MIDDLEMEN AT A PRICE: THE ROLE OF STATE-LEVEL LAWS IN RESTRICTING PHARMACY BENEFIT MANAGERS

by
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Pharmacy Benefit Managers (PBMs) have evolved from simple third-party payors into powerful intermediaries controlling prescription drug access for over 289 million Americans. Operating with minimal federal oversight, just six PBMs dominate 96% of the market, employing practices that systematically increase drug costs while claiming to reduce them. This Comment examines four primary mechanisms through which PBMs exploit the pharmaceutical supply chain: rebate manipulation, spread pricing, step therapy requirements, and formulary control. Federal regulatory efforts remain nascent and ineffective. The Centers for Medicare and Medicaid Services requires only basic reporting without substantive restrictions. Proposed federal legislation has repeatedly stalled, leaving states to craft their own regulatory frameworks.

This Comment analyzes three distinct state approaches. Florida's comprehensive 2023 Prescription Drug Reform Act mandates pass-through pricing and restricts step therapy. Colorado incrementally constructed similar protections through multiple statutes over two decades. Oregon, despite recognizing PBMs' harmful practices, maintains only minimal registration requirements without prohibiting spread pricing or rebate retention. This Comment concludes that meaningful PBM reform requires state action. States must prohibit spread pricing, mandate rebate pass-through, and limit formulary manipulation. Until federal legislation materializes, state legislatures bear responsibility for protecting consumers from practices that artificially inflate prescription drug costs while enriching pharmaceutical middlemen.

* J.D., Lewis & Clark Law School, 2025; Editor in Chief, Lewis & Clark Law Review, 2024–2025. In memory of Professor Barbara J. Safriet, whose commitment to eliminating barriers to access adequate health care inspired countless students, including myself. This Comment is dedicated to my partner, Jillian, and the millions of people just like her who suffer from chronic conditions and fear each time they have to enter a pharmacy. Thank you to the editors of the Lewis & Clark Law Review for their work on this Comment, and engaging in a thankless, difficult, yet all too crucial, aspect of our legal system.

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INTRODUCTION

Prescription medications are prohibitively expensive for millions of people in the United States. Individuals who receive prescriptions from their doctors may ultimately never even pick up those medications because they know that the cost will be much more than they can handle.[1] A simple assumption is that the price of prescription medications is increasing due to inflation, similar to most other products we purchase at the grocery store. This is not the case. A recent study found that between 2022 and 2023, "more than 4,200 drug products had price increases, of which 46 percent were larger than the rate of inflation."[2] In the eyes of the American public, this drastic increase in cost has been caused by pharmaceutical manufacturers that are putting profits before patients.[3]

Pharmaceutical manufacturers, however, are often not the ones that set prices for patients. Rather, that is done by Pharmacy Benefit Managers (PBMs) who have found their place in the healthcare market as pharmaceutical middlemen. PBMs administer prescription medication plans for health insurance companies. In that

[1] Tori Marsh & Sasha Guttentag, *Nearly One Third of Americans Aren't Filling Their Prescriptions Because of High Costs*, GOODRX, https://www.goodrx.com/healthcare-access/research/third-of-americans-dont-fill-prescriptions-due-to-cost (Oct. 30, 2024).

[2] ARIELLE BOSWORTH, STEVEN SHEINGOLD, KENNETH FINEGOLD, BISMA A. SAYED, NANCY DE LEW & BENJAMIN D. SOMMERS, U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. OF THE ASSISTANT SEC'Y FOR PLAN. & EVALUATION, CHANGES IN THE LIST PRICES OF PRESCRIPTION MEDICATIONS, 2017–2023, at 1 (2023), https://aspe.hhs.gov/sites/default/files/documents/0cdd88059165eef3bed1fc587a0fd68a/aspe-drug-price-tracking-brief.pdf.

[3] Grace Sparks, Ashley Kirzinger, Alex Montero, Isabelle Valdes & Liz Hamel, *Public Opinion on Prescription Drugs and Their Prices*, KFF (Oct. 4, 2024), https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices.

role, they negotiate contracts with pharmaceutical manufacturers and create drug formularies. Drug formularies are the lists of prescription medications that describe what medications a prescription drug plan will cover and how much that medication will cost for the consumer. By having the power to both negotiate contracts and determine what medications a plan will cover, PBMs are able to manipulate drug costs to increase their own profits.[4] With little regulatory oversight until the past few years, PBMs have operated outside of the public's—and governments'—eyes. The regulatory oversight that now exists largely only exists on the state level.[5] These state regulations are not consistent, allowing PBMs to engage in more harmful tactics in some states and not others.

Part I of this Comment discusses the history of PBMs as well as their function in modern healthcare. In Part II, the main problems with PBMs are analyzed, with a focus on discerning those practices that are most negatively affecting consumers. Part III delves into the regulatory frameworks that are seeking to minimize the negative impacts PBMs have. These include Florida, Colorado, and Oregon, which provide examples of the various approaches and deficiencies of state-level restrictions on PBMs. This Comment concludes by encouraging state legislatures to act and do what the federal government is unwilling to—meaningfully restrict PBMs from engaging in practices that harm consumers.

I. WHAT ARE PBMS?

A. Prepayment Plans

Prior to the 1950s, medical science had not yet reached the point where prescription medications were a part of the everyday existence for large swaths of the country.[6] But throughout the 1940s and 1950s, medical advancements led to the creation of many prescription medications that would become commonplace, such as antidepressants, antibiotics, and psychotropics.[7] As private insurance providers began covering prescription medications, companies that would later become the

[4] Kristi Martin, *What Pharmacy Benefit Managers Do, and How They Contribute to Drug Spending*, COMMONWEALTH FUND (Mar. 17, 2025), https://www.commonwealthfund.org/publications/explainer/2025/mar/what-pharmacy-benefit-managers-do-how-they-contribute-drug-spending.

[5] *See* Brian Nowosielski, *What States Are Doing to Regulate Pharmacy Benefit Managers*, DRUG TOPICS (Mar. 25, 2024), https://www.drugtopics.com/view/what-states-are-doing-to-regulate-pharmacy-benefit-managers.

[6] *See* Jessica Y. Ho, *Life Course Patterns of Prescription Drug Use in the United States*, 60 DEMOGRAPHY 1549, 1549–50 (2023).

