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Pharmacy Benefit Managers and Medicaid

Caroline O'Neil and Chris Park



Medicaid and CHIP Payment and Access Commission

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Overview

- Background
 - Medicaid Drug Rebate Program (MDRP)
 - Pharmacy benefit managers (PBMs)
- Concerns with PBM practices
- Federal and state policy actions



The background features a dark blue gradient with several overlapping, semi-transparent shapes in lighter shades of blue and white. These shapes include curved lines, vertical bars, and rounded rectangular forms, creating a layered, geometric effect. The word "Background" is centered in the upper-left quadrant of the image.

Background

MDRP

- Drug manufacturers must provide rebates in order for their products to be recognized for federal Medicaid match (§ 1927 of the Social Security Act (the Act))
 - Federal rebates are calculated based on statutorily defined formulas
- States must generally cover a participating manufacturer's products but may limit use (e.g., prior authorization, preferred drug list (PDL))
- Regulatory requirement to pay pharmacy ingredient cost at actual acquisition cost (AAC) plus dispensing fee in fee for service (FFS) (42 CFR 447.518(a)(2))

PBMs and Medicaid

- PBMs provide a range of administrative and clinical services to help payers administer the prescription drug benefit
 - Central role in drug distribution chain through interactions with payers, pharmacies, and drug manufacturers
- Both state FFS programs and Medicaid managed care plans contract with PBMs
- PBMs provide similar services to both states and plans

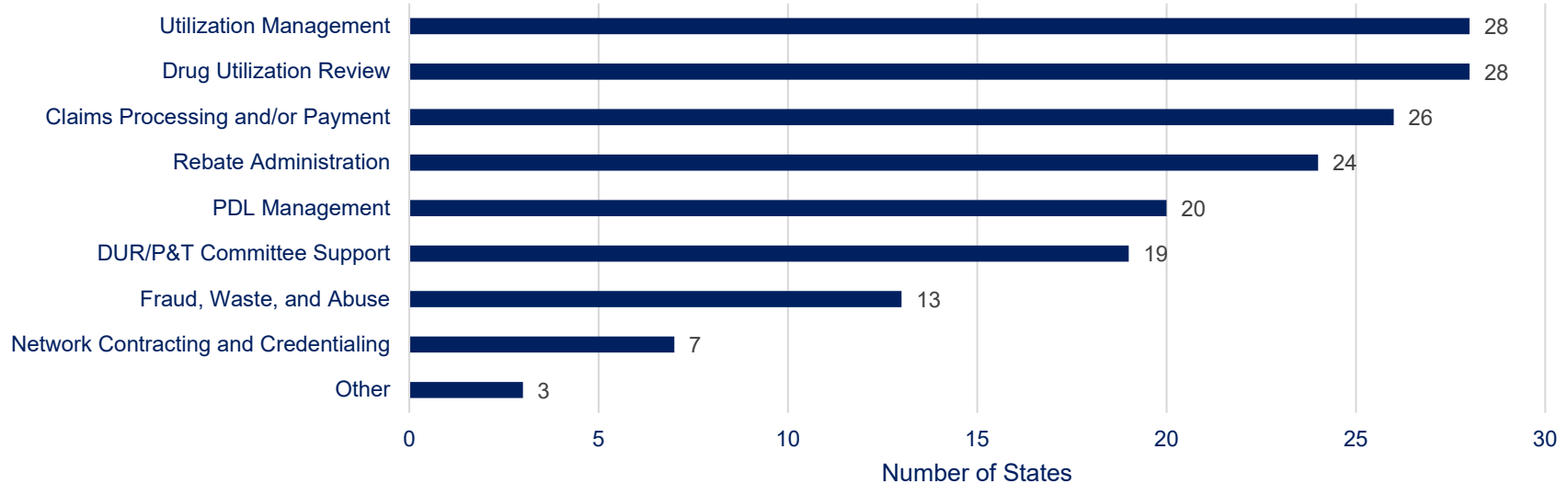
Common PBM Administrative Services

- Process claims and payment
 - PBM systems check for coverage, utilization management requirements, applicable beneficiary cost sharing, and payment terms
 - PBM pays the pharmacy and bills the plan sponsor for the claim
- Establish a network of participating pharmacies
 - PBMs credential providers and negotiate payment terms
 - Network can include any qualified pharmacy or be limited to include a smaller number of pharmacies but offer lower costs to the payer
- Negotiate drug rebates and discounts with drug manufacturers
 - Volume-based rebates provide preferred status on PDL/formulary and fewer restrictions
 - Within Medicaid, these rebates are typically called supplemental rebates and are in addition to the federal rebate under the MDRP

