Pharmacy Benefit Managers and Medicaid

Pharmacy benefit managers (PBMs) have a central role in the drug distribution chain and serve as intermediaries in administering the prescription drug benefit on behalf of payers (Figures 2 and 3). Currently, PBMs process approximately 90 percent of prescription drug claims (NCSL 2024). In context of the Medicaid program, PBMs coordinate with drug manufacturers and pharmacies on behalf of states and Medicaid managed care plans. The majority of states have outsourced some or all fee-for-service (FFS) prescription drug administrative functions to one or more PBMs or other vendors (Gifford et al. 2024). Similarly, Medicaid managed care plans typically contract with PBMs to support prescription drug administration (Levine et al. 2025).

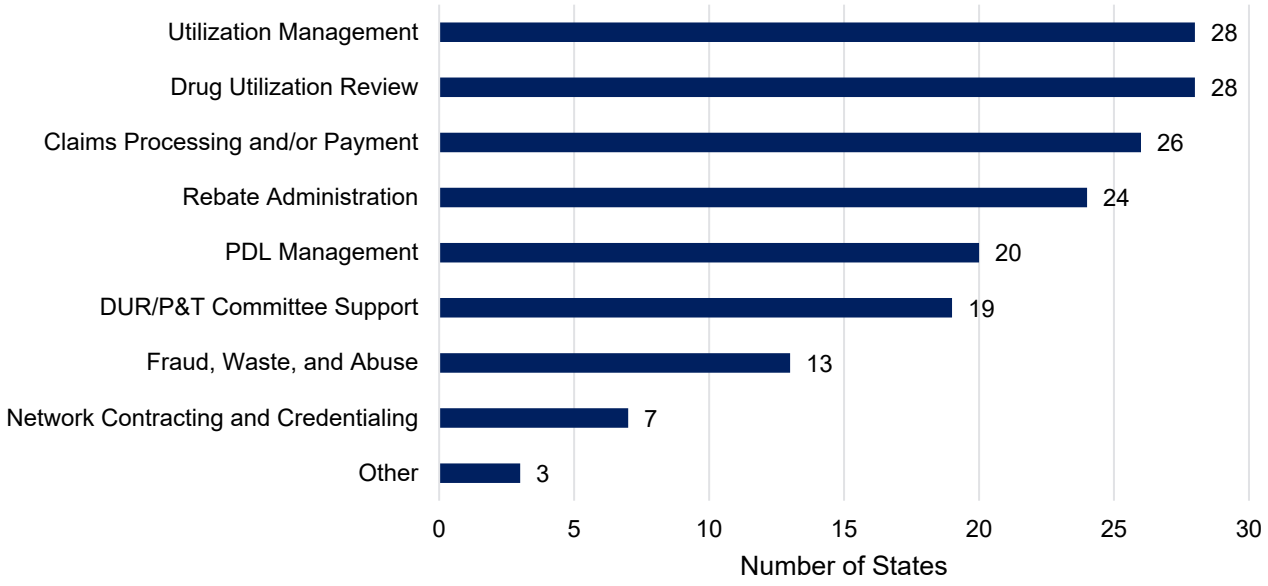
In recent years, some policymakers and stakeholder groups have identified the role of PBMs in the Medicaid drug distribution chain as a potential driver of increased drug spending. Historically, few states had imposed limitations on the PBM relationship or contract (Gifford et al. 2020). However, states have expanded their oversight in recent years, with several states implementing Medicaid-specific PBM requirements to address particular concerns (Gifford et al. 2024). More broadly, all states have passed PBM-focused legislation and regulations to govern and monitor certain PBM practices across all payers (NASHP 2026, NCSL 2024). The Consolidated Appropriations Act, 2026 (P.L. 119-75), signed into law on February 3, 2026, included several provisions regulating PBM operations in private insurance and Medicare Part D; however, no Medicaid-specific provisions were included.

This issue brief provides an overview of PBMs and their interaction with Medicaid. The brief begins with a summary of clinical and operational services PBMs provide their clients, as well as PBMs' sources of revenue. The brief then outlines stakeholder concerns associated with PBMs and summarizes recent federal and state policy efforts to manage and oversee PBM activities and address these issues.

PBM Services

PBMs administer prescription drug benefit services to over 275 million people in the United States, supporting a variety of plan sponsors, including state Medicaid FFS programs and Medicaid managed care plans (Levine et al. 2025). These services include processing claims, developing and managing utilization management tools such as preferred drug lists (PDLs) and prior authorization, negotiating drug rebates, managing pharmacy networks, and conducting drug utilization reviews (DURs). Many states contract for several PBM services at once, with the most common services provided being utilization management, DUR, and claims processing and payment (Figure 1). According to a survey conducted by Health Management Associates (HMA), 33 states reported contracting with a PBM as of July 1, 2023 (Gifford et al. 2024). The major functions that PBMs provide for Medicaid programs are described below. The focus is primarily on the services provided to states under their FFS programs, but PBMs provide the same services to Medicaid managed care plans and other payers.

FIGURE 1. Services Provided by PBM Vendors to State Medicaid Programs, as of July 1, 2023



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

Source: Gifford et al. 2024.

Utilization and PDL management

The Medicaid Drug Rebate Program (MDRP) was created under the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) with the purpose of ensuring that Medicaid pays a net price that is consistent with the lowest or best price that manufacturers charge other payers for the drug. Under the program, a drug manufacturer must enter into a Medicaid national drug rebate agreement with the Secretary of the U.S. Department of Health and Human Services in order for states to receive federal funding for using the manufacturer's products (§ 1927(a)(1) of the Social Security Act (the Act)).[1] In exchange for the rebates, state Medicaid programs generally must cover all of a participating manufacturer's drugs when prescribed for a medically accepted indication, although the states may limit the use of some drugs through utilization management tools such as PDLs, prior authorization, and quantity limits.[2]

PBMs can work with states and managed care plans to develop and implement coverage criteria and utilization management tools to review and assess the appropriateness, necessity, and cost effectiveness of prescription drugs (Levine et al. 2025). One such tool, typically called a PDL in Medicaid FFS programs or a formulary in managed care, is a list of preferred drugs that is designed to encourage providers and beneficiaries to use specific drugs. Preferred drugs typically face fewer utilization management requirements (e.g., prior authorization) than therapeutically equivalent drugs that are not on the list. Placement on the PDL or formulary is frequently tied to rebates negotiated with drug manufacturers. Additionally, payers typically increase beneficiary cost sharing for drugs not on the list, and PDLs and formularies may also include tiers for which drugs included in higher tiers have greater cost sharing associated with them (KFF 2019). However, under the Medicaid statute, beneficiary cost sharing is limited to nominal amounts (§ 1916, 1916A of the Act). In 2023, 44 states reported a PDL for FFS prescription drugs (Gifford et al. 2024). Twenty states reported contracting with a PBM for PDL management and 28 states used a PBM for utilization management more broadly (Figure 1).