[7] *See, e.g.*, Benoît Majerus, *Making Sense of the 'Chemical Revolution.' Patients' Voices on the Introduction of Neuroleptics in the 1950s*, 60 MED. HIST. 54, 54, 57 (2016) (discussing the early development of psychotropic drugs).

foundation for PBMs were created to facilitate the flow of those medications.[8] In the late 1950s, Prescription Services Inc. was created in Canada by a group of pharmacists who sought to increase access to prescription medications by acting as a third-party payor and entering into prepayment plans with subscribers.[9] Subscribers would pay an amount to Prescription Services Inc. per paycheck depending on the size of their family and, in return, pay a set price for medications at the pharmacy.[10] Prescription Services Inc. was a non-profit organization that contracted with pharmacies and subscribers to provide medications at a set cost.[11] It did not meddle with which prescriptions a doctor was prescribing and was concerned solely with minimizing prices of the medications.[12]

Around 1965, third-party payors began popping up in the United States marketplace. PAID Prescriptions was founded as a nonprofit with similar principles as Prescription Services Inc.[13] It was the first nationwide prepayment program and began operations in 1966.[14] Prepaid Prescription Plans, Inc. was also established in 1966 as a for-profit corporation that acted as a third-party payor providing prepayment plans.[15] Participants in these plans did not pay a set cost for medications but were instead reimbursed for a percentage of the total cost of the medication. Patients had to pay the pharmacy the full amount of the medication at the time of receiving it, then wait for a later reimbursement from Prepaid Prescription Plans, Inc.[16] A third prepayment plan provider, Pharmaceutical Card System, began operations in 1969 and would become the most similar to modern PBMs.[17] By the 1970s, Pharmaceutical Card System did more than just set prices between pharmacies and patients; it processed claims for these medications and negotiated prices with the pharmaceutical manufacturers.[18] Pharmacists quickly criticized all of these companies for their inconsistent reimbursements and poor record-keeping

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[8] T. Joseph Mattingly & David A. Hyman, *Pharmacy Benefit Managers: History, Business Practices, Economics, and Policy*, JAMA HEALTH F., Nov. 3, 2023, at 1, 2.

[9] W.A. Wilkinson, *Insurance Against Drug Costs—A Progress Report*, 50 AM. J. PUB. HEALTH 670, 671, 673 (1960).

[10] *See id.* at 672–73.

[11] *Id.* at 671.

[12] *Id.* at 671–72.

[13] *See* Norman A. Campbell & Robert W. Hammel, *Development of the Third Party Payment Concept for Medical and Pharmaceutical Services*, 15 PHARMACY HIST. 117, 122 (1973) (describing the formation of PAID Prescriptions).

[14] *Id.*

[15] *Id.*

[16] *Id.*

[17] *See id.*

[18] *Id.*; Kevin Merigian, *PBMS*, STONE INST.: BLOG (June 20, 2017), https://thestoneinstitute.com/blog/posts/pbms.

practices, and even threatened the companies with litigation over their control of drug prices.[19] Regardless, PBMs continued to evolve.

B. The Functions of Modern PBMs

As PBMs evolved, they began taking on a more significant role in how patients access prescription medications and how those prescription medications are managed.[20] More than 289 million Americans are now dependent on PBMs to administer their prescription drug plans, regardless of whether they have public or private health insurance.[21] Although there are 66 PBMs operating, a mere six of them control roughly 96% of the market.[22] Modern PBMs have five main functions: creating drug formularies; negotiating prices between pharmacies, manufacturers, and health insurance companies; managing how patients access medications; organizing pharmacy networks; and managing their own specialty and mail-order pharmacies.[23]

Formularies are lists of prescription medications that identify which medications a specific prescription drug plan will cover and how much those medications will cost.[24] If a prescription medication is on the formulary, then it will either be covered entirely or in part, commonly depending on what tier it is in. Medications in lower tiers are typically the generic version of name-brand drugs, which cost the consumer less.[25] Higher tier medications are the name-brand version of the drugs or specialized drugs that cost more for the consumer.[26] If a medication is not on the formulary, then the patient must either apply for an exception, seek alternative treatment, or pay the total cost of the medication out of pocket.[27] Each

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[19] Campbell & Hammel, *supra* note 13, at 122–23.

[20] ROBIN J. STRONGIN, NAT'L HEALTH POL'Y F., THE ABCS OF PBMS 2–3 (1999), https://www.ncbi.nlm.nih.gov/books/NBK559746/pdf/Bookshelf_NBK559746.pdf.

[21] *The Value of PBMs*, PCMA, https://www.pcmanet.org/value-of-pbms/ (last visited Aug. 9, 2025).

[22] The six largest PBMs are CVS Caremark, Express Scripts, Optum Rx, Humana Pharmacy Solutions, Prime Therapeutics, and MedImpact Healthcare Systems. Mattingly & Hyman, *supra* note 8, at 6; STAFF OF H. COMM. ON OVERSIGHT AND ACCOUNTABILITY, 118TH CONG., THE ROLE OF PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS 7 (July 2024) [hereinafter PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS], https://oversight.house.gov/wp-content/uploads/2024/07/PBM-Report-FINAL-with-Redactions.pdf.

[23] Mattingly & Hyman, *supra* note 8, at 3–5.

[24] *Understanding Drug Tiers*, PATIENT ADVOC. FOUND., https://www.patientadvocate.org/explore-our-resources/understanding-health-insurance/understanding-drug-tiers/ (last visited Aug. 9, 2025).

[25] *Id.*

[26] *Id.*

[27] *See id.*

formulary is specific to the plan it is attached to; when a consumer switches insurance companies or changes their policy, the formulary that is applicable to them will also change.[28] A medication's placement on the formulary and what tier it is in largely determines whether a patient can access a medication or if that medication will be too costly to afford.[29]

In conjunction with creating formularies, PBMs negotiate prices for the medications that will be on the formularies. Acting as purchasers for the thousands of insurance plans across the country, PBMs are able to negotiate lower costs than if each insurance plan did it alone.[30] Pharmaceutical manufacturers also offer rebates to PBMs that are said to decrease drug costs. These rebates are partial refunds or payments for a percentage of a medication's list price from manufacturers to PBMs as a means of encouraging PBMs to purchase the medication.[31] In practice, a manufacturer can offer a rebate that decreases the cost of the medication in exchange for the PBM giving it a more preferred placement on formularies over other similar—and often cheaper—medications.[32]

PBMs manage how patients access prescription medications through practices such as prior authorization and step therapy. For an increasing number of medications, doctors must receive prior authorization from their patient's drug plan's associated PBM to be able to prescribe that medication.[33] This burdensome process lacks predictability, leading doctors to second-guess their recommendations or face hours arguing over the phone with PBMs.[34] Step therapy occurs when a patient is prescribed a drug on a higher tier but the formulary requires the patient to "fail" on a medication on a lower tier prior to being able to obtain the originally prescribed medication.[35] For a patient to fail on the lower tier medication, the patient must not get the intended results from the medication—their suffering must persist.[36]

PBMs create pharmacy networks to ensure the prices they have negotiated are paid. These networks are comprised of both large chain pharmacies and smaller local pharmacies who contract with PBMs to provide medications to the patients they

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[28] Mattingly & Hyman, *supra* note 8, at 3.

[29] *See* PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS, *supra* note 22, at 27.

[30] John Tozzi, *Drug Benefit Firms Devise New Fees That Go to Them, Not Clients*, BLOOMBERG (Aug. 22, 2023, 2:00 AM), https://www.bloomberg.com/news/articles/2023-08-22/drug-price-negotiations-enrich-pharmacy-benefit-managers.