Common PBM Clinical Services

- **Formulary/PDL:** a list of preferred drugs that are designed to encourage providers and beneficiaries to use specific drugs
- **Utilization management:** tools and strategies to manage use of covered medications such as prior authorization, step therapy, and quantity limits
- **Pharmacy and therapeutic (P&T) committee:** group of experts who develop coverage policies, formularies/PDLs, utilization management protocols
 - PBM can develop policies using their own internal P&T committee or provide research, data, and analyses to inform deliberations of state's or plan's committee
- **Drug utilization review (DUR):** monitor and address patterns of prescription drug misuse

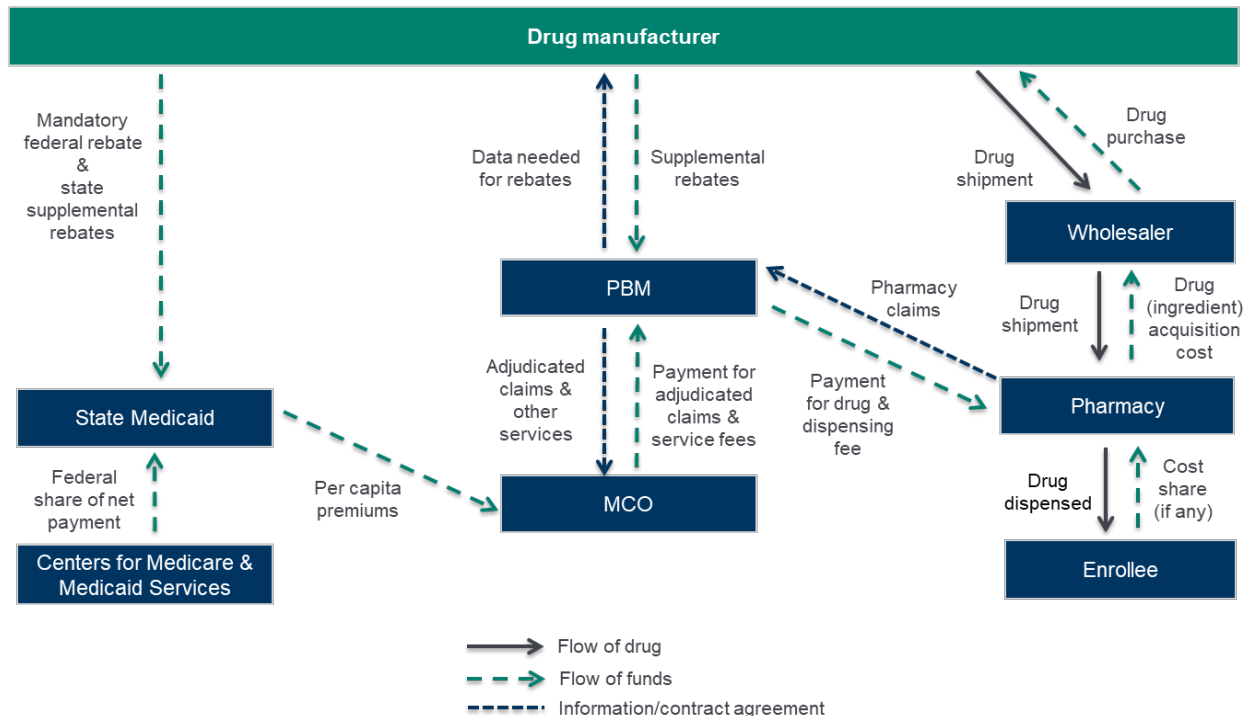
Services provided by PBMs as of July 1, 2023



Notes: PBM is pharmacy benefits manager. PDL is preferred drug list. DUR is drug utilization review. P&T is pharmacy and therapeutics committee.