States must follow a prescribed process to publish and implement formal coverage criteria. If a state uses a PDL, the state is required to use a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the governor of the state (§ 1927(d)(4)(A) of the Act). To fulfill this requirement, states typically use a pharmacy and therapeutics (P&T) committee to develop their PDLs and make recommendations on appropriate utilization protocols, such as prior authorization, for each drug. The P&T committee may use a contractor, such as the state's PBM, to assist in compiling and reviewing the evidence. Some states may use a DUR board (§ 1927(g)(3) of the Act) instead of a P&T committee to fulfill some or all of these duties in developing the PDL and utilization management protocols (MACPAC 2019). In 2023, 19 states reported using a PBM to support P&T and DUR committees (Figure 1).

Similarly, Medicaid managed care plans typically use a PBM to assist in the development and implementation of formularies and other utilization management tools. However, not all Medicaid managed care programs include the prescription drug benefit as part of the managed care contract. In 2023, eight states carved out the prescription drug benefit from managed care (Gifford et al. 2024).[3] Some states use an alternative approach with PBMs in their managed care programs. States may require their contracted managed care plans to use a single state-selected PBM (e.g., Kentucky) or contract the prescription drug benefit to a separate limited benefit plan to serve as a PBM for the Medicaid program (e.g., Ohio, Tennessee) (Gifford et al. 2024). In these cases, the state or the contracted PBM retains responsibility for managing the prescription drug benefit and developing a single state PDL that all managed care plans follow.

DUR

State Medicaid programs are required to establish DUR programs to monitor and address patterns of prescription drug misuse (§ 1927(g) of the Social Security Act (the Act)). DUR activities include both a prospective and retrospective review. Prospective review includes a review of prescription drug claims to check for issues such as clinical misuse or abuse, therapeutic duplication, or improper drug dosage, frequency, or duration. States also retrospectively review prescription data to identify fraud, abuse, adverse events, unfavorable health outcomes, non-medically necessary care, or underutilization of generic drugs or preferred therapies (MACPAC 2020). In 2023, state PBM vendors supported state DUR activities in 28 states (Figure 1). Medicaid managed care plans may also contract with PBMs to conduct their own DUR functions and provide the necessary information to the state to fulfill the Medicaid statutory requirements. As mentioned above, 19 states in 2023 reported using a PBM to support P&T and DUR committees (Figure 1).

Claims processing and payment

PBMs can process prescription drug claims on behalf of the payer (Levine et al. 2025). These services can encompass a broad range of activities. For example, when a pharmacy receives a prescription, a PBM's systems can verify the individual's eligibility under a health plan, determine whether the medication is covered, and whether any utilization management requirements apply and have been met. The PBM can then use the payer's PDL or formulary to determine any applicable cost sharing for the patient. The PBM then processes the payment for the pharmacy based on the applicable payment terms for the state or managed care plan. In 2023, 26 states reported contracting with a PBM for claims processing services (Figure 1).

Payment to the pharmacy typically includes two components: 1) an amount to cover the estimated cost of the drug, known as the ingredient cost, and 2) an amount to cover the pharmacist's overhead and services to fill the prescription, known as the dispensing fee. Under FFS, the state has some flexibility within federal regulations in setting these payment amounts (§ 1902(a)(30)(A) of the Act and 42 CFR 447). State FFS payment methodology for ingredient cost must be in accordance with the actual acquisition cost (AAC) of the drug (42 CFR 447.518(a)(2)) (CMS 2016). This means that under FFS, ingredient costs are tied to specific benchmark prices, and states generally pay all participating pharmacies the same amount for a particular drug. Dispensing fees may vary depending on certain pharmacy characteristics such as claims volume.

Similar to payments under Medicaid FFS, Medicaid managed care plans pay pharmacies for ingredient cost and dispensing fees. However, managed care plans are not required to pay for ingredient costs based on AAC but instead must make payments sufficient to ensure appropriate access for their enrollees (CMS 2016). The PBM typically negotiates with individual pharmacy providers instead of having a general payment formula that applies to all contracted pharmacies, like under Medicaid FFS.

Rebates and discounts

Under the MDRP, drug manufacturers must pay rebates to the Medicaid program for their products to be covered (i.e., eligible for federal match) (§ 1927(a)(1) of the Act). These rebates are defined in statute for brand-name and generic drugs. States collect the federal Medicaid rebate each quarter from manufacturers through a process that is separate from their payments to pharmacies (§ 1927(c) of the Act). Every state receives the same federal rebate amount for each unit of a particular drug regardless of how much they pay the pharmacy (MACPAC 2018).

Most states (47 states and the District of Columbia) have negotiated supplemental rebates with drug manufacturers on top of the federal rebates (CMS 2026).[4] States, often through a contract with a PBM, negotiate with manufacturers to obtain supplemental rebates for what they determine to be therapeutically equivalent drugs. Manufacturers generally provide these supplemental rebates to ensure that their products get placed on a state's PDL. Drugs on the PDL typically face fewer utilization management requirements, and this results in a shift in market share to the preferred drugs. Some states pursue supplemental rebate agreements on their own while others have joined multi-state coalitions for negotiation purposes (CMS 2026). In 2023, 24 states reported using a PBM for rebate administration (Gifford et al. 2024). Besides negotiating the rebates, PBM functions can include support with rebate reporting and dispute resolution. This includes compiling data and computing unit volumes of dispensed prescriptions for submission under the MDRP, as well as coordinating with the state to address manufacturer disputes (Gifford et al. 2020).

