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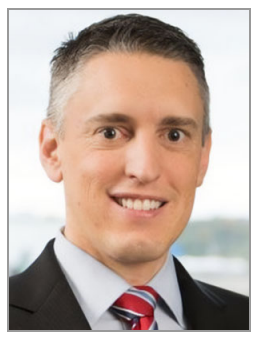
A Shift In How Policymakers Are Approaching PBM Regulation

By **Brad Gallagher and Alix Hirsh** (July 31, 2026, 5:55 PM EDT)



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Recent federal and state legislative and regulatory activity involving pharmacy benefit managers may bring some much-needed good news for independent pharmacies.

In just the past few months, the Federal Trade Commission **settled** a major antitrust matter with CVS Caremark, Florida's attorney general **opened** an investigation into Caremark's competitive practices, Congress introduced legislation to bar common ownership of PBMs and pharmacies, and the Consolidated Appropriations Act of 2026 **imposed** new Medicare-related PBM requirements. Together, these actions indicate a heightened focus on PBM oversight and regulation at multiple levels of government.

For decades, independent pharmacies have been an essential component of the nation's healthcare infrastructure, offering accessible medication services, personalized counseling, chronic disease support and pharmacist-led care within communities. These pharmacies often serve as a critical access point in areas with limited pharmacy options, including communities affected by pharmacy closures and pharmacy deserts in rural and urban settings.

As policymakers increasingly focus on pharmacy access, preserving community-based pharmacies has become a central consideration in the broader pharmacy benefit manager reform debate.

Independent pharmacies also have operated in an increasingly challenging marketplace where PBMs occupy multiple roles within the prescription drug supply chain: claims administrators, reimbursement decision-makers, formulary managers and — through affiliated retail, mail-order and specialty pharmacies — competitors.

Critics have argued that this vertical integration has allowed PBMs to significantly influence reimbursement methodologies, network participation, patient steering and pharmacy audits, increasing the financial pressure accelerating pharmacy market consolidation.

The regulatory landscape, however, is changing rapidly. The policy debate increasingly centers not only on drug costs and reimbursement but also on whether the current prescription drug supply chain structure supports a sustainable community pharmacy network capable of serving patients where they live.

Since early 2026, Congress, federal regulators, the Federal Trade Commission and state authorities have taken significant steps to increase PBM business practices oversight.

The CAA imposes new transparency and compensation requirements on PBMs participating in Medicare Part D.[1]

Separately, the U.S. Department of Labor has taken steps affecting PBM disclosures and transparency obligations for health plans covered by the Employee Retirement Income Security Act.

The FTC also has taken increasingly aggressive action involving the nation's largest PBMs, addressing alleged competitive concerns within PBM business practices, while states have pursued broader reforms through legislation, insurance regulation, attorney general enforcement, pharmacy board oversight and litigation.

FTC scrutiny of PBM practices reflects a separate but related federal focus on competition, consolidation and incentives within the prescription drug supply chain. Following its multiyear inquiry into PBM business practices, the FTC's July 2024 interim report identified concerns regarding vertical integration, rebate arrangements, fees charged to pharmacies and PBM practices' impact on independent pharmacies.

The agency also has pursued enforcement against the three largest PBMs. In February, it announced a landmark **settlement** with Express Scripts requiring significant changes to certain rebate, formulary and transparency practices. The agency has also reached proposed resolutions or initiated consent proceedings involving Optum Rx and CVS Caremark, reflecting an increasingly active federal enforcement posture toward PBM business practices.[2]

Together, these various developments reflect a shift from transparency-focused oversight to PBM compensation structures, vertical integration and competitive effects. State investigations, including Florida's inquiry, are addressing competition concerns through antitrust and consumer protection authorities.

Although many of the CAA's Medicare Part D provisions will become effective beginning in 2028, states have already begun reshaping the PBM landscape through reforms that often address issues outside the scope of the federal legislation.

These include regulatory initiatives; investigations; enforcement proceedings; and court challenges addressing reimbursement practices, patient steering, pharmacy access and vertical integration. PBMs have responded with constitutional, statutory preemption and administrative law challenges that may define the future scope of PBM regulation.