Source: Gifford, K. A. Lashbrook, C. Payne. 2024. State Approaches to Managing the Medicaid Pharmacy Benefit. Washington, DC: Health Management Associates. https://www.healthmanagement.com/wp-content/uploads/2024-Medicaid-Rx-Survey-Rpt_FINAL.pdf.

Illustration of PBM Role in Drug Distribution Chain







Notes: PBM is pharmacy benefit manager. MCO is managed care organization. PBMs process claims, provide data needed for rebate administration, receives some supplemental rebates (which may be shared with the MCO), and provide other administrative and clinical services to the MCO. PBMs adjudicate claims, pay the pharmacies, and bill the state for the full cost of those claims along with fees for operational and clinical services. The federal rebates and state-negotiation supplemental rebates still flow from the manufacturer to the state, as they do in the FFS context.

Sources of PBM Revenue

- PBM-Payer revenue
 - Spread pricing: PBM charges payer an agreed-upon price that is typically more than they pay the pharmacy and keeps the difference
 - Administrative fee: separate management or administrative fee, which is independent of the costs associated with the drugs dispensed
- PBM-Manufacturer revenue
 - PBM retains a portion of the rebates or discounts negotiated on behalf of their clients
 - Recent studies estimate that 90 to 95 percent of rebates are passed on to the plan sponsor
- PBM-Pharmacy revenue
 - Fees or adjustments applied after the point of sale such as fees for participation in preferred pharmacy networks or performance-based fees
 - More common in Medicare

Differences between FFS and Managed Care

PBM service	FFS	Managed care
 Payment to pharmacy	AAC plus dispensing fee; spread pricing less likely	Negotiated rates; spread pricing more likely
 Supplemental rebate	Pass through of rebates	May retain portion of rebate
 Pharmacy network	Any willing pharmacy	May have limited pharmacy network
 PDL/ formulary	Single statewide PDL	Each plan may be allowed to develop own formulary

PBM Issues and Medicaid

Spread Pricing

- Lack of transparency into the use of spread pricing and how much revenue this generates for PBMs
 - Spread pricing creates incentives for PBMs to lower payments that may be lower than a pharmacy's costs
- Regulatory AAC payment standards in Medicaid limit spread pricing in FFS but it may be more prevalent in managed care where PBMs negotiate payment terms
- No comprehensive study of spread pricing in Medicaid, but some states have published their own studies showing prices PBMs charged in managed care were often higher than FFS prices
- Switch to pass-through pricing may not reduce overall drug spending
 - Spread pricing commonly used for generic drugs, which creates incentive to use these lower cost products
 - Increasing payment to pharmacy may not lower overall cost
 - Administrative fees for PBM services may be similar to the amount obtained through the spread

PDLs, Formularies, and Rebates

- PBMs who keep a portion of the rebate have incentive to prioritize drugs on the PDL or formulary based on the highest rebate instead of lowest total cost to payer
 - Can also create an incentive for manufacturers to raise list price and offer larger rebates, which can affect beneficiary cost sharing
- Rebate retention is likely to be less of a concern in Medicaid because vast majority of rebates are statutorily defined in the MDRP and paid directly to state
 - 14 states allow plans to negotiate their own rebates; 10 of those states require the plan PBM to pass through all rebates to plan
- Multiple Medicaid plan formularies can create administrative complexity for state and beneficiaries
 - Plans and their PBMs do not receive or know the amount of federal rebates, so their formularies and associated rebates may not prioritize drugs that represent the lowest cost to the state after federal rebates
 - Many states have moved toward a uniform PDL or standardized clinical criteria

Pharmacy Networks

- Limited pharmacy networks can lower costs for plans and enrollees but could create access issues
 - Particular challenge for beneficiaries in areas with low pharmacy access (e.g., rural areas)
- PBM-owned or affiliated pharmacies in network raise concerns of patient steering to increase PBM revenue
- In Medicaid, states covering drugs through FFS typically allow any willing pharmacy to be in network

