunction to halt implementation of the Act. The judge's order explained that the Act was likely in violation of the U.S. Constitution's Commerce Clause in that, *"the burden Act 624 imposes on interstate 'commerce is clearly excessive in relation to the putative local benefits'."* The order also explained that the Act was likely explicitly preempted by TRICARE, the U.S. Department of Defense's health insurance program, in that the Act prohibits a specific avenue for health care delivery within the program, as well as impliedly preempted by TRICARE because the Act prevents the program from achieving what Congress intended[25].

Mississippi can anticipate similar reactions and potential legal challenges if it pursues comparable legislation or regulations. By studying Arkansas' recent experience with Act 624, Mississippi should ensure its legislation is legally sound by clearly articulating its objectives and emphasizing consumer protections. Framing PBM regulations around the goal of protecting Mississippi residents from high drug costs, ensuring patient access to medications, and preserving patient choice can align state law with its

inherent power to safeguard public health and welfare. **By enacting strong reforms, Mississippi could address PBM regulation and further strengthen its own efforts to enhance oversight and transparency in the pharmaceutical supply chain. Mississippi could take a similar approach by enacting legislation that minimizes incentives for PBMs to favor their own pharmacies over independent ones, while also strengthening protections for independent pharmacies, promoting fair competition, and establishing clear compliance deadlines and enforcement mechanisms for the Mississippi Board of Pharmacy.**

LOUISIANA

The second state recognized for being at the forefront of PBM oversight regulation is Louisiana which enacted the Louisiana Revised Statute §22:1657.1 in 2024[26]. With this legislation, PBMs are now classified within Louisiana's existing state regulatory structures and deemed to be third-party administrators (TPAs) for insurance purposes, subjecting them to all provisions of that part of the state's insurance code. Louisiana also implemented a mandatory licensure requirement for PBMs. This means that Louisiana law now explicitly requires every PBM to be licensed by the Commissioner of Insurance, notwithstanding certain exceptions for TPAs. The law also enacted a direct and forceful prohibition of pharmacist gag clauses. This Louisiana law directly prohibits pharmacist gag clauses so that a pharmacy or pharmacist can inform a patient of all relevant options when inquiring about their prescription medication, including more affordable alternatives. Enacting an equally explicit and forceful prohibition of gag clauses in Mississippi would ensure that pharmacists are legally protected when they discuss lower- cost options with patients. This clear mandate would strengthen patient access to cost-saving information and empower pharmacists to act in their patients' best financial interests.

The Louisiana legislation established a state-managed, publicly accessible online resource for PBM-related information, including their formularies. Louisiana's Commissioner of Insurance is required to provide a dedicated location on the department's website for PBM information and resources. Furthermore, PBMs in Louisiana must provide the department with health benefit plans' formularies and timely notification of formulary changes, with this information being made available in a centralized, consumer-accessible format on the website[27]. **Classifying PBMs as TPAs would provide a clear legal basis for applying existing state insurance regulations to their operations, as well as a more established and comprehensive oversight mechanism for Mississippi. Transparency could also be enhanced in Mississippi by creating a similar state-managed online resource that includes not only general PBM information but easily accessible and up-to-date drug formularies from various health plans operating in the state as well.**

PBM REGULATION IN MISSISSIPPI AND POTENTIAL ENHANCEMENTS

In order to conduct business in Mississippi, PBMs must obtain a Pharmacy Benefit License and submit annual financial statements to the Mississippi Board of Pharmacy that include the balance sheet and income statements from the previous year. Currently, Mississippi state law pertaining to PBMs is mostly limited to prohibitions for gag clauses and for reimbursement claw backs – a scenario in which a PBM retroactively denies or reduces the payment of a claim after the claim has been adjudicated[28].

During the 2025 Regular Session of the Mississippi Legislature, House Bill 1123 (HB 1123) was introduced to further regulate PBM business practices in the state. While HB 1123 ultimately died as a result of a rules violation, the legislation had serious potential to become law. HB 1123 would have prohibited the use of spread pricing and enhanced the state's existing prohibition on what is currently defined as "referrals" in state code. The current prohibition on "referrals" is limited to patient-pharmacist interactions that would direct the patient to a PBM-affiliated pharmacy. The bill would have replaced the term "referrals" with

"steering" and revised the definition to expressly prohibit prescription drug plan designs, including their formularies or pharmacy network structures, from directly or indirectly steering patients to PBM-affiliated pharmacies. Additionally, HB 1123 would have provided for more robust reporting requirements related to the PBMs business practices and finances[29].

As we analyzed successful legislation in Arkansas and Louisiana, we were also confronted with what both states do or did, that Mississippi does not. Arkansas's legislation included a first-in-the-nation prohibition on PBMs owning pharmacies or obtaining or holding pharmacy permits. While the law is currently going through the litigation process and may be deemed unconstitutional, it was a direct measure to address conflicts of interest that have resulted from vertical integration[30]. The law would forces companies to choose between operating a PBM or pharmacies. **In contrast, Mississippi proposed Senate Bill 2677 during the 2025 Regular Session and aimed to restrict PBMs from steering patients to affiliated pharmacies, but it did not propose a complete ban on PBM ownership of pharmacies as a more structural type of reform[31].**

Louisiana law explicitly classifies PBMs as third-party administrators under its insurance code and requires them to be licensed by the Commissioner of Insurance. This clear classification provides a strong legal framework for state oversight and allows for the application of existing insurance regulations to PBMs. They also enacted a direct and forceful prohibition of pharmacist gag clauses, ensuring that pharmacists can inform patients of all relevant options, including more affordable alternatives. Additionally, Louisiana requires the commissioner of insurance to provide a dedicated location on the department's website for PBM information and requires PBMs to provide formulary information for public access. **Mississippi's legislative efforts during the 2025 Regular Session with House Bill 1123 focused on enhancing transparency, prohibitions on spread pricing and patient steering, and granting the Mississippi Board of Pharmacy more investigative and enforcement authorities[32,33]. The bill also intended for the Mississippi Board of Pharmacy to develop a public website that included the information reported by PBMs.**

For future deliberations, alignment with federal efforts that avoid preemption are encouraged. The Mississippi Legislature should actively monitor federal PBM reform efforts and draft its legislation in a manner that complements and aligns with federal goals of transparency and lower drug costs, while carefully considering potential preemption issues under federal laws like ERISA. By focusing on areas of clear state authority, such as pharmacy practice and insurance regulation (as Louisiana did by classifying PBMs as TPAs), Mississippi can enact strong state-level protections without directly conflicting with federal statutes.

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