For independent pharmacies, the central issue is whether regulatory changes can help preserve patient access to local pharmacy services at a time when communities nationwide are experiencing reduced pharmacy availability. The answer will depend on the substance of new laws and regulations, how courts define the limits of state authority, and how PBMs adapt their business models.

States Lead PBM Regulation Reshaping

States have become primary drivers of near-term PBM reform and controversy. Federal reforms often require lengthy implementation periods, but states can respond more quickly through legislation, regulation and enforcement directed at specific market practices.

Unlike the federal reforms, state initiatives in multiple forms have targeted the day-to-day market practices independent pharmacies and patients encounter across both government and commercial markets.

State legislatures have enacted laws addressing reimbursement methodologies, spread pricing, patient steering and ownership structures. Some have begun using existing antitrust, consumer protection and insurance oversight authority to examine PBM conduct. Insurance departments are regulating PBM contracting and network practices.

Attorneys general have pursued investigations and enforcement actions involving competition and consumer protection concerns. Pharmacy boards and other regulators have also overseen PBM-related practices affecting pharmacies within their jurisdictions.

The result is a patchwork of state approaches addressing concerns that PBM market concentration and vertical integration may limit pharmacy choice, increase administrative burdens and contribute to reduced access to community pharmacy services.

Tennessee: Vertical Integration

Among the most aggressive state efforts is Tennessee's recent attempt to directly address PBM ownership structures.

In May, Gov. Bill Lee signed the Freedom, Access, and Integrity in Registered Pharmacy Act, which will begin phased implementation in 2028. It will restrict certain ownership and control relationships involving PBMs, pharmacies and health plans operating within Tennessee.

Specifically, it bars any entity from holding more than a 5% simultaneous interest in a pharmacy and either a PBM or health insurance provider, effective July 1, 2028, subject to applicable statutory definitions, exemptions and implementation requirements. PBMs must demonstrate clear divestiture efforts to unaffiliated entities by Dec. 31, 2028.

The law reflects a growing concern among policymakers that PBM ownership of affiliated pharmacies may incentivize favoring those entities through network design, reimbursement decisions and patient steering practices.

CVS Caremark and Express Scripts have challenged the statute.

On May 22, CVS Caremark filed suit in the U.S. District Court for the Middle District of Tennessee seeking declaratory and injunctive relief, arguing that the law violates constitutional protections, including the dormant commerce clause. Among other arguments in CVS Pharmacy Inc. v. Tennessee Board of Pharmacy, Caremark contends that the law improperly burdens interstate commerce by requiring changes to its existing business structure.

Express Scripts' separate challenge — Express Scripts Inc. v. Tennessee State Board of Pharmacy, filed on June 12 — emphasizes the potential impact on specialty pharmacy services provided through its affiliate, Accredo, arguing that restricting its integrated model could affect patients who rely on specialty medications and related clinical support services.

This litigation will test whether states may regulate PBM ownership structures directly or whether constitutional protections — including interstate commerce principles — or federally regulated healthcare arrangements may limit these efforts.

Illinois: State PBM Oversight

Illinois has focused on PBM business practices.

In July 2025, Gov. JB Pritzker signed the Prescription Drug Affordability Act, which includes provisions addressing spread pricing, patient steering, rebate arrangements and PBM reporting requirements. It is part of Illinois' broader effort to regulate PBM practices affecting prescription drug affordability and pharmacy access. Unlike Tennessee, the Illinois law seeks to regulate economic and operational practices influencing how patients access prescription medications and how pharmacies are reimbursed.

The Pharmaceutical Care Management Association — the PBM national trade group — challenged the law in the U.S. District Court for the Central District of Illinois, arguing that portions of the statute are preempted by ERISA and impermissibly interfere with employer-sponsored health plan administration.

The case — Pharmaceutical Care Management Association v. Gillespie, filed on June 16 — will test how far states may go in regulating PBM conduct in commercial markets. The litigation also highlights a key legal question: where permissible state regulation of PBM business practices ends and impermissible regulation of employee benefit plan design begins.