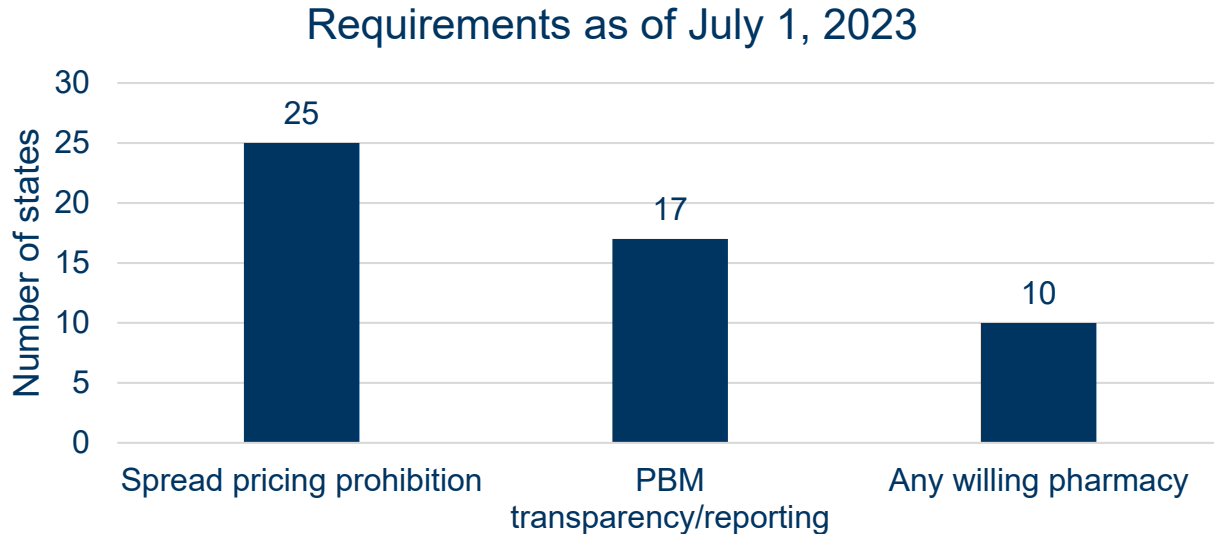


State and Federal Actions Regarding PBMs

Types of PBM Regulation

- Consolidated Appropriations Act, 2026 (CAA 2026, P.L. 119-75) included several provisions regulating PBM operations in commercial insurance and Medicare Part D, including:
 - Pass through of all rebates
 - PBM compensation tied to bona fide service fees
 - Detailed reporting on rebates, pricing, and PBM fees
 - Government Accountability Office study of price-based PBM compensation in Medicare and Medicaid
- CAA 2026 did not include Medicaid-specific provisions
- All 50 states have passed some form of legislation regulating PBMs
- Several states have used their contracting authority to oversee PBM operations in Medicaid managed care

