Oregon Prescription Drug Affordability Board

Policy Memorandum

To: Oregon Prescription Drug Affordability Board
From: Cortnee Whitlock, program and senior policy analyst
Re: Pharmacy benefit manager practices
Date: Sept. 8, 2026

Summary

This memorandum presents policy options for the Oregon Prescription Drug Affordability Board to address key issues in pharmacy benefit manager (PBM) practices. Oregon's pharmacy benefit landscape, similar to the national market, is dominated by a small number of large PBMs. While state law requires PBM licensure, current regulations do not mandate full transparency, comprehensive reporting, or limits on PBM compensation structures. As a result, gaps remain in oversight of PBM pricing methods and conduct, affecting purchasers' and the state's ability to track costs, evaluate incentives, and ensure patient access. This memorandum specifically analyzes policy concepts to eliminate spread pricing, decouple PBM compensation from drug prices, and establish standards for PBM conduct and rebate management. It reviews current evidence and regulatory approaches in Oregon and other states, examines associated risks and incentives, and proposes policy designs with implementation considerations. It concludes that a phased, integrated regulatory framework anchored in transparency, standardized reporting, and audit authority offers the most robust means for Oregon to improve accountability, align PBM incentives with purchaser and patient interests, and evaluate impacts on cost and access.

Background

A PBM acts under contract with a plan sponsor which may be a health plan, insurance carrier, employer, or public purchaser. At the point of sale, the PBM adjudicates the pharmacy claim, determines patient cost sharing, and establishes the amount payable to the dispensing pharmacy. Separately, PBMs may invoice the plan sponsor for the claim and may later receive rebates, administrative fees, price-protection payments, data fees, or other remuneration from a manufacturer. The PBM may also own or be affiliated with the insurer, a rebate-aggregating group purchasing organization, and pharmacies that dispense specialty or mail-order drugs.[1]

A 2024 peer-reviewed study found that the three largest PBMs processed approximately 79 percent of retail prescription claims in 2021. The PBM markets were highly concentrated

[1] Federal Trade Commission. (2023, May 17). FTC deepens inquiry into prescription drug middlemen. https://www.ftc.gov/news-events/news/press-releases/2023/05/ftc-deepens-inquiry-prescription-drug-middlemen

nationally and across many payer-specific state markets.[2] Concentration does not by itself establish harmful conduct. Still, it can reduce a purchaser's ability to negotiate contract terms and can make exclusion from a PBM network or formulary consequential for pharmacies and manufacturers. The Federal Trade Commission's (FTC) 2024 interim report similarly described a highly concentrated and vertically integrated.[3]

Oregon currently requires PBMs to be licensed by the Department of Consumer and Business Services. Licensing provides an existing regulatory relationship on which additional reporting, examination, and conduct requirements could be built.[4]

Recent federal policy changes

The Consolidated Appropriations Act, 2026, enacted Feb. 3, 2026, establishes new federal requirements for pharmacy benefit managers serving Medicare Part D plans and private group health plans.[5] These reforms are relevant to Oregon because they address portions of PBM compensation and reporting nationally while leaving other practices and market segments available for state action.

Beginning with the 2028 plan year, PBMs serving Medicare Part D prescription drug plans, including Medicare Advantage drug plans, generally must pass through manufacturer rebates and other price concessions to the plan sponsor. Compensation associated with Part D drug utilization generally must be a flat-dollar, fair-market-value fee for bona fide services and may not vary based on drug price, rebate amount, formulary placement, or the volume or value of business generated.[6] The law also requires standardized reporting on drug prices, rebates, pharmacy reimbursement, patient cost sharing, affiliated-pharmacy activity, formulary design, and other compensation; provides audit and enforcement mechanisms; and strengthens federal oversight of pharmacy-network terms.[7]

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[2] Qato, D. M., Chen, Y., & Van Nuys, K. (2026). Pharmacy benefit manager market concentration for prescriptions filled at retail pharmacies by state and payer type. JAMA Health Forum, 7(2), e256546. https://doi.org/10.1001/jamahealthforum.2025.6546

[3] Federal Trade Commission. (2024). Pharmacy benefit managers: The powerful middlemen inflating drug costs and squeezing Main Street pharmacies (Interim staff report). U.S. Federal Trade Commission. https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[4] Oregon Division of Financial Regulation. (n.d.). Pharmacy benefit manager licensing. Retrieved July 16, 2026, from https://dfr.oregon.gov/business/licensing/insurance/institutions/pages/pharmacy-benefit-manager.aspx; Or. Rev.Stat. § 735.532 (2025).

[5] Consolidated Appropriations Act, 2026, Pub. L. No. 119-72 (Feb. 3, 2026), H.R. 7148. https://www.congress.gov/bill/119th-congress/house-bill/7148

[6] Health Affairs Forefront. (2026). Federal PBM reforms in action and in context. https://www.healthaffairs.org/content/forefront/federal-pbm-reforms-action-and-context

[7] Health Affairs Forefront. (2026). Federal PBM reforms in action and in context. https://www.healthaffairs.org/content/forefront/federal-pbm-reforms-action-and-context.

For private group health plans, PBMs must report at least twice each year on spread pricing, pharmacy acquisition costs, rebates and discounts, broker compensation, patient out-of-pocket spending, specialty-drug classifications, and affiliated-pharmacy dispensing. The law also generally conditions the reasonableness of a PBM contract on full pass-through of manufacturer rebates and a transparent and quantifiable compensation structure. These provisions apply broadly to private group plans, including self-funded ERISA plans and insurers serving fully insured ERISA plans, and generally take effect for plan years beginning 30 months after enactment, which is Jan. 1, 2029, for most calendar-year plans.