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) extended the federal Medicaid drug rebates to prescriptions paid for by Medicaid managed care plans (§ 2501(c) of ACA). Previously, the federal rebates were only available on drugs paid for by the state on a FFS basis. Plans submit Medicaid drug utilization data to the state; the state then combines this information with FFS utilization and collects the rebates for the entire Medicaid population. Similar to the state supplemental rebates, managed care plans can negotiate their own rebates with manufacturers, typically through their contracted PBM. However, states may include managed care utilization as part of their own state supplemental rebate agreements with manufacturers, which would likely reduce or eliminate the ability of managed care plans to negotiate their own rebates. In the 2024 HMA survey, 14 of 30 responding non-carve-out managed care states allowed their managed care plans to negotiate supplemental rebates (Gifford et al. 2024). Ten out of the 14 states that allow plans to negotiate supplemental rebates require the PBM to pass the rebates through to the plan, and the plan must report the total supplemental rebate collections to the state Medicaid agency.

Pharmacy networks

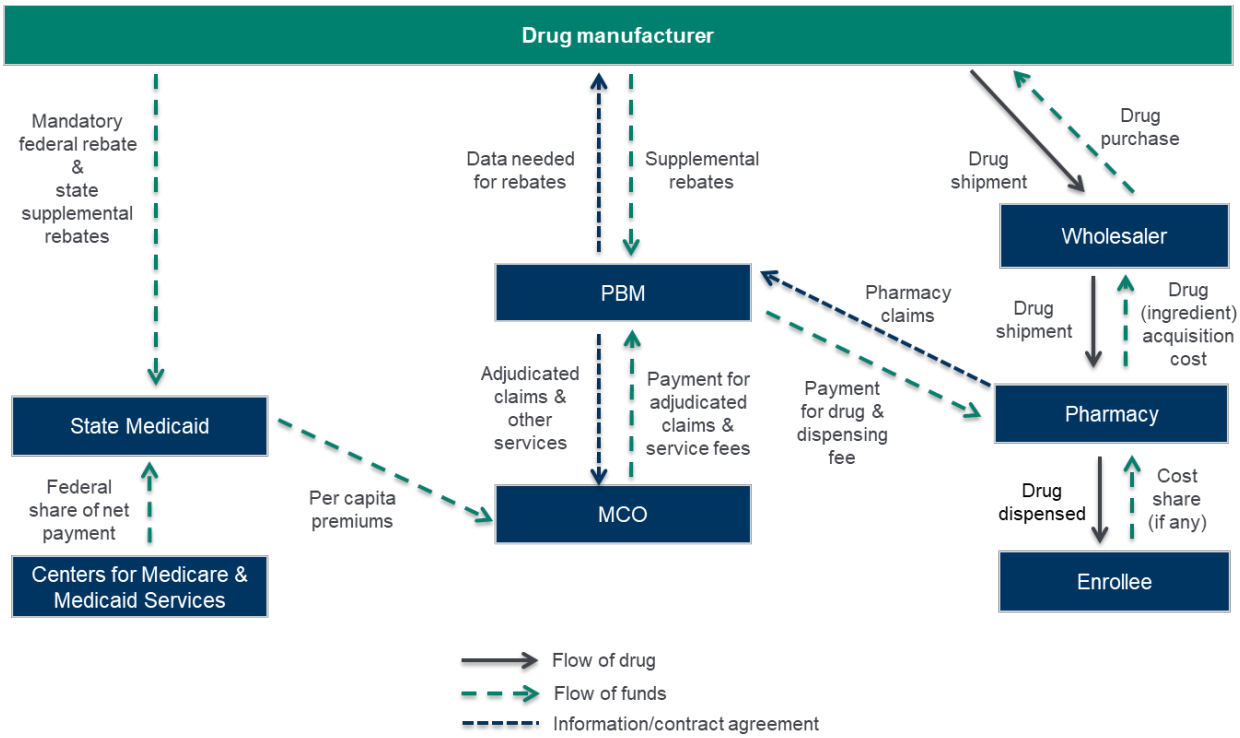
PBMs often negotiate terms with pharmacies, such as payment conditions, to be included in a payer's network. PBMs can provide additional support in credentialing participating providers to ensure that they are qualified providers (Carlton et al. 2024). Networks can be developed as open networks that include any qualified pharmacy to more narrow networks that include a smaller number of pharmacies but offer lower costs to the payer. Beneficiaries typically benefit from lower cost sharing when visiting in-network pharmacies (Levine et al. 2025).

Pharmacy networks in the Medicaid program can differ based on whether the state uses FFS or managed care. Under FFS, states typically accept any willing licensed pharmacy, though five states have limited networks for certain specialty drugs as of July 1, 2023 (Gifford et al. 2024). PBM vendors supported seven states in contracting and credentialing their FFS pharmacy networks (Figure 1). Managed care plans are more likely to designate

preferred pharmacy networks, and PBMs can support plans to develop preferred pharmacy lists based on a variety of factors, including proximity to the health plan members and costs (EHPPI 2022).