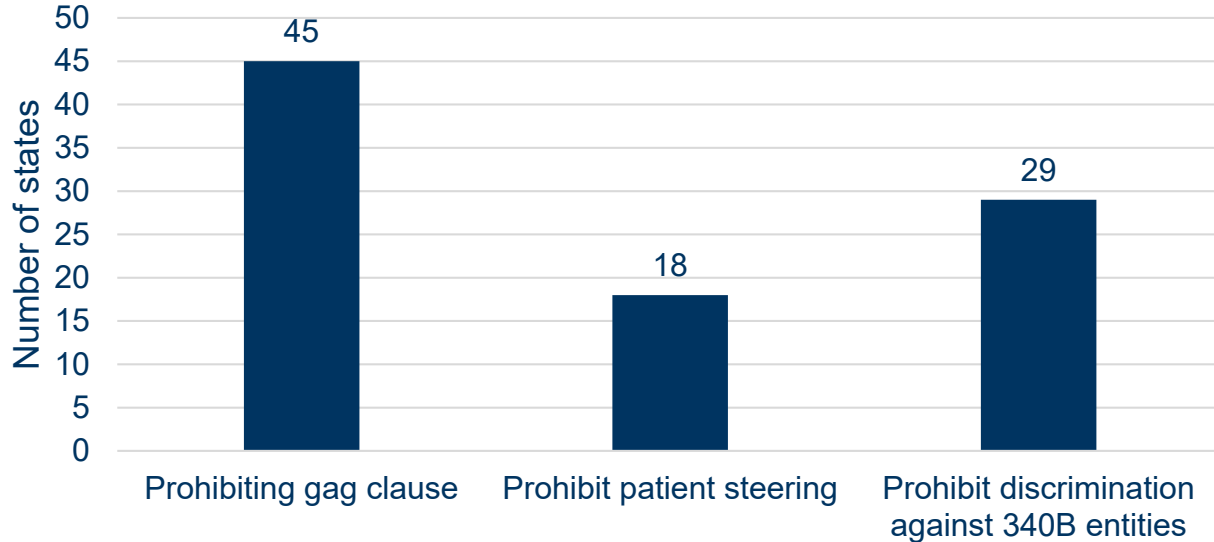
Medicaid PBM-Managed Care Contract Requirements



Notes: PBM is pharmacy benefit manager.

Source: Gifford, K., A. Lashbrook, C. Payne. 2024. *State approaches to managing the Medicaid pharmacy benefit. Insights from a national survey for state fiscal years 2023 and 2024.* Washington, DC: Health Management Associates. https://www.healthmanagement.com/wp-content/uploads/2024-Medicaid-Rx-Survey-Rpt_FINAL.pdf.

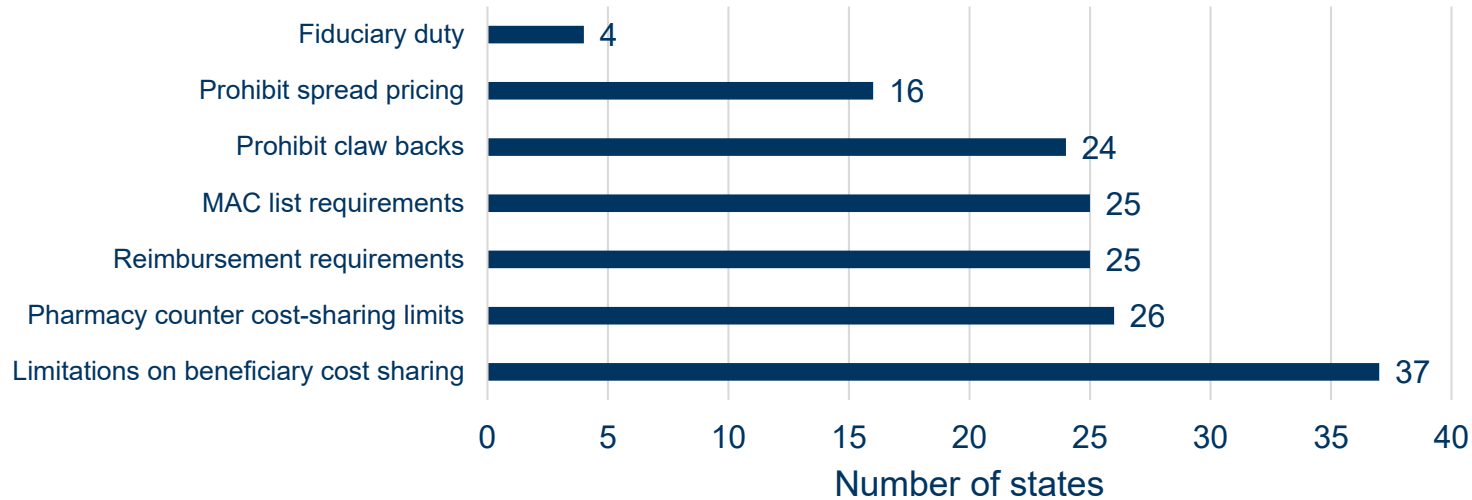
State Actions Related to PBMs and Pharmacies



Notes: PBM is pharmacy benefit manager. 340B is a federal program that requires drug manufacturers participating in Medicaid to provide outpatient drugs to certain safety-net providers at reduced prices.