[31] PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS, *supra* note 22, at 24.

[32] *Id.*

[33] *See* AM. MED. ASS'N, 2024 AMA PRIOR AUTHORIZATION PHYSICIAN SURVEY 4 (2024), https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[34] *See id.* at 2.

[35] *See* PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS, *supra* note 22, at 36.

[36] *See infra* Section II.C; PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS, *supra* note 22, at 36.

serve.[37] Patients are steered toward getting their prescriptions filled only by in-network pharmacies and will face higher costs if they go to an out-of-network pharmacy.[38] By joining a PBM's network, a pharmacy is able to guarantee that it will have a steady flow of patients.[39] With only six PBMs managing prescription benefits for millions of Americans, a pharmacy that chooses not to contract with one of these PBMs has a very limited pool of patients to access.[40]

Many PBMs, including all of the largest ones, also operate mail-order and specialty pharmacies.[41] Through mail-order pharmacies, PBMs can deliver medications directly to patients by mail.[42] This makes medication more accessible to those who live in rural communities or are unable to leave their homes, but not all medications are eligible and there can be a long delay in receiving medications.[43] Patients can be incentivized to use mail-order pharmacies by getting a larger supply of their medication by mail than they can in a retail pharmacy.[44] Specialty pharmacies dispense only high-cost medications prescribed to those patients with complex diseases such as cancer and multiple sclerosis.[45] A PBM's own mail-order pharmacies and specialty pharmacies will be preferred within their plans' pharmacy networks, meaning patients are encouraged to use them.[46] If a member wants to use a mail-order or specialty pharmacy that is not in-network, and thus not owned by the PBM, they will face higher copays and possibly have to pay for the medication out of pocket.[47]

These core functions of PBMs are where most of the problems arise. The amount of control they exert over access to prescription medications only compounds with each step in the chain from manufacturer to consumer. Within each of these steps lies a distinct practice that only encourages further manipulation of the medication market in order to maximize profits for PBMs. It is these practices that must be regulated, restricted, and deterred if the massive amount of control PBMs have over the American public is to be diminished.

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[37] PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS, *supra* note 22, at 11.

[38] *Id.* at 16.

[39] *See* STRONGIN, *supra* note 20, at 6.

[40] PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS, *supra* note 22, at 7, 11.

[41] *Id.* at 16.

[42] *Mail-Service Pharmacy*, PCMA, https://www.pcmanet.org/mail-service-pharmacy (last visited Aug. 9, 2025).

[43] HaVy Ngo-Hamilton, *What Is a Mail Order Pharmacy?*, BUZZRX, https://www.buzzrx.com/blog/what-is-a-mail-order-pharmacy (Mar. 17, 2024).

[44] *See id.*

[45] *Specialty Pharmacy*, AM. PHARMACISTS ASS'N, https://www.pharmacist.com/Practice/Patient-Care-Services/Specialty (last visited Aug. 9, 2025).

[46] PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS, *supra* note 22, at 16.

[47] *Id.*

II. THE PROBLEMS WITH PBMS

A. Market Control

There are not too many PBMs, with only 66 operating in the United States.[48] Of these 66 PBMs, 96% of the market is controlled by only six of them.[49] Of those six, just three PBMs control 80% of the market.[50] These three—CVS Caremark, Express Scripts, and Optum Rx—also operate their own specialty and mail-order pharmacies.[51] PBMs argue that the small number of them is not a problem, and that there is still healthy competition in the PBM market.[52] However, the American Medical Association has been outspoken in its belief that the lack of competition amongst PBMs could be detrimental to patients due to increased drug prices and a lack of innovation.[53] PBMs have also begun vertically integrating with health insurers and pharmacies,[54] allowing PBMs to exert even greater control over the millions of patients for whom they administer prescription plans. By owning pharmacies, PBMs are put in direct competition with other pharmacies in their networks. When negotiating with pharmacies in their networks about the cost of medications, PBMs are incentivized to give the pharmacies they own a better rate than those that are independently owned.[55]

Because only a few PBMs have massive control over the market, any decisions by these PBMs affect millions of people. In 2024, the Federal Trade Commission (FTC) filed an administrative suit against the three largest PBMs, alleging that they worked together to artificially inflate the price of insulin.[56] According to the FTC, CVS Caremark, Express Scripts, and Optum Rx used their control of the market to force drug manufacturers to provide larger rebates to put their medications in a more favorable position on formularies.[57] Even when lower-cost alternatives became available that would save patients money, these PBMs maintained the preferred positioning of the high-cost insulin on formularies because they were making a

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[48] *Id.* at 7.

[49] *Id.*

[50] *Id.*

[51] *Id.*

[52] *See* Richard Payerchin, *PBMs 'Deserve Regulatory Scrutiny' as They Increase Market Share in 2021, AMA Says*, MED. ECON. (Sept. 12, 2023), https://www.medicaleconomics.com/view/pbms-deserve-regulatory-scrutiny-as-they-increase-market-share-in-2021-ama-says.

[53] *Id.*

[54] PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS, *supra* note 22, at 7–8.

[55] *Id.* at 10–11.

[56] Press Release, FTC, FTC Sues Prescription Drug Middlemen for Artificially Inflating Insulin Drug Prices 1 (Sept. 20, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-sues-prescription-drug-middlemen-artificially-inflating-insulin-drug-prices.

[57] *Id.*

larger profit from it.[58] These allegations by the FTC highlight the issues that arise by such a small number of PBMs controlling such a large portion of the market. The lack of competition enables them to make decisions they otherwise could not if they had to fear losing business as a result, and allows them to bully drug manufacturers into giving them what they want—rebates that increase their own earnings.

B. Rebates

Being both the negotiator for the price of medications and the entity that determines how the medication will fit into formularies gives PBMs the ability to manipulate costs for their own gain. Although drug manufacturers are also implicated as possibly helping PBMs with the market manipulation of insulin, the Vice President of Novo Nordisk, a drug manufacturer, has said that PBMs are "'addicted to rebates.'"[59] Through rebates, PBMs will get a discount on medications if they put the medications in a preferred tier.[60] Rebates are frequently calculated as a percentage of the medication's cost set by the manufacturer; so if the medication is more costly for the PBMs, the rebates will also be higher.[61] This benefits the PBMs because, although they are getting the drug for a cheaper price, they are not changing the price for the consumer.[62] The pharmacies and patients pay the same high cost that they would be paying regardless of whether the PBM is getting a rebate.[63] In fact, one study found that an increase in rebates by $1 equated to a $1.17 increase in the medication's list price.[64] This finding shows that rebates are leading to an increase in medication prices starting at the manufacturer that will only perpetuate itself as rebates continue to thrive.