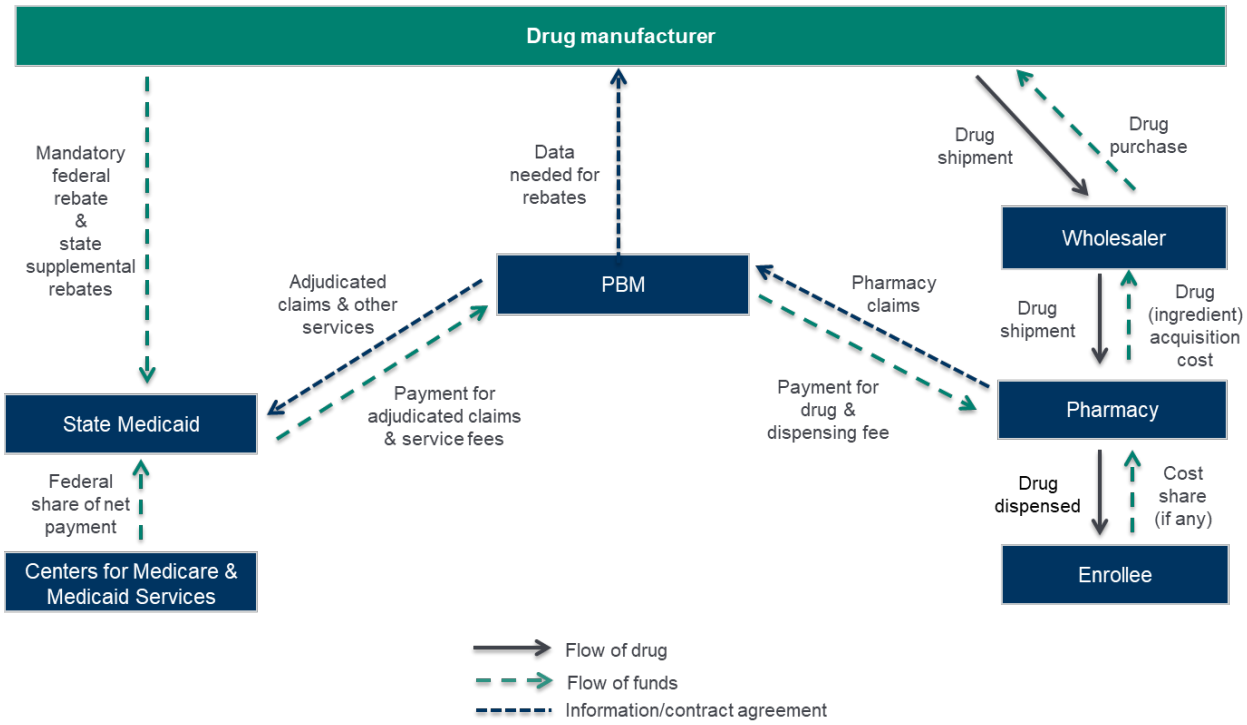
PBMs provide these services on behalf of Medicaid programs through interactions with various entities in the prescription drug supply chain (Figures 2 and 3).

FIGURE 2. PBMs in a Medicaid Managed Care Drug Benefit Program



Note: 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.

FIGURE 3. PBMs in the FFS Medicaid Drug Benefit Program



Note: PBM is pharmacy benefit manager. PBMs process claims, provide data needed for rebate administration, and provide other administrative and clinical services to the state. PBMs do not receive or retain rebates. 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.

PBM Revenue

PBMs generate revenue through fees or payments from states and managed care plans, drug manufacturers, and pharmacies.

PBM-Payer revenue

PBMs generally utilize one of two models: spread pricing and pass-through pricing (CTBA 2022, EHPPI 2022). Through the spread pricing model, the PBM charges the state or managed care plan an agreed-upon price for prescription drugs that is typically greater than the amount paid to the pharmacy. The PBM then retains this difference, referred to as the spread, as compensation for its services. This practice is more common in the managed care context, where the PBM negotiates payment terms with participating pharmacies. Under a spread pricing model, there are usually no separate administrative fees or they are far less than in other contracting models (CTBA 2022, EHPPI 2022). Under a pass-through pricing model, the PBM charges the payer the exact amount paid to the pharmacy. This model is typical in Medicaid FFS as state payment methodology must be in accordance with the AAC of the drug (42 CFR 447.518(a)(2)). Under the pass-through model, the PBM charges the state or plan a separate management or administrative fee, which is independent of the costs associated with the drugs dispensed. This management or administrative fee may be an aggregate annual fee, a per transaction fee, or an enrollment-base fee (CTBA 2022, EHPPI 2022).

PBM-Manufacturer revenue

PBMs may receive revenue from drug manufacturers by retaining a portion of the rebates or discounts negotiated on behalf of their clients (Levine et al. 2025). Depending on the type of PBM contract, any rebates that are paid to the PBM by the manufacturer may be required to be passed through to the state or managed care plan (Garfield et al. 2021). Recent studies estimate that 90 to 95 percent of rebates are passed on to the plan sponsor (Levine et al. 2025).

PBM-Pharmacy revenue

PBMs can receive revenue from pharmacies, through fees or payment adjustments applied after the point of sale. This fee is often referred to as direct and indirect renumeration (DIR). DIR can include reconciliations for overpayments, fees for participation in preferred pharmacy networks, and performance-based fees. This form of revenue is more common in the Medicare program (EHPPI 2022).

PBM Issues

PBMs' role as intermediaries between payers, drug manufacturers, and pharmacies has drawn attention and debate from policymakers looking to address costs for the prescription drug benefit. A few PBM pricing strategies and business practices in particular have come under scrutiny.

Spread pricing

Some stakeholders have raised concerns with the use of spread pricing and lack of transparency into how much revenue this generates for PBMs (Bendicksen and Kesselheim 2022, NCPA 2023). By definition, spread pricing means payers are charged more than what is paid to the pharmacy; therefore, PBMs' use of spread pricing could result in higher costs to payers such as Medicaid (PBM Accountability Project 2021). Spread pricing is most commonly used by PBMs for generic drugs where there are frequently large discounts offered by manufacturers to wholesalers and pharmacies, leading to a large difference between a pharmacy's acquisition cost and common price benchmarks (e.g., average wholesale price) used to determine payment (PBM Accountability Project 2021). There are concerns that spread pricing creates incentives for PBMs to push toward lower payments to pharmacies that may be lower than the pharmacy's costs, particularly for smaller, independent pharmacies (Mattingly et al. 2023, FTC 2024).

The effect of spread pricing in Medicaid has not been studied comprehensively, due in part to inconsistent reporting of paid amounts on drug claims across states (OIG 2024). It is unclear whether the paid amount on managed care claims reported to states and CMS represent the amount the plan or PBM paid to the pharmacy or whether it is the amount the plan paid to its PBM, which could include the spread. However, states have begun their own investigations into this issue. One analysis of Medicaid MCOs in Massachusetts found that the prices PBMs charged for generic drugs were, on average, $15.97 more than FFS prices per unique drug in 2018 (although prices paid by FFS were higher for 58 percent of unique drugs) (Massachusetts Health Policy Commission 2019). A 2018 audit in Ohio found that PBMs charged the state 31 percent more than acquisition costs for generic drugs (The Ohio Auditor of State 2018). The Kentucky Cabinet for Health and Family Services reported a spread of nearly 13 percent in 2018 among MCOs that contracted with PBMs (The Kentucky Cabinet for Health and Family Services 2018). Reports sponsored by pharmacists' associations in Michigan and New York estimated spreads of more than 30 percent for generic drugs in 2018 and 2017 respectively (Three Axis Advisors 2019). In the HMA survey, 25 states reported a prohibition on spread pricing in plan-PBM contracts (Gifford et al. 2024).