Sources: National Academy for State Health Policy (NASHP), 2026, *State laws passed to lower prescription drug costs: 2017-2025*, <https://nashp.org/state-tracker/state-drug-pricing-laws-2017-2025/>; National Conference of State Legislatures (NCSL), 2024, *State policy options and pharmacy benefit managers (PBMs)*, <https://www.ncsl.org/health/state-policy-options-and-pharmacy-benefit-managers#:~:text=Approximately%2090%25%20of%20prescription%20drug,patient%20access%20through%20PBM%20reform.>

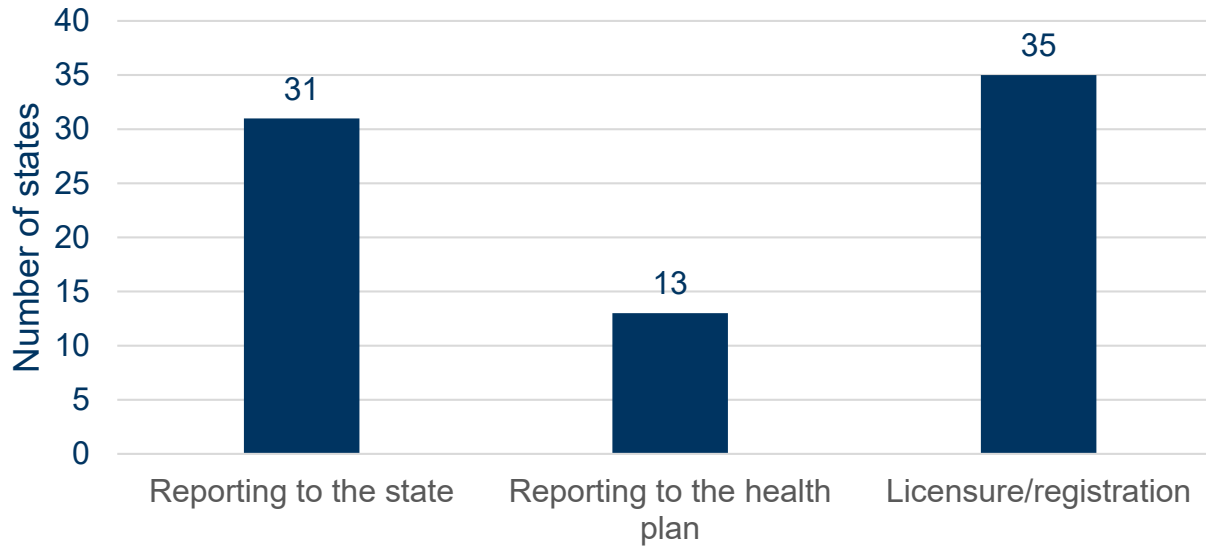
State Actions Related to PBM Payment and Beneficiary Cost Sharing



Notes: PBM is pharmacy benefit manager. MAC is maximum allowable cost.

Source: National Academy for State Health Policy (NASHP), 2026, *State laws passed to lower prescription drug costs: 2017-2025*, <https://nashp.org/state-tracker/state-drug-pricing-laws-2017-2025/>

State Actions Related to PBM Oversight



Notes: PBM is pharmacy benefit manager.

Source: National Academy for State Health Policy (NASHP), 2026, *State laws passed to lower prescription drug costs: 2017-2025*, <https://nashp.org/state-tracker/state-drug-pricing-laws-2017-2025/>

Key Takeaways

- PBMs have a central role in the drug distribution chain and provide a wide range of services
- CAA 2026 changes required for PBM contracts with private insurers and Medicare Part D plans could result in broad market reforms that are reflected in Medicaid contracts
- All states have already taken some actions to regulate PBM operations within the state
- Within Medicaid, states currently have the ability to implement PBM transparency and reporting requirements in both FFS and managed care settings

Next Steps

- Publish issue brief
- Staff welcome Commissioner questions or comments

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