Rebates also play a massive role in how medications are classified on formularies, thus determining whether a patient will have access to them. If a PBM is getting a large rebate for a medication, then the medication is going to be preferred

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[58] *See id.*

[59] *Id.*

[60] Nicole Rapfogel, *5 Things to Know About Pharmacy Benefit Managers*, CTR. FOR AM. PROGRESS (Mar. 13, 2024), https://www.americanprogress.org/article/5-things-to-know-about-pharmacy-benefit-managers.

[61] *Id.*; Martin, *supra* note 4.

[62] *See* Rapfogel, *supra* note 60; Martin, *supra* note 4.

[63] Thomas Waldrop, *How Pharmacy Benefit Managers Are Harming Patients—and What Policymakers Can Do About It*, CENTURY FOUND. (Nov. 7, 2024), https://tcf.org/content/commentary/how-pharmacy-benefit-managers-are-harming-patients-and-what-policymakers-can-do-about-it; *see* NEERAJ SOOD, ROCIO RIBERO, MARTHA RYAN & KAREN VAN NUYS, UNIV. S. CAL. SCHAEFFER INST. FOR PUB. POL'Y & GOV'T SERV., THE ASSOCIATION BETWEEN DRUG REBATES AND LIST PRICES 3 (2020), https://schaeffer.usc.edu/wp-content/uploads/2024/10/SchaefferCenter_RebatesListPrices_WhitePaper-1.pdf.

[64] SOOD ET AL., *supra* note 63, at 3.

by the PBM and, as a result, other, cheaper medications will be less accessible.[65] PBMs will make similar medications more expensive, or just not cover them at all, to encourage patients to receive a specific medication that the PBM is receiving a larger rebate for.[66] This also makes it difficult for cheaper generic drugs to infiltrate the market, as they are without the funds to provide massive rebates to get a preferred placement on a PBM's formulary.[67] A study by the Association for Accessible Medicines found that generic medications are experiencing a delay in reaching the market—and patients—due to PBMs preferring high-cost medications that come with large rebates.[68] The current use of rebates by many PBMs provides no real benefit to patients and instead increases costs for medications in exchange for increasing profits of PBMs.

C. Step Therapy

When a doctor prescribes a medication to a patient, they are prescribing the medication they believe the patient needs based upon a review of their symptoms and oftentimes a physical examination.[69] Through step therapy PBMs can override this individualized recommendation from a doctor by only listing a similar medication that is cheaper for the PBM on the formulary that covers the patient.[70] For the patient's insurance to then cover the cost of the medication the doctor originally prescribed, the patient must take the medication preferred by the PBM and receive no benefits from it—the patient's symptoms must persist despite taking the medication.[71] This delay in receiving the medication that the patient's doctor actually prescribed can lead to poorer health outcomes. In extreme cases, this can result in significant harm to a patient that was entirely avoidable.[72]

Step therapy requirements are applicable to all patients who are prescribed specific medications and fail to take into account an individual patient's

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[65] SARA SIROTA, AM. ECON. LIBERTIES PROJECT, WHY WE SHOULD BAN PBM REBATES 5 (2024), https://www.economicliberties.us/wp-content/uploads/2024/02/20240103-AELP-Rebates-Brief_Final.pdf.

[66] *Id.* at 6.

[67] *Id.* at 7–8.

[68] ASS'N FOR ACCESSIBLE MEDS., MIDDLEMEN INCREASINGLY BLOCK PATIENT ACCESS TO NEW GENERICS 4 (2023), https://accessiblemeds.org/wp-content/uploads/2024/11/AAM-Middlemen-Block-Patient-Access-New-Generics-2023-1.pdf.

[69] *See, e.g.*, Majid Davari, Elahe Khorasani & Bereket MollaTigabu, *Factors Influencing Prescribing Decisions of Physicians: A Review*, 28 ETH. J. HEALTH SCI. 795, 797 (2018) (describing how physicians make prescribing decisions).

[70] PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS, *supra* note 22, at 12, 36.

[71] *Id.* at 36.

[72] Stephanie Lomas, *The Debate Over Step Therapy*, APPLIED POL'Y (June 10, 2023), https://www.appliedpolicy.com/step-therapy (reporting "examples of harm due to optimal treatment delay" across various medical specialties).

circumstances that could make one treatment preferred over another.[73] For example, a doctor may choose to prescribe a medication to a patient knowing that they would be unable to benefit from physical therapy because they have transportation issues.[74] This patient would then have to go through an appeals process with their insurance company, only further elongating the time it takes to receive the medication they need, or else pay full price for the medication.[75]

Step therapy is another way that PBMs can leverage their role of creating formularies when it comes to negotiations with medication manufacturers. PBMs choose which medications a patient must take and fail on, giving them the power to direct patients toward medications that benefit the PBM more than they might benefit the patient.[76] By offering to a manufacturer that their medication will be included in a step therapy requirement for a competing medication, PBMs can negotiate larger rebates.[77] This practice only furthers PBMs' ability to use their market share and position within the healthcare industry to maximize their own profits.[78] The needs of the patient are cast to the side, leading to potentially physical and financial harm to the patient and also a degradation of the doctor-patient relationship.[79]

D. Spread Pricing

Spread pricing is arguably the most egregious practice of PBMs, as it increases prescription medication prices for consumers without even the guise of an added benefit. Spread pricing occurs when a PBM charges a health insurance company (the payor) more than they reimburse the pharmacy for the cost of the drug.[80] For example, a "PBM charges the [payor] $20 for a prescription but only pays $12 to the pharmacy. The PBM keeps the $8 spread as profit, and often does not disclose

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[73] *Id.*

[74] *Id.*

[75] *See id.*; Alex Evans & Alyssa Billingsley, *What is Step Therapy? How to Get Insurance to Pay for Your 'Non-Preferred' Medication*, GOODRX, https://www.goodrx.com/drugs/savings/what-is-step-therapy (Feb. 21, 2023).

[76] *See* Lomas, *supra* note 72.

[77] *Id.*

[78] *See* JENNIFER SNOW, MADELAINE FELDMAN & JENNA KAPPEL, XCENDA, THE IMPACT OF STEP-THERAPY POLICIES ON PATIENTS 15 (2019), https://www.xcenda.com/-/media/assets/xcenda/english/content-assets/white-papers-issue-briefs-studies-pdf/impact-of-step-therapy-on-patients_final_1019.pdf ("Market-dominant manufacturers have an edge in negotiating with payers to disfavor or exclude newer drugs that lack the market share needed to provide a comparable level of rebates from their formulary—even if these newer drugs offer better outcomes for a lower price.").

[79] *Id.* at 4.

[80] PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS, *supra* note 22, at 20.

the spread to the [payor] or pharmacy."[81] The increased costs for health insurance companies are then passed onto the consumer through larger insurance premiums.[82] The prices PBMs are charging health insurance companies and paying pharmacies are often not made public, allowing the practice to exist without any transparency or oversight.[83] As a result, many states, private health insurance companies, and even the federal government have overpaid millions of dollars to PBMs.