While spread pricing can increase costs to the payer, it is not definitive that a switch to pass-through payments to the pharmacy would reduce overall drug spending in the system. Because the spread is typically higher on generic drugs, some stakeholders have highlighted this as an incentive for PBMs to shift utilization toward lower-cost generic products, which could ultimately lower overall costs to the payer (Snook and Filipek 2011). Similarly, the ability of pass-through payments to reduce overall drug spending will depend on how the dollars associated with the spread are distributed to either reduce the amount the plan pays to the PBM or increase the amount paid to the pharmacy. Increasing payments to the pharmacy would not necessarily reduce overall drug spending in the system. For example, Florida conducted an independent analysis of PBM practices in their Medicaid managed care program, including a review of spread pricing (AHCA 2021). The analysis found that while much of the PBM's revenue was related to spread pricing, paying those claims based the state's FFS payment methodology would have resulted in a net increase to the program due to higher payments to the pharmacy offsetting the reduction in PBM revenue from the spread. Additionally, some stakeholders have commented that the loss of PBM revenue from the spread would likely result in higher administrative fees to the payer and it is unclear whether that would lead to a net reduction in the cost of PBM services (Fiedler et al. 2023, Snook and Filipek 2011).

PDLs, formularies, and rebates

PBMs help develop and implement utilization management tools such as PDLs and formularies, and the preferred status of specific products on these lists are frequently tied to the rebates that are negotiated with drug manufacturers. PBMs can generate revenue by keeping some portion of the rebate dollars they negotiate on behalf of their clients (Levine et al. 2025). Because rebates are often calculated as a percentage of a drug's list price, stakeholders have raised concerns that PBMs are incentivized to prioritize drugs on the PDL or formulary based on the highest rebate instead of the lowest total cost to payer (FTC 2024, Shepherd 2019, Seeley and Kesselheim 2019). Likewise, this practice can also create incentives for drug manufacturers to increase list prices and offer larger rebates to obtain preferred status because this can be more attractive to PBMs that retain a portion of the rebate rather than a low-cost, low-rebate drug (Mattingly et al. 2023). While the net price to the payer may be similar, high list prices can increase the cost to covered enrollees when the individual is in the deductible phase or when cost sharing is calculated as a percentage of the list price (Seeley and Kesselheim 2019).

The issue of PBM rebate retention is likely to be less of an issue for Medicaid than it is for other programs. The Medicaid program is unique in that the vast majority of the drug rebates obtained by the program are mandated by the MDRP through statutorily defined formulas (§ 1927 of the Act). In exchange for the rebates, state Medicaid programs must generally cover a participating manufacturer's drugs, with some exceptions (§ 1927(d) of the Act). PBMs may assist states with any data reporting required to invoice for these federally mandated rebates, but manufacturers pay the entire amount of the federal rebates directly to the state. While states and managed care plans can negotiate their own rebates (e.g., supplemental rebates) with drug manufacturers for preferred status on PDLs and formularies, the federally mandated rebates and requirement to cover most drugs under the MDRP limits the size of these supplemental rebates. As such, these supplemental rebates, for which PBMs could retain some of the rebate, only account for a small portion of Medicaid drug rebate dollars (MACPAC 2022).

States with managed care programs typically contract with multiple managed care plans, each of which may develop their own formulary and utilization management criteria.[5] Managed care plans prefer to control their own formularies because it gives the plans flexibility to make coverage decisions specific to their enrolled populations and apply utilization and care management approaches with the full context of the enrollees' needs (Morley et al. 2020). However, multiple plan formularies can create administrative complexity for the state in aligning drug coverage across the entire Medicaid population and ensuring their plans are providing appropriate coverage in line with the MDRP requirements. Additionally, this can create administrative burden for pharmacies who must deal with multiple plan formularies and can create disruption for beneficiaries when switching into a different plan (Bendicksen and Kesselheim 2022, Morley et al. 2020).

Furthermore, managed care plans and their PBMs do not collect or know the amount of the federal rebates given to the state. This can create a misalignment of incentives in which the plan and PBM steer volume to low-cost alternatives (e.g., generic) or brand drugs for which they have negotiated rebates that do not actually represent the lowest net cost to the Medicaid program after the federal rebates have been applied (Bendicksen and Kesselheim 2022, Morley et al. 2020).

To address these potential misalignments of PDLs, formularies, and rebates, many states have moved toward a uniform PDL or standardized clinical criteria across their FFS and managed care programs. In 2023, eight states carved out the entire prescription drug benefit from managed care and cover the benefit through FFS (Gifford et al. 2024). For states that include prescription drug coverage in managed care, 19 reported having a uniform PDL for some or all classes. Additionally, 15 states review and approve managed care plans' PDL changes, and 21 carve-in states reported that they require uniform clinical protocols for some or all drugs with clinical criteria.

On the supplemental rebate side, many states include managed care utilization as part of their negotiations for state supplemental rebates with manufacturers (CMS 2026). In the 2024 HMA survey, 14 of the 30 responding carve-in states reported allowing managed care plans to negotiate supplemental rebates, and 10 of these states require the plan's PBM to pass the rebates to the plan. All of the reporting states required the plans to report the aggregate amount of supplemental rebates to the state (Gifford et al. 2024).

Pharmacy networks

PBMs may offer plan sponsors a limited pharmacy network. Limited pharmacy networks can lower costs for plans through lower reimbursement rates, and beneficiaries may have lower cost sharing when filling prescriptions at a preferred pharmacy (EHPPI 2022). However, these limited networks could potentially create access issues for some enrollees.

Limited pharmacy networks can be particularly challenging for beneficiaries living in areas with low pharmacy access. Patients in these areas may struggle to fill their prescriptions, resulting in low medication adherence and higher future medical costs (Snook and Filipek 2011). Evidence of pharmacy closures exacerbate this concern. The number of pharmacy closures exceeded pharmacy openings between 2018-2021 (Guadamuz et al. 2024), and according to a Federal Trade Commission analysis, about 10 percent of independent retail pharmacies have closed between 2013 and 2022. Further, chain pharmacy closures have also increased recently (FTC 2024).