Current Oregon PBM regulation

Oregon regulates PBMs primarily through ORS 735.530 to 735.552, which states a person may not transact business as a PBM in Oregon without an annually renewable license from the Department of Consumer and Business Services.[8] The statutory definition generally covers entities that contract with pharmacies on behalf of an insurer, coordinated care organization, or the Oregon Prescription Drug Program to process or pay claims, negotiate manufacturer rebates or discounts, manage formularies, design pharmacy benefits, or perform other listed functions. DCBS may examine PBM records and may deny, suspend, or revoke a license for specified violations.

Oregon also establishes pharmacy-facing requirements for maximum allowable cost lists, pharmacy reimbursement, certain retroactive claim reductions and post-sale fees, denied or reduced claim notices, mail-order dispensing, and retaliation. A network pharmacy may appeal certain maximum allowable cost reimbursement decisions to the PBM. If dissatisfied with the determination, or if the PBM fails to follow the statutory process, the pharmacy may file a complaint with DCBS. This is a limited regulatory remedy focused primarily on pharmacy reimbursement and compliance with enumerated requirements and is not a general contract appeal or an independent adjudication of every pharmacy-PBM payment dispute.

Licensed PBMs must report annually to DCBS under ORS 735.537. Required aggregated information includes manufacturer rebates and other payments, amounts passed through or retained, dispensing fees, administrative fees, and revenue from spread pricing, pay-for-performance arrangements, or similar means. PBM-specific submissions are confidential, but DCBS must publish aggregated information. Current reporting does not provide transaction-level claim data, drug-specific amounts, plan-specific results, or complete affiliate-level information sufficient to independently calculate total net costs and identify revenue substitution.

[8] Or. Rev. Stat. 735.530-735.552 (2025). https://www.oregonlegislature.gov/bills_laws/ors/ors735.html.

Policy concerns

The policy concern is not that every rebate, fee, or utilization-management decision is inappropriate. Rebates can lower a plan sponsor's net drug costs, formularies can encourage clinically appropriate prescribing, and PBMs must be compensated for legitimate services. Concern arises when compensation is structured in ways that increase with a drug's list price, gross cost, rebate amount, or the spread between two undisclosed prices. Such arrangements can create incentives that make a PBM's most profitable option different from the lowest-net-cost, clinically appropriate option for purchasers and their enrollees.

Issue 1: Eliminating spread pricing

Definition and evidence

Spread pricing occurs when a PBM charges a plan sponsor more for a pharmacy claim than it reimburses the dispensing pharmacy and retains some or all the difference. The spread may be stated or embedded in contrast with pricing guarantees. Spread pricing is distinct from an administrative fee because the purchaser may not know the pharmacy reimbursement amount or the PBM's margin on an individual claim.

The U.S. Government Accountability Office (GAO) reviewed five states—Arkansas, California, Louisiana, Maine, and New York—and found that each had adopted laws addressing PBM drug pricing or pharmacy reimbursement, including limits on paying a pharmacy less than the amount charged to a health plan.[9] The U.S. Department of Health and Human Services Office of Inspector General has also found that state Medicaid agencies did not consistently define and validate paid-amount fields in managed-care encounter data, limiting their ability to determine what managed care organizations and PBMs actually paid pharmacies.[10] These findings are important for policy design; a statutory framework is difficult to enforce unless claim reporting distinguishes the amount paid to the pharmacy from the amount charged to the plan.

Spread pricing can create at least three risks. First, it can reward selection by the PBM of products or pharmacies that generate a larger spread rather than the lowest, total net cost to the plan sponsor. Second, it can conceal the cost of PBM services from the purchaser. Third, low pharmacy reimbursement may impair pharmacy participation or access even when the plan sponsor's charge appears adequate. However, replacing spread pricing with pass-through pricing may result in a visible administrative fee. For example, if a plan sponsor previously paid

[9] U.S. Government Accountability Office. (2024). Prescription drugs: Selected states' regulation of pharmacy benefit managers (GAO-24-106898). https://www.gao.gov/products/gao-24-106898

[10] U.S. Department of Health and Human Services, Office of Inspector General. (2024). Medicaid managed care: States do not consistently define or validate paid amount data for drug claims (OEI-03-20-00560). https://oig.hhs.gov/reports/all/2024/medicaid-managed-care-states-do-not-consistently-define-or-validate-paid-amount-data-for-drug-claims/

$110 to a PBM under a contract allowing spread pricing, with $100 reaching the pharmacy and $10 retained as undisclosed PBM revenue, a shift to pass-through pricing could involve a $100 pharmacy payment plus a clearly itemized $10 administrative fee. In both scenarios, the plan sponsor's gross expenditure is identical, but the pass-through model increases transparency regarding the allocation of funds.

Supporters of permitting spread-pricing contracts argue that they can provide plan sponsors with predictable claim costs and transfer some short-term price risk to the PBM. Under a guaranteed-price arrangement, the PBM may retain the difference when pharmacy reimbursement is below the guaranteed amount but may absorb a loss when reimbursement exceeds it.[11] Some plan sponsors may value that budget predictability and administrative simplicity. However, the value of the risk transfer is difficult to evaluate when the plan sponsor cannot compare the guarantee with actual pharmacy payments or identify the retained margin. If Oregon permits these arrangements, disclosure and audit requirements could support an informed contractual choice.