Centene, a PBM based in Ohio, settled a lawsuit for $88.3 million brought by the state's Attorney General alleging that the PBM had artificially inflated prescription medication prices.[84] An investigation into Centene's practices found that, on average, the PBM was pocketing $5.71 per prescription.[85] Centene was making more from generic medications that accounted for over 86% of prescriptions, with an average spread of $6.14.[86] In total, Centene's spread pricing practices in Ohio cost the state nearly $225 million in taxpayer funds.[87] Through an investigation carried out by the Office of the Inspector General in Washington, D.C., officials learned that the PBM Washington, D.C., contracted with for their Medicaid program overcharged the District by over $20 million through spread pricing between 2016 and 2019.[88] The PBM was hiding this amount it earned through spread pricing amongst the other various fees it charged.[89] This combination of fees and spread-priced profits was comingled on an individual line item on each report provided to state officials during the investigated period.[90]

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[81] *Id.* at 20–21, fig.8.

[82] *What Is Spread Pricing?*, SMITHRX (Aug. 14, 2024), https://www.smithrx.com/blog/what-is-spread-pricing.

[83] Stephen Barlas, *Employers and Drugstores Press for PBM Transparency*, 40 PHARMACY & THERAPEUTICS 206, 206 (2015).

[84] Press Release, Ohio Att'y Gen., Centene Agrees to Pay a Record $88.3 Million to Settle Ohio PBM Case Brought by AG Yost (June 14, 2021), https://www.ohioattorneygeneral.gov/Media/News-Releases/June-2021/Centene-Agrees-to-Pay-a-Record-$88-3-Million-to-Se.

[85] DAVE YOST, OHIO AUDITOR OF STATE, OHIO'S MEDICAID MANAGED CARE PHARMACY SERVICES 2 (2018), audits.ohioauditor.gov/Reports/AuditReports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf.

[86] *Id.* at 2–3.

[87] RACHEL DOLAN & MARINA TIAN, KFF, MANAGEMENT AND DELIVERY OF THE MEDICAID PHARMACY BENEFIT 6 (Dec. 2019) (citing YOST, *supra* note 85).

[88] OFF. OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUM. SERVS., REP. NO. A-03-20-00200, THE DISTRICT OF COLUMBIA HAS TAKEN SIGNIFICANT STEPS TO ENSURE ACCOUNTABILITY OVER AMOUNTS MANAGED CARE ORGANIZATIONS PAID TO PHARMACY BENEFIT MANAGERS 2, 5 (2023) https://oig.hhs.gov/documents/audit/6855/A-03-20-00200-Complete%20Report.pdf.

[89] *Id.* at 5.

[90] *Id.*

Exactly how much has been overpaid by the U.S. government to PBMs through Medicare Part D[91] plans is largely unknown. A 2019 report from the United States Government Accountability Office had an optimistic outlook and concluded that the federal government had overpaid minimal amounts in the years prior.[92] This report estimated that PBMs had made a mere $300,000 from spread pricing in 2016 and did not make any revenue from spread pricing in 2014 or 2015.[93] However, the results of a study done in 2021 point to a different conclusion.[94] Researchers analyzed the costs of 45 commonly-prescribed medications that more than one million Medicare recipients take to determine where the revenue was going.[95] They found more than 40% of monies paid for these medications were going to PBMs, whereas the pharmacies were only making 17% and manufacturers 30%.[96] This drastic difference between what PBMs are making per prescription and what manufacturers and pharmacies are making per prescription is indicative of PBMs utilizing spread pricing in Medicare plans.

Spread pricing also negatively impacts pharmacies, as they are reimbursed at a lower rate. In addition to PBMs funneling patients to the pharmacies they own or that are in their network, smaller pharmacies must submit to PBMs to survive. Pharmacies' dependence on PBMs allows PBMs to implement opaque policies that can hurt a pharmacy's business and even lead to closure. Reimbursement rates change daily, providing little stability when it comes to ensuring a pharmacy's operational costs can be met. In some cases, the rates at which PBMs reimburse pharmacies are less than the actual cost of the medication itself, forcing the pharmacy to absorb the cost.[97]

Spread pricing has been such a large focus in recent years that it has become one of the main issues states are seeking to cure through the legislative regulation of

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[91] Medicare Part D is an optional add-on to Medicare that provides prescription drug coverage for Medicare recipients. Medicare Part D plans are administered by private insurance companies that contract with the federal government. *What's Medicare Drug Coverage (Part D)?*, MEDICARE.GOV, https://www.medicare.gov/health-drug-plans/part-d (last visited Aug. 12, 2025).

[92] U.S. GOV'T ACCOUNTABILITY OFF., GAO-19-498, MEDICARE PART D: USE OF PHARMACY BENEFIT MANAGERS AND EFFORTS TO MANAGE DRUG EXPENDITURES AND UTILIZATION 17 (2019).

[93] *Id.*

[94] *See generally* T. Joseph Mattingly & Kenechukwu C. Ben-Umeh, *Pharmacy Benefit Manager Pricing and Spread Pricing for High-Utilization Generic Drugs*, JAMA HEALTH F., Oct. 10, 2023.

[95] *Id.* at 1.

[96] *Id.* at 1–2.

[97] PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS, *supra* note 22, at 23.

PBMs.[98] To fully rein in and restrict PBMs to their foundational purposes—minimizing the cost of, and increasing access to, prescription medications—both states and the federal government must use their regulatory powers.

III. REGULATING PBMS

There is currently minimal federal regulatory oversight of PBMs. In the federal realm, PBMs are only regulated when administering prescription drug plans through a Medicare health plan, known as Medicare Part D.[99] These federal regulations do not limit PBMs' practices or restrict their ability to take advantage of consumers.[100] Rather, these regulations simply require that PBMs report:

> (1) The percentage of all prescriptions that were provided under the QHP through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed;
>
> (2) The aggregate amount, and the type of rebates, discounts or price concessions (excluding *bona fide* service fees) that the pharmacy benefits manager (PBM) negotiates that are attributable to patient utilization under the QHP, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the QHP issuer, and the total number of prescriptions that were dispensed.
>
> . . .
>
> (3) The aggregate amount of the difference between the amount the QHP issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.[101]

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[98] *See* Dorthula H. Powell-Woodson, Brooke M. DeLoatch & Jordan Ross, *Proposed State and Federal PBM Legislation: Is There Reason for Action Now?*, WILEY (May 1, 2024), https://www.wiley.law/alert-Proposed-State-and-Federal-PBM-Legislation-Is-There-Reason-for-Action-Now (stating that "[s]pread pricing is one of the main PBM practices being targeted in ongoing federal and state legislation").