In some cases, pharmacies in the limited network may be PBM owned or affiliated, resulting in additional concerns about patient steering to those pharmacies to increase PBM revenue (NAIC 2023). The three largest PBMs operating today each own retail, mail order, and specialty pharmacies that are categorized as preferred in-network pharmacies under the pharmacy benefit. According to a 2024 House Committee on Oversight and Accountability report, patient steering, or tactics to steer patients to PBM-affiliated pharmacies, include offering discounts on prescriptions from PBM-affiliated pharmacies and restricting other pharmacies from offering 90-day prescriptions (House Committee on Oversight and Accountability 2024).

There are concerns that the incentive to steer patients toward PBM-affiliated pharmacies is particularly strong when it comes to specialty prescriptions, which carry high prices and high margins. The FTC analysis found that between 2016 and 2023, specialty drugs accounted for a disproportionate share of the growth in dispensing revenue for pharmacies. Much of that growth in revenue came from pharmacies affiliated with the top three PBMs. Specialty pharmacies affiliated with the top three PBMs saw a 14 percentage point increase in their share of revenues within the specialty pharmacy segment while their share of traditional retail and mail order prescription revenues stayed relatively consistent (FTC 2024). There are concerns that routing specialty prescriptions to PBM-affiliated pharmacies may lead to delays in care (House Committee on Oversight and Accountability 2024).

Some studies have found that limited pharmacy networks reduce costs for payers and beneficiaries without a significant effect on access for most beneficiaries (Shepherd 2014, Visante 2013). However, these findings may not be as applicable to the Medicaid program. In Medicaid, the savings from these limited networks mostly accrue to the plan or PBM because most Medicaid beneficiaries are subject to nominal amounts of cost sharing. Additionally, federal regulations require payment for ingredient cost at AAC in Medicaid FFS programs, which leads to little variation in FFS payment to pharmacies. Several states also require pass through payments between the plan, PBM, and pharmacy, which may reduce the incentive for pharmacies to offer discounts to be in a preferred network. Finally, low-income Medicaid beneficiaries may be more likely to live in areas that have less access to pharmacies in general, so a limited pharmacy network could have a greater effect on access in Medicaid than for other payers. In the HMA survey, 10 states with pharmacy carve-ins reported having "any willing" pharmacy requirements in place that require plans and their PBMs to participate in the network if they are willing to accept the contract's standard terms (Gifford et al. 2024).

Federal and State Activity

State and federal policymakers have reacted to mounting concerns about PBM practices by enacting legislation and regulations to better oversee these entities.

In February 2026, Congress enacted several provisions aimed at providing additional oversight and transparency into PBM practices in the Consolidated Appropriations Act, 2026 (P.L. 119-45). Most of these provisions, which apply to private insurance and Medicare Part D, go into effect in 2028.

For commercial payers, PBMs must fully disclose and pass through 100 percent of rebates to the plan; PBMs may receive bona fide services fees as compensation. PBMs must disclose all direct and indirect compensation and provide plan clients with detailed reports including information on manufacturer rebates, fees, and other remuneration the PBM receives; spread pricing arrangements with network pharmacies and pharmacy network reimbursement amounts; formulary structure and prescription drug benefit design; drug dispensing through PBM-affiliated pharmacies; and member out-of-pocket cost metrics (Carnegie et al. 2026, KFF 2026).

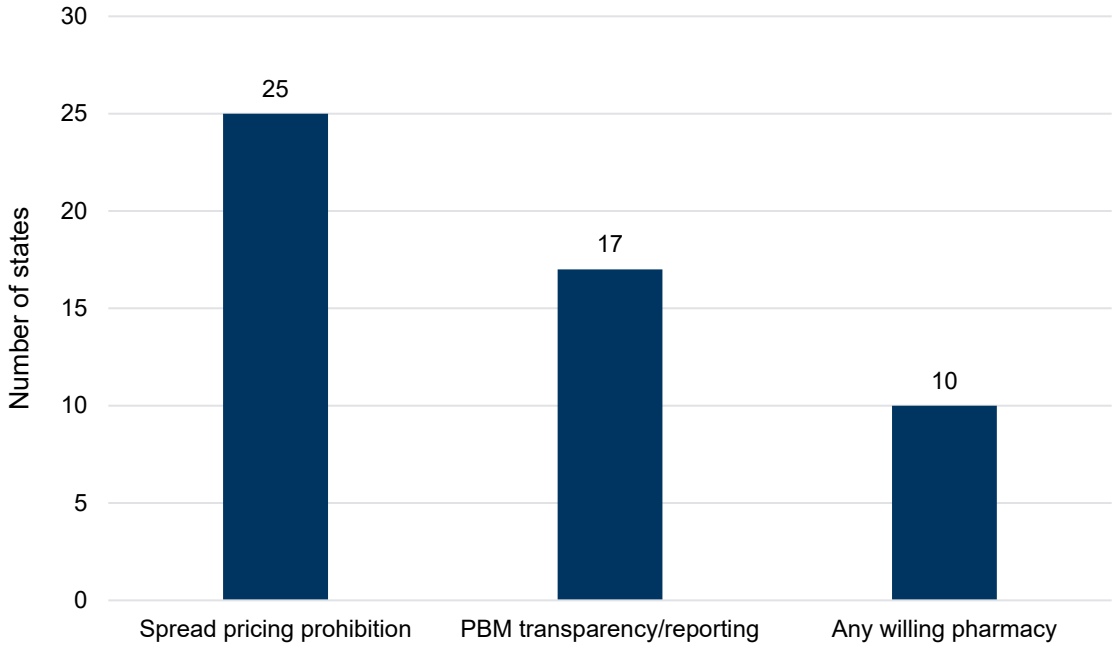
For Medicare Part D plans, PBM compensation is delinked from the price of the drug or any rebates and discounts, and must be in the form of a flat, bona fide service fee consistent with fair market value; this would require 100 percent pass through of rebates and other discounts. PBMs must submit annual reports to plans and CMS, including information on utilization, pricing and revenues for covered drugs; activity and policies related to PBM-affiliated pharmacies; formulary and benefit design; aggregate spending metrics; and other compensation to third-parties related to the PBM services provided. The legislation also reinforces "any willing pharmacy" contract standards with Medicare Part D (Carnegie et al. 2026, KFF 2026).