Oregon reporting confirms that these compensation arrangements occur in the state. For 2024 operations, 15 licensed PBMs reported business subject to Oregon requirements. Seven reported receiving revenue through spread pricing, pay-for-performance arrangements, or similar means, totaling roughly $11.6 million.[12] PBMs also reported receiving and retaining approximately $33.9 million in administrative fees from carriers.[13] Because the reporting template combined spread pricing with pay-for-performance arrangements and similar revenue, the amount attributable specifically to spread pricing cannot be determined. The aggregated data also do not identify affected plan sponsors, market segments, drugs, or individual claims.

Proponents of vertical integration argue that aligning payer and pharmacy operations can improve data sharing, streamline care coordination and utilization management processes, and reduce operational barriers to medication access.[14] Recent research involving Medicare Advantage beneficiaries found that use of an insurer-integrated specialty pharmacy associated with faster access to specialty medications and lower beneficiary pharmacy costs, although the broader effects of vertical integration remain mixed.[15]

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[11] Pharmaceutical Care Management Association. Employers choose spread pricing for a reason. https://www.pcmanet.org/employers-choose-spread-pricing-for-a-reason/.

[12] Oregon Division of Financial Regulation. (2025). Prescription Drug Price Transparency Program results and recommendations - 2025, pp. 41-43. https://dfr.oregon.gov/drugtransparency/Documents/20251204-dpt-hearing/Prescription-Drug-Price-Transparency-Annual-Report-2025.pdf.

[13] Ibid.

[14] Hames, A. G., Bejarano, G., & Poonawalla, I. B. (2026). Association between integrated specialty pharmacy care model and pharmaceutical access and costs. *Health affairs scholar*, *4*(8), qxag192. https://doi.org/10.1093/haschl/qxag192.

[15] Ibid.

Policy design

A workable framework to eliminate spread pricing should:

1. Require the PBM to charge the plan sponsor no more for the ingredient cost and dispensing fee for a claim than the amount paid or payable to the dispensing pharmacy.
2. Permit PBM compensation only through a separately invoiced, fixed-dollar administrative fee established in the contract.
3. Define "amount paid or payable" to include post-adjudication adjustments, reconciliation payments, pharmacy fees, effective-rate true-ups, and remuneration paid by or recouped from the pharmacy or its pharmacy services administrative organization.
4. Require transaction-level reporting of the plan charge, pharmacy payment, patient cost-sharing, and all subsequent adjustments, using standardized data fields.
5. Prohibit reclassification of spread as a network, data, credentialing, reconciliation, or other fee unless it reflects a documented service and is included in the permitted compensation schedule.
6. Authorize independent audits and recovery of overpayments, with records retained for a defined period.

This approach is commonly described as pass-through pricing. It should apply consistently to retail, mail-order, and specialty claims, including claims dispensed by a PBM-affiliated pharmacy. An exception for affiliated pharmacies would create a significant gap because internal transfer prices may otherwise obscure the economic spread. Enforcement would rely on Oregon regulators requiring detailed transaction-level data, enabling regular audits and validation of reported prices and payments. The state would have the authority to examine plan and pharmacy data, investigate discrepancies, and pursue corrective action in cases of noncompliance. These oversight mechanisms are key to ensuring that spread pricing is effectively eliminated in practice, rather than shifted or hidden through alternative means.

Issue 2: Delinking PBM compensation from drug prices

Definition and rationale

Delinking means prohibiting PBM compensation from being calculated by reference to the list price, wholesale acquisition cost, ingredient cost, rebate amount, discount, or other drug-price measure.[16] Under a delinked model, the PBM is paid a fixed dollar amount for specified services, such as a per-member-per-month fee, a per-claim fee, or a defined project fee.

[16] Avalere Health Advisory. (2025, April 21). PBM delinking: Policy considerations. https://advisory.avalerehealth.com/insights/pbm-delinking

Performance incentives may be permitted if they are based on independently measurable outcomes and are not a proxy for drug price or rebate volume.

The Congressional Budget Office (CBO) has explained that a delinking provision may limit manufacturer payments to PBMs to bona fide service fees and prohibit linking compensation to drug prices.[17] CBO also cautioned that delinking in the commercial market would be less effective without transparency because compensation could be shifted or relabeled if net prices and fees are not reported to employers.[18] This observation supports pairing delinking with a comprehensive definition of remuneration, transaction-level reporting, and audit authority.

The rationale for delinking is that when PBM fees are tied to a percentage of a drug's list price or rebate, PBM revenue increases as those prices or rebates rise—even if utilization and the PBM's workload remain unchanged.[19] Moving to fixed-dollar compensation makes the cost of PBM services more transparent and eliminates this mechanical link between PBM revenue and drug prices. It does not, by itself, guarantee lower manufacturer list prices or reduced premiums.

A strict delinking requirement may also constrain legitimate performance-based arrangements if compensation or drug-price measures are defined too broadly.[20] A plan sponsor may want to reward independently verified improvements in adherence, access, clinical outcomes, claims accuracy, or total net spending. A carefully designed exception could permit performance payments based on measurable outcomes while prohibiting measures that function primarily as proxies for list price, rebate amount, formulary placement, or utilization volume.

Policy design

Oregon could define PBM compensation broadly to include any payment, credit, offset, retained amount, or other economic benefit received directly or indirectly by a PBM or an affiliated entity in connection with administering a pharmacy benefit. The definition should cover manufacturer administrative fees, rebate aggregator or group purchasing organization fees, data-sale revenue tied to formulary access, pharmacy fees, and amounts transferred to affiliates.