[99] *See* 45 C.F.R. § 184.50 (2023); NAT'L ASS'N OF INS. COMM'RS, A GUIDE TO UNDERSTANDING PHARMACY BENEFIT MANAGER REGULATION AND ASSOCIATED STAKEHOLDER REGULATION 13, 16–17 (2023), https://content.naic.org/sites/default/files/pmbwhitepap.pdf. PBMs are also subject to certain laws, such as antitrust, as discussed *supra* Section II.B.

[100] *See generally* Medicare Contract Year 2023 Policy and Technical Response to COVID-19 Public Health Emergency, 87 Fed. Reg. 27704, 27850 (May 9, 2022) (to be codified at 42 C.F.R. pt. 423) (implementing technical changes to Medicare Part D administration, including pharmacy price concessions and negotiated price definitions, without imposing comprehensive restrictions on PBM business practices such as spread pricing, rebate retention, or formulary manipulation).

[101] 45 C.F.R. § 184.50(a)(1)–(3) (2023).

Additional reporting requirements are found in the Social Security Act that require more specific data from PBMs, but these regulations also do not restrict PBMs' practices outright.[102]

Although reporting statistics, such as those above, are said to increase transparency and thus improve PBMs' business practices to be more consumer friendly,[103] this has not been the case. In 2017, the Centers for Medicare and Medicaid Services (CMS) found that PBMs were not reporting Direct and Indirect Remuneration (DIR) fees that were increasing the out-of-pocket prices for prescription medications.[104] DIR fees are functionally a PBM's way of charging pharmacies after-the-fact, as a means to increase their own profits.[105] PBMs are now required to be transparent regarding DIR fees and include them in the negotiated price paid by patients.[106] However, PBMs have responded by decreasing the reimbursement rates for pharmacies, which has increased the out-of-pocket costs for consumers.[107]

Federal legislation has been proposed that sought to remedy PBMs' abuse of consumers, but none of these bills have passed. In 2023, the Pharmacy Benefit Manager Transparency Act of 2023 was introduced in the Senate.[108] With a focus on PBMs' predatory practices, this bill would have prohibited the use of spread pricing and unfair DIR fees entirely.[109] The punishment for engaging in either of these practices would have been a fine up to $1 million.[110] Greater oversight of PBMs would have been implemented that included reviewing PBMs' creation of formularies and requiring them to identify whether their formulary arrangement increased their own profit without decreasing prices for consumers.[111] This bill has

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[102] *See, e.g.*, 42 U.S.C. § 1395w-104.

[103] PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS, *supra* note 22, at 49–50.

[104] *See id.* at 14.

[105] *Id.* at 12–13. For example, a pharmacy distributes a drug to a patient and charges that patient $100. The PBM reimburses the pharmacy $95 for the cost of the drug, of which the pharmacy has to pay the manufacturer $90. Sometime later, the PBM charges the pharmacy a DIR fee of $15, leaving the pharmacy with a net income of -$10. *Id.* at 13 fig.4.

[106] Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 87 Fed. Reg. 27704, 27850 (May 9, 2022) (to be codified at 42 C.F.R. pt. 423); PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS, *supra* note 22, at 15.

[107] PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS, *supra* note 22, at 15.

[108] Pharmacy Benefit Manager Transparency Act of 2023, S. 127, 118th Cong. (as introduced to Senate, Jan. 26, 2023).

[109] *Id.* § 2(a)(1).

[110] *Id.* § 6(a)(3)(A).

[111] *Id.* § 4(a).

not made it past the Senate.[112] Also in 2023, Senator Bernie Sanders introduced the Pharmacy Benefit Manager Reform Act in the Senate.[113] This bill sought to establish additional reporting requirements, as well as outright prohibit spread pricing and require pass-through pricing for both Medicare Part D plans and employer-sponsored plans.[114] Unfortunately, this bill also never made it out of the Senate.[115] Most recently, sweeping legislation dubbed the One Big Beautiful Bill Act was expected to finally protect consumers from PBMs, including banning PBMs from engaging in spread pricing for Medicaid administered health plans.[116] But, to the detriment of American consumers, Congress eliminated these protections from the Bill before it was ultimately signed into law.[117]

With minimal federal oversight of PBMs, each state has taken it upon itself to regulate the pharmaceutical middlemen. All 50 states have passed some legislation that seeks to make PBMs' practices more transparent.[118] While most states have only passed legislation that requires PBMs to be licensed by the state and report certain earnings, some states have gone beyond mere transparency by also restricting practices of PBMs that harm consumers, such as spread pricing.[119] However, the way states have gone about providing these protections for consumers has differed.

A. Florida

Prior to 2018, Florida had very limited regulations on PBMs and did not even require them to register with the state. When Florida began requiring PBMs to register with the state, the registration process guaranteed a PBM was granted a registration certificate so long as they filled out the form correctly and paid a nominal fee.[120] This registration did need to be updated every two years, but there was no punishment for failing to register.[121] The first steps to restrict PBMs came in 2018 when PBMs were banned from charging a consumer more for a prescription drug than the drug would cost without prescription drug coverage and were required

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[112] *S.127 - Pharmacy Benefit Manager Transparency Act of 2023*, CONGRESS, https://www.congress.gov/bill/118th-congress/senate-bill/127 (last visited Aug. 12, 2025).

[113] Pharmacy Benefit Manager Reform Act, S. 1339, 118th Cong. (as introduced to Senate, Apr. 27, 2023).

[114] *Id.*

[115] *S.1339 - Pharmacy Benefit Manager Reform Act*, CONGRESS, https://www.congress.gov/bill/118th-congress/senate-bill/1339/all-actions (last visited Aug. 12, 2025).

[116] H.R. 1, 119th Cong. § 44124 (as reported in House, May 20, 2025).

[117] *See* H.R. 1, 119th Cong. (2025) (enacted).

[118] *See State Laws Passed to Lower Prescription Drug Costs: 2017–2024*, NAT'L ACAD. FOR STATE HEALTH POL'Y, https://nashp.org/state-tracker/state-drug-pricing-laws-2017-2024 (July 23, 2025).

[119] Sixteen states restrict PBMs' use of spread pricing. *See id.*

[120] *See* FLA. STAT. § 624.490(2)–(4) (2018); 2018 Fla. Laws ch. 91, at 1–2.

[121] *See* FLA. STAT. § 624.490(5) (2018).

to update their prices in a timely manner based on market changes.[122] Outside of these minimal confines and a few others, PBMs were free to act in their own best interest. In 2022, Florida passed additional legislation that created a fine for failing to register with the state.[123] However, this legislation, which remains in effect, again failed to do anything more than provide a minimal level of oversight of PBMs.