The Consolidated Appropriations Act, 2026 did not include provisions specific to PBM services under the Medicaid program. The legislation did include a requirement for the Government Accountability Office to study price-based PBM compensation across both Medicaid and Medicare (Carnegie et al. 2026). Early drafts of the legislation included provisions mirroring proposed legislation under H.R. 4317, PBM Reform Act of 2025, and S. 3345, PBM Price Transparency and Accountability Act. These Medicaid-specific provisions included requirements for all pharmacies under Medicaid to respond to the National Average Drug Acquisition Cost survey, pass-through pricing to pharmacies, fee-based PBM compensation reflecting fair market value, and additional PBM transparency and reporting requirements on costs and payments related to covered outpatient drugs and accompanying administrative services.

Even though the Consolidated Appropriations Act, 2026 did not directly address Medicaid, states have already taken several actions at the state level similar to those proposed in federal legislation (Figures 4−7). To date, all 50 states have passed some form of legislation regulating PBMs (NASHP 2026).

Several states have used their authority in establishing and overseeing Medicaid managed care contracts to address these issues specifically within the program. In the HMA survey, 25 states reported a prohibition on spread pricing, 10 states required PBMs to contract with any willing pharmacy, and 17 states had other transparency and reporting requirements (Figure 4).

FIGURE 4. Number of States with PBM Managed Care Contract Requirements, as of July 1, 2023



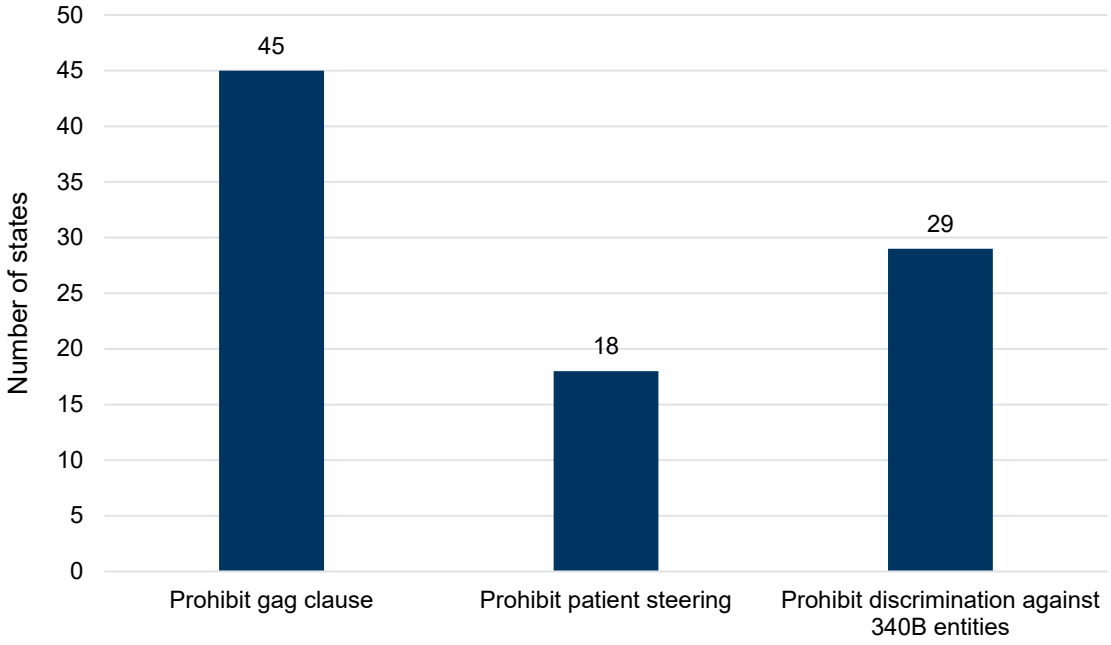
Note: PBM is pharmacy benefit manager.

Source: Gifford et al. 2024.

More broadly, several states have passed legislation or regulations not specific to Medicaid that govern PBM operations within the state.

According to the National Academy of State Health Policy, at least 45 states have passed laws prohibiting gag clauses, which otherwise prevent pharmacies from informing patients if their prescription is available at a lower cost (Figure 5). This policy was nationalized in 2018 under the Patient Right to Know Drug Prices Act (P.L. 115-263). At least 29 states prohibit PBMs from discriminating against 340B covered entities by imposing different reimbursement rules on these pharmacies. According to the National Conference of State Legislatures, at least 18 states have passed legislation prohibiting PBMs from engaging in patient steering (Figure 5).

FIGURE 5. State Actions Related to PBMs and Pharmacies

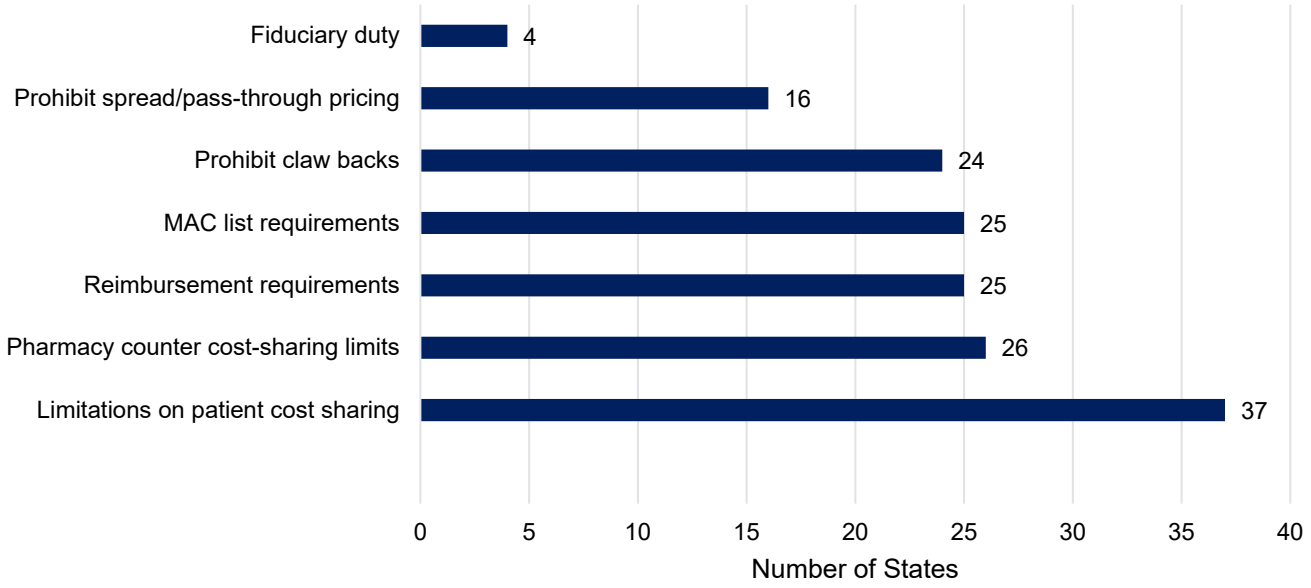


Note: PBM is pharmacy benefit manager. 340B is a federal program that requires drug manufacturers participating in Medicaid to provide outpatient drugs to certain safety-net providers at reduced prices.