Permitted compensation could be limited to:

- Fixed-dollar fees stated in advance in the contract and reasonably related to an identified service;

[17] Congressional Budget Office. (2024, August 1). Answers to questions for the record following a hearing on prescription drug costs. https://www.cbo.gov/publication/60590
[18] Ibid.
[19] Avalere Health Advisory. (2025, April 21). PBM delinking: Policy considerations. https://advisory.avalerehealth.com/insights/pbm-delinking
[20] Ibid.

- Fees that do not vary with a drug's list price, ingredient cost, rebate, discount, or formulary position; and
- Carefully-defined performance payments based on clinical quality, adherence, access, accurate claims processing, or independently-verified, total net-cost targets.

A fee should be supported by a written description of the service, a reasonable allocation methodology, and evidence that the payment is not contingent on formulary placement, market share, utilization volume, or a drug-price measure unless the statute expressly permits that basis.

Issue 3: PBM conduct and rebate dynamics

Rebates and formulary incentives

Manufacturer rebates are retrospective payments or price concessions commonly negotiated in exchange for preferred formulary access, higher market share, or greater utilization. Rebates can lower the net cost borne by a plan. They can also contribute to an incentive conflict when the PBM retains part of the rebate, receives a percentage-based administrative fee, or benefits through an affiliate such as a group purchasing organization or dispensing pharmacy.

Peer-reviewed literature explains that a PBM may design formularies to prefer a high-list-price, high-rebate product over a lower-list-price product when the retained remuneration is greater, particularly when the contract does not require full pass-through.[21] For example, if a PBM receives a higher share of rebates from a branded drug with a high list price than from a therapeutically-similar drug with a lower list price, the PBM may have a financial incentive to promote the former, even if it is not the most cost-effective choice for the plan sponsor or patient. This does not mean that every preferred formulary placement is rebate-driven; clinical evidence, negotiated net price, utilization management, and plan-design choices also affect placement. However, the existence of such incentive conflicts provides a credible policy basis for requiring the PBM to document the clinical and net-cost rationale for its decisions and to disclose conflicts of interest.

This incentive was described in another peer-reviewed article that when a PBM retains a portion of rebates and the contract does not require full pass-through, a high-list price product with a larger rebate may generate more PBM revenue than a comparable lower-list price product.[22]

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[21] Federal Trade Commission. (2024). Pharmacy benefit managers: The powerful middlemen inflating drug costs and squeezing Main Street pharmacies (Interim Staff Report). https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[22] Mattingly, T. J., II, Lewis, M., & Pope, N. (2023). Pharmacy benefit managers: History, business practices, economics, and policy. JAMA Health Forum, 4(11), e233804. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2811344

Rebates retained by or passed to a plan may reduce aggregate plan costs or premiums, while a patient whose deductible or coinsurance is based on a gross price can face costs that do not reflect the rebate. Research on branded drug sales in the U.S. found that manufacturer discounts increased substantially while both list and estimated net prices rose, although at different rates.[23] The finding illustrates why policymakers should evaluate gross price, net price, patient cost sharing, and the destination of concessions separately.

Conduct concerns in vertically integrated markets

The FTC's first interim report identified concerns involving steering patients to affiliated pharmacies, pharmacy reimbursement, access to specialty drugs, and the movement of drugs onto specialty lists.[24] Its second interim report analyzed a sample of specialty generic drugs and reported substantial markups at PBM-affiliated pharmacies; the report is an interim staff analysis, not a final adjudication of liability.[25] The FTC has also brought an administrative complaint alleging that the three largest PBMs and affiliated group purchasing organizations used rebate practices that distorted insulin formulary access.[26] Those allegations remain subject to the administrative process and should not be stated as established violations.

The FTC subsequently resolved portions of the administrative case through consent agreements. Its final order with Express Scripts took effect in February 2026, and the FTC announced a proposed consent agreement with Caremark in July 2026.[27] The agreements address compensation tied to list prices, transparency, point-of-sale treatment of certain rebates, and pharmacy reimbursement. In July 2026, the FTC also withdrew the case against Optum from adjudication while considering a proposed consent agreement.[28] These settlements create enforceable obligations for settling respondents but are not judicial findings that every allegation in the original complaint was proven.

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[23] Hernandez, I., San-Juan-Rodriguez, A., Good, C. B., & Gellad, W. F. (2020). Changes in list prices, net prices, and discounts for branded drugs in the US, 2007–2018. JAMA, 323(9), 854–862. https://doi.org/10.1001/jama.2020.1012

[24] Federal Trade Commission. (2024). Pharmacy benefit managers: The powerful middlemen inflating drug costs and squeezing Main Street pharmacies (Interim Staff Report). https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[25] Federal Trade Commission. (2025, January). Specialty generic drugs: A growing profit center for vertically integrated pharmacy benefit managers—Second interim staff report. Specialty Generic Drugs: A Growing Profit Center for Vertically Integrated Pharmacy Benefit Managers

[26] Federal Trade Commission. (2024, September 20). FTC sues prescription drug middlemen for artificially inflating insulin drug prices. https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-sues-prescription-drug-middlemen-artificially-inflating-insulin-drug-prices

[27] Federal Trade Commission. (2026, February 4). FTC secures landmark settlement with Express Scripts to lower drug costs for American patients. https://www.ftc.gov/news-events/news/press-releases/2026/02/ftc-secures-landmark-settlement-express-scripts-lower-drug-costs-american-patients

[28] Federal Trade Commission. (2026, February 4). FTC secures landmark settlement with Express Scripts to lower drug costs for American patients. https://www.ftc.gov/news-events/news/press-releases/2026/02/ftc-secures-landmark-settlement-express-scripts-lower-drug-costs-american-patients

These developments suggest that rebate policy should address both conduct and cash flow. A requirement to pass through rebates may protect the purchaser while leaving unchanged incentives related to affiliated dispensing, data fees, or formulary access.