More recently, in 2023, Florida passed the Prescription Drug Reform Act that was largely focused on regulating and restricting PBMs.[124] As of 2024, PBMs must apply for and obtain a certificate of authority that allows them to act as an administrator in the state.[125] PBMs must be more transparent and make all of their contracts and subcontracts with pharmacies available for review by the state.[126] Since PBMs often operate their own pharmacies, they must identify this ownership even if the pharmacy is operated by an intermediary.[127] Striking at the heart of how they profit from consumers, this Act requires that all contracts PBMs enter into for prescription drug services must include a pass-through pricing model.[128] By using this pass-through pricing model, Florida can deter PBMs from engaging in spread pricing as they pass on all savings from rebates to consumers.[129] If the rebate is so large that the PBM makes a profit even after passing the savings on to the consumer, they must reinvest these earnings into minimizing copays and deductibles.[130] Florida already had a protocol in place to limit the use of step therapy for medications a patient has been prescribed and approved for in the past, but until the passage of this Act it was not applicable to PBMs.[131] Now, PBMs are prohibited from requiring step therapy if a patient underwent step therapy and received the prescribed medication in previous years, regardless of whether a different health plan provided the authorization.[132]

With the passage of the Prescription Drug Reform Act, PBMs in Florida are less able to take advantage of consumers through backroom dealings and artificially inflated drug prices. With one bill, Florida was able to minimize the harmful practices of PBMs and rein in businesses that have gone far too long without

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[122] *See* FLA. STAT. § 627.64741 (2018); 2018 Fla. Laws ch. 91, at 2–3.

[123] 2022 Fla. Laws ch. 200, at 3; FLA. STAT. § 624.490(6) (2024).

[124] *See* Prescription Drug Reform Act, 2023 Fla. Laws ch. 29; FLA. STAT. §§ 626.8805, 626.8825 (2024).

[125] 2023 Fla. Laws ch. 29, 11–12; FLA. STAT. § 626.8805(1) (2024).

[126] 2023 Fla. Laws ch. 29, at 12; FLA. STAT. § 626.8805(4)(a)–(b) (2024).

[127] 2023 Fla. Laws ch. 29, at 13; FLA. STAT. § 626.8814(2) (2024).

[128] 2023 Fla. Laws ch. 29, at 16; FLA. STAT. § 626.8825(2)(a), (d) (2024).

[129] *See* FLA. STAT. § 626.8825(2)(a), (d) (2024).

[130] *Id.* § 626.8825(2)(d).

[131] *Step Therapy Protocols Restricted*, NFP (Apr. 12, 2022), https://www.nfp.com/insights/step-therapy-protocols-restricted; 2023 Fla. Laws ch. 29, at 27; FLA. STAT. § 627.42393(5) (2024).

[132] 2023 Fla. Laws ch. 29, at 27–28; FLA. STAT. § 627.42393(5) (2024).

adequate regulation. Many states have yet to take this approach and have instead passed regulations piecemeal, such as Colorado.

B. Colorado

Colorado first passed legislation regulating PBMs in 1999.[133] This legislation was applicable to its state-employee health plans and only required that PBMs contract with any non-mail-order pharmacy so long as the pharmacy agreed to the terms established by the PBM.[134] In 2001, Colorado slightly amped up its regulation by disallowing PBMs from transferring a consumer's prescription away from the pharmacy of the consumer's choosing.[135] Transparency increased in 2015 when Colorado passed a law that allowed pharmacies to obtain information from PBMs regarding how PBMs create pricing lists, and created an appeal process for pharmacies should they believe they are being reimbursed unfairly.[136] Consumers received some protections in 2018 through a law that prohibits PBMs from disallowing the pharmacies they contract with from informing consumers of a lower-cost alternative to the medication they were prescribed.[137] This law also caps the amount a patient can pay for a prescription at the amount a pharmacy gets reimbursed.[138]

In more recent years, Colorado has taken an active approach toward restricting PBMs' practices that directly harm consumers and small businesses. To deter PBMs from funneling consumers to the pharmacies they have an ownership interest in, Colorado enacted legislation that prohibits PBMs from reimbursing unaffiliated pharmacies at a lower rate than they reimburse affiliated ones.[139] Shortly thereafter, another bill was passed that made it unlawful for PBMs to limit a patient's access to prescription medications at any in-network pharmacy.[140] This bill also created a process consumers can use to obtain "cost, benefit, and coverage data" from the PBM that administers their prescription drug plans.[141] To stop PBMs from manipulating formularies to benefit themselves, Colorado restricts PBMs from removing a drug from a formulary and replacing it with a higher-cost drug in the midst of a plan year.[142] PBMs are also required to make their step therapy policies

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[133] 1999 Colo. Sess. Laws ch. 117; COLO. REV. STAT. § 24-51-1202(1)(b) (2024).

[134] 1999 Colo. Sess. Laws ch. 117; COLO. REV. STAT. § 24-51-1202(1)(b) (2024).

[135] 2001 Colo. Sess. Laws ch. 310; COLO. REV. STAT. § 10-16-122(4)(a) (2024).

[136] 2014 Colo. Sess. Laws ch. 362; COLO. REV. STAT. § 10-16-122.6(1)(a), (3) (2024).

[137] 2018 Colo. Sess. Laws ch. 181, at 1233–34; COLO. REV. STAT. § 10-16-122.7(3)(a) (2024).

[138] 2018 Colo. Sess. Laws ch. 181, at 1234; COLO. REV. STAT. § 10-16-122.7(3)(c) (2024).

[139] 2020 Colo. Sess. Laws ch. 98, at 381; COLO. REV. STAT. § 10-16-122.3(1)(a) (2024).

[140] 2021 Colo. Sess. Laws ch. 452, at 2992; COLO. REV. STAT. § 10-16-122.1(3)(a) (2024).

[141] 2021 Colo. Sess. Laws ch. 452, at 2994; COLO. REV. STAT. § 10-16-122.9(1)(a) (2024).

[142] 2022 Colo. Sess. Laws ch. 184, at 1229; COLO. REV. STAT. § 10-16-122.4(1)(a) (2024).

public, and provide exemptions to step therapy when the patient has already taken the prescribed medication or been unsuccessful on other, similar medications.[143] A bill signed into law in 2023 restricts PBMs from charging a health plan an amount that is higher than the amount they are reimbursing the pharmacy, functionally prohibiting spread pricing.[144] It was also in 2023 that Colorado finally passed legislation that requires PBMs to register with the state prior to conducting business.[145]

Over the past 25 years, Colorado has taken incremental steps toward protecting consumers from PBMs. However, it has only been in the past couple of years it has actually restricted PBMs from engaging in the practices that harm consumers most, such as spread pricing. Unlike Florida, Colorado chose to pass these restrictions in independent bills, with each providing one or two protections for consumers. The approaches that Colorado and Florida have taken to reining in PBMs differ, yet the underlying motivations by both states remain constant—PBMs need to be restricted in order to reduce prescription drug costs for consumers. With the majority of states having this same belief about PBMs, it is surprising that some states have yet to meaningfully restrict PBMs from engaging in harmful practices, such as Oregon.