The 2020 landmark U.S. Supreme Court decision in Rutledge v. Pharmaceutical Care Management Association confirmed that states may regulate certain PBM reimbursement practices without triggering ERISA preemption. However, in PCMA v. Mulready in 2023, the U.S. Court of Appeals for the Tenth Circuit demonstrated that state regulation may face limits when it dictates plan administration, network design or benefit structures.

These and future state PBM cases will likely continue defining that boundary.

Oklahoma: State Enforcement

Through the Oklahoma Attorney General's Office's PBM Compliance and Enforcement Unit, state officials have used existing authority to investigate reimbursement, audit and transparency concerns affecting pharmacies.

In December 2025, Attorney General Gentner Drummond announced a settlement with CVS Caremark resolving allegations that certain reimbursement practices resulted in reimbursement to Oklahoma pharmacies below acquisition cost.

The settlement provided more than $5 million in payments to pharmacies for approximately 68,000 prescriptions filled between January 2024 and August 2025.[3] The settlement resolved the allegations without an admission of wrongdoing.

Oklahoma's attorney general has also pursued broader challenges involving PBM audit and reimbursement practices. In March, the office announced a settlement with Script Care following a review of pharmacy audits, resulting in payments to impacted pharmacies and additional oversight requirements.[4] In another matter, the attorney general directed Optum Rx to stop "illegal, retroactive reimbursement clawbacks" involving Oklahoma pharmacies.[5]

Unlike legislative reforms that may take years to implement, such enforcement actions can provide more immediate remedies for pharmacies while also shaping future PBM compliance expectations.

State attorneys general, insurance regulators and other enforcement authorities are increasingly using existing statutory tools to address reimbursement practices and protect pharmacy access. For independent pharmacies, these actions provide more immediate relief while broader legislative and regulatory reforms continue to develop.

Florida: Competition Enforcement

Florida has employed another emerging approach: using antitrust and consumer protection authority to examine PBM market practices.

In June, Florida Attorney General James Uthmeier issued a civil investigative demand to CVS Health Corporation and Caremark, probing potential anticompetitive practices affecting Florida consumers and pharmacies.

The investigation focuses on CVS Health's ownership of both Caremark and CVS retail pharmacies, and seeks information regarding whether the company's vertically integrated structure could influence competition, pharmacy choice and access to prescription medications.[6] The action reflects a broader trend among state officials: evaluating PBM conduct through competition and consumer protection frameworks.

Although the investigation remains ongoing, it represents another potential avenue for examining the competitive effects of vertically integrated PBM models: antitrust investigations to determine how PBMs operate within the prescription drug marketplace.

The Litigation Battle Ahead

The future of PBM reform will likely be shaped not only by legislation and regulation but also by litigation, competition enforcement and settlement agreements, as well as how courts and regulators define the limits of PBM market power. As states pursue broader restrictions on PBM practices, PBMs have responded with constitutional, ERISA preemption and administrative law challenges seeking to limit state authority.

The central question in many of these cases is how far states may regulate PBM business practices without conflicting with federal law,

exceeding constitutional limits or improperly interfering with federally regulated health plans or interstate commerce. Prior decisions have confirmed states' authority to regulate certain PBM reimbursement practices but indicated limits on that authority when they affect plan administration or pharmacy network design.

Because PBMs generally operate through national business models, these cases will likely influence PBM regulation and pharmacy contracting practices well beyond the jurisdictions where they are litigated.

Conclusion

The current wave of PBM reform represents a significant shift in how policymakers, regulators and courts evaluate PBMs' role within the prescription drug supply chain. While Medicare Part D reforms and DOL initiatives have addressed transparency, accountability and ERISA-covered health plan disclosure obligations, states continue pursuing broader measures addressing reimbursement practices, patient choice and vertical integration.

As communities across the country experience reduced pharmacy availability, policymakers are increasingly focused on whether the current market structure supports meaningful patient access to local pharmacy services. Whether recent reforms achieve that goal will depend on how courts resolve ongoing challenges and how regulators enforce new requirements.

The next several years will likely determine whether PBM reform produces lasting changes in the pharmacy marketplace. For independent pharmacies, continued engagement with regulatory developments and clear documentation of their role in patient care will be critical as courts, regulators and policymakers determine whether these reforms meaningfully improve pharmacy access.

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