Proponents of vertical integration argue that aligning payer and pharmacy operations can improve data sharing, streamline care coordination and utilization management processes, and reduce operational barriers to medication access.[29] Recent research involving Medicare Advantage beneficiaries found that use of an insurer-integrated specialty pharmacy associated with faster access to specialty medications and lower beneficiary pharmacy costs, although the broader effects of vertical integration remain mixed.[30]

Manufacturer data fees may compensate a PBM for legitimate reports, claims analysis, or other services. They become a policy concern when the amount is based on a drug's list price, rebate, market share, formulary placement, or utilization rather than the fair-market value of a documented service. Without a comprehensive definition of remuneration, compensation could be routed through an affiliate or relabeled as a data, administrative, or service fee. Oregon could require a description of the service, a reasonable allocation methodology, fair-market-value support, and disclosure of payments to PBM affiliates.

Policy design

Conduct standards could require a PBM to:

1. Act in accordance with a statutory duty to the plan sponsor, including a duty to disclose material conflicts and avoid self-dealing not authorized through informed, written consent.[31]
2. Provide a lower-net-cost alternative analysis when a higher-list-price product receives preferred placement over a therapeutically-comparable product.[32]
3. Refrain from requiring use of an affiliated pharmacy when a nonaffiliated pharmacy meets objective terms, except where a documented clinical or distribution limitation applies.[33]

[29] Hames, A. G., Bejarano, G., & Poonawalla, I. B. (2026). Association between integrated specialty pharmacy care model and pharmaceutical access and costs. *Health affairs scholar*, *4*(8), qxag192. https://doi.org/10.1093/haschl/qxag192.
[30] Ibid.
[31] Federal Trade Commission. (2024). Pharmacy benefit managers: The powerful middlemen inflating drug costs and squeezing Main Street pharmacies (Interim Staff Report). https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf
[32] Ibid.
[33] Ibid.

4. Apply equivalent reimbursement and audit standards to affiliated and nonaffiliated pharmacies and report material differences.[34, 35]
5. Base formulary and utilization-management recommendations on documented clinical evidence and total net cost to the plan sponsor and enrollee, rather than the amount of PBM or affiliate compensation.[36]
6. Disclose, before contract execution and at least annually, all categories and calculation methods of direct and indirect payments.[37]
7. Pass through 100 percent of manufacturer rebates and other price concessions to the plan sponsor, with the contract specifying whether amounts reduce claims expense, point-of-sale cost sharing, or offset the overall cost of coverage.[38, 39]
8. Disclose ownership and other financial relationships with insurers, manufacturers, group purchasing organizations, wholesalers, pharmacy services administrative organizations, and dispensing pharmacies.[40]

State policy models and evidence of impact

All 50 states have enacted some form of PBM legislation, but the scope, regulated market, and maturity of those laws vary substantially.[41] Some states regulate only Medicaid or public employee contracts; others regulate PBMs serving state-regulated commercial plans. Common provisions include PBM licensure, spread-pricing limits, rebate and fee reporting, pharmacy reimbursement protections, fiduciary or duty-of-care requirements, steering restrictions, and

[34] Federal Trade Commission. (2024). Pharmacy benefit managers: The powerful middlemen inflating drug costs and squeezing Main Street pharmacies (Interim Staff Report). https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[35] Federal Trade Commission. (2024). Specialty generic drugs: A growing profit center for vertically integrated pharmacy benefit managers (Second Interim Staff Report). https://www.ftc.gov/system/files/ftc_gov/pdf/PBM-6b-Second-Interim-Staff-Report.pdf

[36] Seeley, E., & Kesselheim, A. S. (2019). Pharmacy Benefit Managers: Practices, Controversies, and What Lies Ahead. The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/sites/default/files/2019-03/Seeley_pharmacy_benefit_managers_ib.pdf

[37] U.S. Department of Health and Human Services Office of Inspector General. (2024). Medicaid managed care: States do not consistently define or validate paid amount data for drug claims (OEI-03-20-00560). https://oig.hhs.gov/documents/evaluation/9898/OEI-03-20-00560.pdf

[38] Actuary.info. (2025). Federal PBM reform mandates full rebate passthrough by 2029. https://actuary.info/insights/federal-pbm-reform-rebate-passthrough-2029-actuarialFederal Trade Commission. (2024).

[39] FTC sues prescription drug middlemen for artificially inflating insulin drug prices. https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-sues-prescription-drug-middlemen-artificially-inflating-insulin-drug-prices

[40] Ibid.

[41] National Academy for State Health Policy. (2026, March 10). State pharmacy benefit manager legislation. https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/

examination authority. Federal preemption and federal program requirements may limit application of state policies to self-funded employee benefit plans governed by ERISA, Medicare plans, and other federally-regulated coverage.

Eliminating an accounting category such as spread does not necessarily reduce overall prescription drug spending. Similarly, increases in manufacturer rebates or other price concessions passed through by a PBM to a public plan sponsor may reduce the sponsor's net drug costs without necessarily reducing total health care system spending. . Further studies should consider all components of the drug-spending ecosystem, including pharmacy reimbursement, PBM and affiliate compensation, manufacturer payments, patient cost sharing, utilization patterns, drug mix, and state administrative costs. To guide Oregon's ongoing oversight, specific evaluation metrics should be recommended and monitored. These metrics include changes in net plan sponsor cost, patient out-of-pocket spending, pharmacy participation rates, formulary coverage, access to essential medications, and the distribution of manufacturer concessions. Collecting and analyzing standardized data on these indicators will support a comprehensive, evidence-based evaluation of policy interventions. In summary, policy interventions should be evaluated for their ability to achieve net savings for the health care system and improved access for patients, rather than solely for redistributing costs within the system.