C. Oregon

Compared to Florida and Colorado, Oregon allows PBMs to run wild. Oregon laws did not even mention PBMs until 2003.[146] The first mention of PBMs was actually to codify the use of them to administer prescription drug plans for the state's Medicaid program.[147] In 2009, Oregon put reporting requirements on PBMs.[148] This reporting requirement was not to identify how PBMs were profiting from prescription drugs, rather, the law merely required PBMs to report "capital projects," which are basically costly construction endeavors.[149] Oregon then began requiring PBMs to register with the state prior to conducting business in 2013.[150] However, this registration simply required a nominal fee as well as a registration

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[143] 2022 Colo. Sess. Laws ch. 184, at 1231–32; COLO. REV. STAT. § 10-16-145(3), (4)(a) (2024).

[144] 2023 Colo. Sess. Laws ch. 158, at 684; COLO. REV. STAT. § 10-16-163(1) (2024).

[145] 2023 Colo. Sess. Laws ch. 160, at 694; COLO. REV. STAT. § 10-16-122.1(2.5)(a) (2024).

[146] *See* OR. REV. STAT. § 414.312(1)(a) (2003) (defining "pharmacy benefit manager" for the first time in Oregon statutory law as part of the Oregon Prescription Drug Program establishment).

[147] 2003 Or. Laws ch. 810, § 13 (enacting OR. REV. STAT. § 414.744(1)) (repealed 2009 Or. Laws ch. 595, § 1204).

[148] 2009 Or. Laws ch. 595, §§ 1197, 1198; OR. REV. STAT. §§ 442.361, 442.362 (2024).

[149] 2009 Or. Laws ch. 595, §§ 1197, 1198; OR. REV. STAT. §§ 442.361, 442.362 (2024).

[150] 2013 Or. Laws ch. 570, § 3; OR. REV. STAT. § 735.532(1) (2023).

form, but did not involve thoroughly vetting the PBM or its practices.[151] It was not until 2017 that Oregon established a process by which a PBM can be denied registration or have their registration suspended or revoked for conduct such as criminal behavior or failing to produce required documentation.[152] Much like Colorado, it has only been in the past few years that Oregon has started restricting PBMs.

In 2019, Oregon began prohibiting PBMs from requiring consumers to get certain medications via mail-order pharmacies.[153] Through this legislation, Oregon was able to minimize the power PBMs have to direct consumers to PBM-owned pharmacies. Four years later, in 2023, Oregon passed legislation that requires formularies to have alternative medications listed, including a generic version, for all medications where PBMs cap the amount they will reimburse a pharmacy. These caps are known as "maximum allowable costs."[154] Maximum allowable costs, if unregulated, decrease the amount a pharmacy will be reimbursed for medications that the PBM sets a maximum allowable cost for, without minimizing the cost of the drug for the pharmacy.[155] In 2024, Oregon enacted legislation that allows consumers to get their prescription from any pharmacy they choose, regardless of whether that pharmacy is preferred by the PBM.[156] By doing so, Oregon has provided its citizens freedom to choose the pharmacy they go to, and restricts PBMs from directing patients to their own pharmacies.

Oregon has highlighted the damages of tactics such as spread pricing as recently as 2024,[157] but no law has been passed that prohibits the practice. A piece of legislation introduced in the Oregon legislature in 2024 included a definition of spread pricing.[158] Unfortunately, that definition was not included as part of a prohibition on the practice.[159] Instead, this bill, as passed, only requires PBMs to report the amount they earn from spread pricing.[160]

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[151] 2013 Or. Laws ch. 570, § 3; OR. REV. STAT. § 735.532(1) (2023).

[152] 2017 Or. Laws ch. 73, § 2; OR. REV. STAT. § 735.533(1) (2023).

[153] 2019 Or. Laws ch. 526, § 2; OR. REV. STAT. § 735.536(2)(a) (2023).

[154] H.B. 4149, 2024, 82d Leg., Reg. Sess. (Or. 2024).

[155] *See* OHIO PHARMACISTS ASS'N, THE NEED FOR MAXIMUM ALLOWABLE COST (MAC) PHARMACY PRICING REFORM (last visited Aug. 12, 2025), https://www.ohiopharmacists.org/aws/OPA/asset_manager/get_file/99424.

[156] 2024 Or. Laws ch. 24, § 2.

[157] *Ore. Enacts PBM Licensure Bill*, NAT'L CMTY. PHARMACISTS ASS'N (Apr. 22, 2024), https://www.ncpa.org/newsroom/qam/2024/04/22/ore-enacts-pbm-licensure-bill (noting that Oregon's HB 4149, enacted in 2024, "requires PBM licensure, transparency and reporting to identify spread pricing" without prohibiting the practice); *see* Enrolled H.B. 4149, 82d Leg., Reg. Sess. (Or. 2024).

[158] 2024 Or. Laws ch. 87, § 8.

[159] *Id.*

[160] *Id.*

Much like Florida and Colorado, Oregon is aware that PBMs are a problem. A 2023 report from Oregon's Prescription Drug Affordability Board noted that PBMs' use of spread pricing and rebates has a negative effect on the prescription drug market.[161] Yet, even with this knowledge, the legislature still declined to actually prohibit spread pricing a year later. Without such protections, Oregonians are at the whims of PBMs who may choose to increase the price for a medication or make generic medications nearly impossible to obtain.[162] With the heightened level of attention paid toward PBMs, and an understanding of their practices that can harm consumers, Oregon is doing a disservice to its citizens by failing to provide adequate protections.

CONCLUSION

In theory, PBMs can be beneficial. They are able to negotiate drug prices on behalf of millions of individuals, which greatly strengthens their position during these negotiations compared to each individual health plan negotiating alone. If there were not such collective negotiations, health plans with a lower number of enrollees would be unable to negotiate reasonable prices because their bargaining power would be minimal. PBMs are also able to efficiently review and pay out claims for prescription drug medications as it is one of their sole functions. Leaving this to health insurance companies alone would likely lead to delays in claims processing as they will have to institute new procedures that may be bogged down by the massive amount of claims they process for actual medical treatment.

Even with the positive aspects of PBMs taken into account, the practices they engage in across wide swaths of the country are directly harming consumers as well as small businesses. The federal government has thus far been unwilling to actually institute regulations that will minimize the effect PBMs have on increasing prescription medication prices, so individual states must spring into action. Many states have already done so, yet others such as Oregon have failed to meaningfully protect their citizens from PBMs. As shown by Florida and Colorado, there is not one right way of doing this—states can choose to pass piecemeal legislation or simply enact one larger bill that restricts PBMs. Until practices such as spread pricing, step therapy, and unreported rebates are outright prohibited through legislation, PBMs will continue to thrive. Oregon, and states like it, should use the momentum created by others to finally outlaw these practices.

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[161] STAFF OF OR. PRESCRIPTION DRUG AFFORDABILITY BD., GENERIC DRUG REPORT PURSUANT TO SENATE BILL 844 (2021), at 11, 14 (2024), https://dfr.oregon.gov/pdab/Documents/reports/PDAB-Generic-Drug-Report-2024.pdf.

[162] *Id.* at 17.