Sources: National Academy of State Health Policy (NASHP) 2026; National Conference of State Legislatures (NCSL) 2024.

Cost management and reimbursement reform has been a focus of state and federal regulatory activities. At least 16 states prohibit spread pricing (Figure 6). Other reimbursement-related state provisions include prohibiting claw backs or retroactive denials in 24 states, reimbursement requirements in 25 states, maximum allowable cost (MAC) list requirements in 25 states, and limitations on patient cost-sharing in 37 states. Additionally, at least four states require a PBM to have a fiduciary duty to the insurer (Figure 6). In these cases, PBMs have a legal responsibility to protect the financial interests of their clients (i.e., the state or managed care plan).

FIGURE 6. State Actions Related to PBM Payment and Cost Sharing



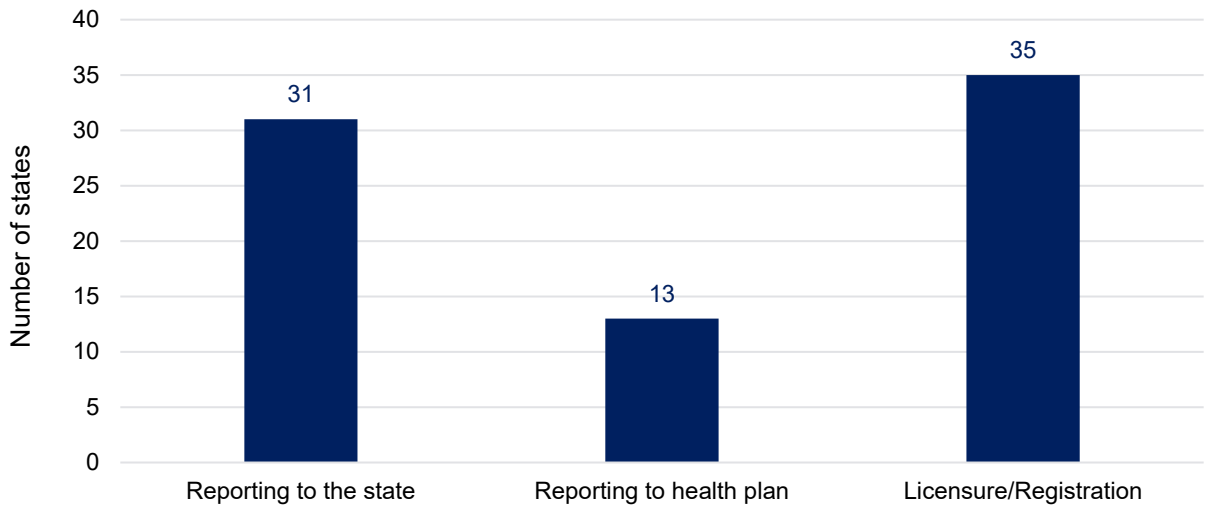
Note: PBM is pharmacy benefit manager. MAC is maximum allowable cost.

Sources: National Academy of State Health Policy (NASHP) 2026.

State policymakers have sought to increase oversight and data collection to monitor PBM activities. Recent regulation requires Medicaid managed care entities to increase transparency in cost reporting to account for PBMs (CMS 2024). Beginning November 19, 2024, CMS required managed care entities that provide covered outpatient drugs to distinguish between expenses for covered benefits, such as drug costs, and administrative expenses, such as PBM fees when reporting their medical loss ratio.

At least 31 states have established rebate reporting requirements to the state, while 13 states require PBMs to share rebate or other information with health plans (Figure 7). Additionally, at least 35 states have implemented PBM licensure or registration requirements, allowing states to have increased oversight of PBMs (Figure 6).

FIGURE 7. State Actions Related to PBM Oversight



Note: PBM is pharmacy benefit manager.

Source: National Academy of State Health Policy (NASHP) 2026.

Conclusion

Although the Consolidated Appropriations Act, 2026 did not include Medicaid-specific provisions, the 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. Additionally, all states have already taken some actions to regulate PBM operations within the state. Within Medicaid, states currently have the ability to implement transparency and reporting requirements in their own PBM contracts, and several states have used their contracting authority with managed care plans to require similar transparency requirements between the plans and PBMs.

Endnote

[1] In addition to executing a Medicaid drug rebate agreement as a condition for Medicaid coverage of their products, drug manufacturers must enter into an agreement that meets the requirements of Section 340B of the Public Health Service Act (P.L. 102-585) and a master agreement with the Secretary of Veterans Affairs (§ 1927(a)(1) of the Act). Additionally, the manufacturer must enter into a Medicaid drug rebate agreement in order for payment to be made under Medicare Part B. A drug not covered under a rebate agreement may be eligible for federal Medicaid funding in limited circumstances if the state has determined that the drug is essential to the health of its beneficiaries.

[2] A medically accepted indication means any use for a covered outpatient drug that is approved under the Federal Food, Drug, and Cosmetic Act (P.L. 75-717) or that is supported by one or more citations included or approved for inclusion in one of the following three compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, or the DRUGDEX Information System (§ 1927(k)(6) of the Act).

[3] California, Missouri, North Dakota, New York, Ohio, Tennessee, Wisconsin, and West Virginia carve out the prescription drug benefit from their comprehensive managed care contracts (Gifford et al. 2024).

[4] Puerto Rico established a supplemental rebate agreement in January 2025, but is not included in this count (CMS 2026).

[5] In states with managed care, they must offer beneficiaries a choice of at least two managed care plans. States may offer a single plan under certain conditions in rural areas or if the plan is a county–operated health insuring organization (§ 1932(a)(3) of the Act).

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