Table 1 outlines multiple states that have considered or enacted statutes to address PBM conduct or to increase transparency.

Table 1: States with PBM reform statues

State and authority	Principal requirements and scope	Implementation status	Reported effects and limitations	Distinction from Oregon[42, 43]
Kentucky—SB 50 (2020)[44]	Single state-contracted PBM for Medicaid; state control over the formulary and rebate administration; spread-pricing prohibition; expanded claims and contract oversight	Implemented beginning in state fiscal year 2021	A 2022 legislative presentation using Medicaid-reported figures showed spread pricing declining from approximately $123.5 million in state fiscal year 2020 to zero in 2021 and 2022. Reported rebate collections also increased, but utilization, drug mix, manufacturer pricing, and accounting changes prevent attributing the full rebate	Oregon only requires spread-pricing reporting.

[42] Or. Rev. Stat. 735.530-735.552 (2025). https://www.oregonlegislature.gov/bills_laws/ors/ors735.html.
[43] Or. Rev. Stat. 836-200-0418 (2026). https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=337252.
[44] Kentucky General Assembly. (2020). Senate Bill 50: An act relating to pharmacy benefits in the Medicaid program and declaring an emergency. https://apps.legislature.ky.gov/recorddocuments/bill/20RS/sb50/bill.pdf

State and authority	Principal requirements and scope	Implementation status	Reported effects and limitations	Distinction from Oregon[42, 43]
			increase to PBM reform.[45]	
Ohio—H.B. 166 (2019)[46] and Ohio Rev. Code 5167.24–5167.243[47]	Single PBM for Medicaid managed care; conflict and affiliate disclosures; prohibition on mandatory use of the PBM's affiliated specialty pharmacy; quarterly reporting of negotiated prices, pharmacy payments, rebates, and the share of savings passed through	Pass-through pricing began in 2019; the single-PBM structure was subsequently implemented	Ohio's early pass-through analysis reported that amounts paid to pharmacies increased approximately 5.74%, or $38.4 million, during the comparison period. This indicates redirection of funds to pharmacies, not necessarily net state savings. A comprehensive public evaluation of total savings, patient affordability, and	Oregon regulates pharmacy reimbursement and reports spread-pricing revenue but does not prohibit it.

[45] Kentucky General Assembly, Interim Joint Committee on Health, Welfare, and Family Services. (2022, September 28). Pharmacy benefit managers' impact on healthcare [Presentation reporting Kentucky Medicaid figures]. https://apps.legislature.ky.gov/CommitteeDocuments/7/20742/09%2028%202022%20Sheldon%20-%20PBM%20Impact%20Presentation.pdf

[46] Ohio General Assembly. (2019). House Bill 166: Operating budget for fiscal years 2020–2021 (133rd General Assembly). https://search-prod.lis.state.oh.us/api/v2/general_assembly_133/legislation/hb166/09_EN/pdf/

[47] Ohio Revised Code 5167.243 (2019). https://codes.ohio.gov/ohio-revised-code/section-5167.243

State and authority	Principal requirements and scope	Implementation status	Reported effects and limitations	Distinction from Oregon[42, 43]
			pharmacy access remains limited.[48]	
California—SB 41 (2025)[49]	Prohibits spread pricing; requires pass-through pricing and manufacturer-rebate pass-through; limits PBM income to disclosed management fees; establishes cost-sharing, pharmacy, conflict, and enforcement provisions for covered state-regulated arrangements	Requirements began applying to specified contracts in 2026, with transition provisions for existing contracts	No post-implementation cost or access results were available at the time of this review. California has a comprehensive statutory model but not yet an outcomes case study.	Oregon requires reporting, but not in the same as California's requirements.
Colorado—HB 25-1094 (2025)[50]	Allows flat-dollar service fees; prohibits PBM income based on a drug's price or cost; prohibits spread pricing and	Principal compensation provisions take effect Jan. 1, 2027	No outcome data is available.	Oregon requires reporting that prohibits drug-price based PBM compensation and specific rebate retention

[48] Ohio Department of Medicaid. (2019). Executive summary: Assessing the impact of pass-through pricing. https://medicaid.ohio.gov/wps/wcm/connect/gov/2ef5a8b4-0f15-4ef4-8883-11fd6238e101/ODM-HDS-Summary.pdf?MOD=AJPERES

[49] California Legislature. (2025). Senate Bill 41: Pharmacy benefits. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB41

[50] Colorado General Assembly. (2025). HB25-1094: Pharmacy benefit manager practices. https://leg.colorado.gov/bills/hb25-1094

State and authority	Principal requirements and scope	Implementation status	Reported effects and limitations	Distinction from Oregon[42, 43]
	specified rebate retention; regulates formulary design and pharmacy reimbursement for covered arrangements			but does not probit them.
New York—Insurance Law Article 29 (2022) and implementing regulations[51]	PBM licensure; duty and conduct standards; annual CEO-attested reports; reporting of spread, pass-through, hybrid, and other pricing models; plan, rebate, affiliate, revenue, and claims information	Annual reporting and regulatory examination are operating	New York has created one of the strongest PBM data infrastructures, but it requires PBMs to offer a pass-through option rather than categorically prohibiting every spread arrangement. Much of the information is confidential, limiting published savings analysis.[52]	Oregon reporting is aggregated and confidential.

[51] New York Public Law. (2026). N.Y. Insurance Law Article 29 – Pharmacy Benefit Managers. https://newyork.public.law/laws/n.y._insurance_law_article_29
[52] New York State Department of Financial Services. (2026). Pharmacy benefit manager 2025 annual report instructions. https://www.dfs.ny.gov/apps_and_licensing/pharmacy_benefit_managers/annual-report-instructions_2025

State and authority	Principal requirements and scope	Implementation status	Reported effects and limitations	Distinction from Oregon[42, 43]
Vermont—Act 127 (2024)[53]	PBM licensure, market-conduct regulation, examination authority, reimbursement and pharmacy protections, and affiliate and conflict oversight	Recently implemented following legislative study and rule development	The law is too recent for a mature statewide analysis of prescription spending or pharmacy access.	Oregon primarily regulates licensure, pharmacy practices, and pharmacy-claim audits.

[53] Vermont General Assembly. (2024). Act 127: An act relating to licensure and regulation of pharmacy benefit managers. https://legislature.vermont.gov/Documents/2024/Docs/ACTS/ACT127/ACT127%20As%20Enacted.pdf

Kentucky: measurable elimination of Medicaid spread

Kentucky provides one of the more developed state examples. SB 50, enacted in 2020, moved Medicaid pharmacy administration to a single PBM directly overseen by the state, centralized rebate administration, and prohibited spread pricing.[54]

A September 2022 legislative presentation reported approximately $123.5 million in Medicaid spread pricing in state fiscal year 2020 and no spread pricing in 2021 and 2022. It also reported that total rebates collected increased from approximately $659.2 million in 2020 to $827.6 million in 2021 and $1.2 billion in 2022.[55] The elimination of reported spread is a meaningful and directly relevant result. However, the rebate figures should be interpreted with greater caution, as rebate revenue is sensitive to multiple operational and market variables, including utilization patterns, beneficiary composition, therapeutic mix, manufacturer pricing strategies, statutory rebate formulas, supplemental rebate negotiations, and accounting methodologies. The available public material is insufficient to attribute the entirety of the observed variation in rebates to SB 50 as the sole savings factor.

Kentucky demonstrates that a state can eliminate spread as a PBM revenue stream in the Medicaid program by regulating the contract, claims data, formulary, and rebate administration. It does not establish that every dollar previously identified as spread resulted in a reduction in total Medicaid spending or patient costs. Medicaid beneficiaries also generally face limited cost sharing, making Kentucky less informative about potential policy impacts on commercial-market affordability at the point of sale.

Ohio Medicaid: pass-through pricing and independent oversight

Ohio used a phased process to reform its Medicaid pharmacy benefit. State reviews first identified substantial differences between amounts managed care organizations paid PBMs and the amounts PBMs paid pharmacies. Ohio moved managed-care pharmacy contracts to pass-through pricing and subsequently created a single state-contracted PBM. Prospective state PBMs must disclosure conflicts, ownership relationships, pharmacy fees, and manufacturer financial arrangements to the Ohio Department of Medicaid. Quarterly reports address

[54] Kentucky General Assembly. (2020). Senate Bill 50: Enrolled version. LegiScan. https://legiscan.com/KY/text/SB50/id/2173919/Kentucky-2020-SB50-Enrolled.pdf

[55] Kentucky General Assembly, Interim Joint Committee on Health, Welfare, and Family Services. (2022, September 28). Pharmacy benefit managers' impact on healthcare [Presentation reporting Kentucky Medicaid figures]. https://apps.legislature.ky.gov/CommitteeDocuments/7/20742/09%2028%202022%20Sheldon%20-%20PBM%20Impact%20Presentation.pdf

negotiated drug prices, pharmacy payments, rebates, and the percentage of savings passed to Medicaid participants.[56]

Ohio's initial assessment found that pass-through implementation was associated with an approximately 5.74 percent increase—about $38.4 million—in payments to pharmacies between the fourth quarter of 2018 and the first quarter of 2019.[57] This result is relevant to pharmacy financial stability and patient network access. It is not a direct measure of savings because the state may pay pharmacies more and pay the PBM a separately-disclosed administrative fee. Ohio's experience illustrates why an evaluation should report total net cost and distributional effects rather than treating elimination of spread as the only outcome.

Ohio also separates claims administration from certain pricing and auditing functions. That structure reduces reliance on a PBM to validate its own payment practices. It offers a useful governance model for states even if the state does not adopt a single, statewide PBM.

California and Colorado: emerging delinking models

California's SB 41 requires a pass-through pricing model, restricts spread pricing, requires manufacturer rebates to be transmitted to payers, and limits PBM income from PBM services to disclosed management fees. It also contains provisions on patient cost-sharing and pharmacy conduct. California began implementation in 2026, and existing contracts are subject to statutory transition rules.[58]

Colorado's HB 25-1094 expressly permits flat-dollar service fees and prohibits PBM income based on the price or cost of a prescription drug. The law also addresses spread pricing, manufacturer remuneration, formulary design, and pharmacy reimbursement. Its principal compensation provisions take effect in 2027.[59]

Neither law has sufficient implementation history to demonstrate effects on manufacturer list prices, plan net costs, premiums, patient out-of-pocket spending, or pharmacy access. They should be reviewed as leading statutory designs rather than proven cost-saving programs. Their implementation will nevertheless provide information concerning definitions, contract

[56] Ohio Revised Code. (2026). Section 5167.243 – Pharmacy benefit manager prohibitions. Retrieved from https://codes.ohio.gov/ohio-revised-code/section-5167.243

[57] Ohio Department of Medicaid. (2019). Executive summary: Assessing the impact of pass-through pricing. https://medicaid.ohio.gov/wps/wcm/connect/gov/2ef5a8b4-0f15-4ef4-8883-11fd6238e101/ODM-HDS-Summary.pdf?MOD=AJPERES

[58] California Legislature. (2025). Senate Bill 41: Pharmacy benefits. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB41

[59] Colorado General Assembly. (2025). HB25-1094: Pharmacy benefit manager practices. https://leg.colorado.gov/bill_files/40563/download

transitions, data specifications, enforcement, and whether prohibited revenue reappears as another fee or through an affiliate.

Conduct, rebate, and oversight models

Maine, New York, and Vermont illustrate complementary regulatory approaches. Maine requires PBMs operating in the state to be licensed and requires PBMs contracting with regulated carriers to act as the carrier's agent and fiduciary.[60] New York requires PBMs operating in the state to be licensed and file annual reports, including PBMs serving health plans with a substantial New York presence. Vermont requires PBMs providing services in the state to be licensed and establishes conduct requirements for PBMs managing benefits from health plans and insurers.[61]

These state approaches demonstrate the PBMs can strengthen oversight, eliminate specific revenue practices, and redirect payment. However, available evidence does not establish that these changes consistently reduce total plan spending, premiums, or patient out-of-pocket costs. State experience and so highlights the importance of clear regulatory authority, standardized data, adequate staffing, and enforcement capacity. Establishing a baseline and monitoring fiscal and access outcome should be considered when implementing PBM reforms.

Policy options

Option 1: Transparency and audit rights only

Require standardized PBM reporting to plan sponsors, contract disclosures, annual attestations, and regulator and purchaser audit rights without restricting compensation methods.

Advantages: Produces baseline information, supports contract oversight, and may be less disruptive to existing arrangements.

Limitations: Does not eliminate incentive conflicts or guarantee that purchasers can negotiate different terms in a concentrated market. Reporting may be incomplete unless affiliate transactions and post-adjudication adjustments are included. Reporting may impose additional administrative costs on PBMs to produce reports and on plan sponsors to review reported data.

[60] Maine Legislature. (2026). Maine Revised Statutes, Title 24-A 4348-4349; Pharmacy benefit managers. https://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4348-A.html.
[61] Vermont Legislature. (2024). Act 127: As enacted. https://legislature.vermont.gov/Documents/2024/Docs/ACTS/ACT127/ACT127%20As%20Enacted.pdf

Option 2: Public-program contracting requirements

Apply pass-through pricing, fixed-dollar compensation, rebate pass-through, and conduct standards to Oregon public purchasers and Medicaid contracts within state authority.

Advantages: Allows implementation through procurement and contract administration; creates an opportunity to measure fiscal and access effects for public purchasers and enrollees before broader application.

Limitations: Does not directly reach the entire commercial market. Program-specific federal requirements and actuarial treatment should be reviewed. Oregon's July 2026 Medicaid sustainability report separately identifies a single-PBM model as a potential means of increasing transparency and purchasing coordination. The report notes that this potential structural change would require additional operational and fiscal analysis.[62]

Option 3: Market-wide integrated regulation

Apply a structured regulatory framework to PBMs serving state-regulated health benefit plans, including necessary statutory limits and federal carve-outs. Policymakers should recognize both political feasibility risks and legal risks with this option. Political challenges may arise because this approach entails significant changes to existing regulatory and market structures and may encounter opposition from industry stakeholders. Approximately a quarter of Oregonians are enrolled in fully insured state-regulated health benefit plans. Federal preemption, particularly under ERISA, and other jurisdictional constraints may restrict the application of state requirements to self-funded employer health plans or federally regulated programs and decrease the number of Oregonians affected by these policies. To mitigate these risks, Oregon could conduct a legal review to clarify the permissible scope of state authority, explicitly exempt federally-regulated plans where required, and coordinate with federal regulators to avoid conflicts. Early stakeholder engagement and transparent rulemaking processes may also reduce resistance and help identify practical implementation strategies.

Advantages: Establishes consistent rules and reduces opportunities to shift revenue across lines of business.

Limitations: Requires more extensive rulemaking, data systems, examination capacity, and legal analysis. Implementation and ongoing oversight could require additional funding for state programs charged with implementation. Contract changes may affect visible administrative fees, premiums, pharmacy reimbursement, and formulary strategy.

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[62] Oregon Health Authority. (2026, July 7). Governor's Advisory Group on Medicaid Sustainability: Report to Governor Kotek. https://www.oregon.gov/oha/OHPB/MtgDocs/4.%20Advisory%20Group%20on%20Medicaid%20Sustainability%20Report%20to%20Governor%20Kotek%20Final.pdf

Conclusion

PBM conduct and oversight reform is most likely to improve accountability when it aligns compensation with identifiable services and provides purchasers and regulators with sufficient information to verify all relevant transactions. Eliminating spread pricing addresses the pharmacy-to-plan price difference; delinking removes the mechanical relationship between PBM revenue and drug prices or rebates; and rebate and conduct standards address formulary incentives, conflicts, and affiliate transactions. However, enacting only one component leaves material avenues for revenue substitution. Enactment should proceed with a phased implementation of an integrated regulatory framework, beginning with establishing standardized data collection and audit authority. The board may also consider outcome evaluation mechanisms to measure both fiscal impacts and effects on patient access. This sequenced approach could enable Oregon to assess whether comprehensive PBM reform results in lower total net costs and improved affordability, and, as evidence develops, refine policies accordingly.