Roberti Global
IRIZARRY • ROBERTI

Legislative Tracker: PBM & Pharmacy-Related Legislation (119th Congress)

Updated: January 5, 2026

Legislation

Comprehensive				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**
H.R. 6703, the *Lower Health Care Premiums for All Americans Act*	12/15/25	**Rep. Mariannette Miller-Meeks (R-IA)** No Cosponsors	Among other things, the bill includes the following provisions addressing PBMs: • **Mandatory PBM reporting to employer plans.** PBMs would be required to provide detailed reports to group health plans at least twice per year (or quarterly upon request), in plain-language and machine-readable formats. These reports would have disclosed what plans paid for drugs versus what pharmacies were reimbursed (spread pricing), net drug costs after rebates and fees, total rebates and other remuneration retained by PBMs, utilization by dispensing channel (retail, mail, specialty), patient out-of-pocket spending, and formulary placement rationales—particularly for high-cost drugs. • **Enhanced transparency for PBM-owned or affiliated pharmacies.** PBMs with ownership interests in pharmacies would be required to disclose benefit designs that steer patients to affiliated pharmacies, the percentage of prescriptions filled by those pharmacies, price comparisons between affiliated and non-affiliated pharmacies, and the lowest available prices within the network for covered drugs. • **Therapeutic class and high-cost drug reporting.** The bill required PBMs to report gross versus net spending by therapeutic class, average net costs for 30- and 90-day supplies, the use of utilization management tools such as prior authorization and step therapy, and enhanced disclosures for the highest-spend drugs and any related formulary changes. • **Plan and patient access to information.** Employer plans would receive standardized summary tools to compare PBM pricing models, fee structures, and overall costs. Plan participants would be entitled to request aggregate summaries explaining drug spending and rebates, as well as claim-level	• **12/15/25:** Introduced; referred to House Energy & Commerce, Education & the Workforce, and Ways & Means. • **12/17/25:** Passed by the House; 216 – 211. • **12/18/25:** Received in the Senate.

Comprehensive				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**
			information showing the spread applied to their own prescriptions. • **Limits on information blocking and privacy protections.** PBMs and other drug supply chain entities would be prohibited from restricting or delaying access to data necessary to produce required reports. All reporting would be subject to HIPAA and federal privacy safeguards, with additional protections to prevent anti-competitive use of disclosed information. • **Enforcement and penalties.** The reporting and disclosure requirements would be enforced by HHS, the Department of Labor, or the Treasury, depending on plan type. Civil penalties included $10,000 per day for failure to report or disclose required information and up to $100,000 per instance for knowingly providing false information, with discretion to waive penalties for good-faith compliance efforts.	
H.R. 4317, *Pharmacy Benefit Manager (PBM) Reform Act*	7/10/25	**Rep. Buddy Carter (R-GA)** 65 Cosponsors (36R, 29D)	• **Ban on Spread Pricing in Medicaid** ○ Prohibits PBMs from charging states or Medicaid managed care plans more than what pharmacies receive. ○ Requires payments to pharmacies to reflect only the drug's ingredient cost plus a professional dispensing fee aligned with state Medicaid fee schedules. ○ Enforces full transparency of costs and limits PBM administrative fees to fair market value. • **Medicare Part D Reforms & Delinking Compensation** ○ Introduces standards under which PBM compensation must be entirely separated from drug price, rebate volume, formulary placement, or referral activity. ○ PBMs would be reimbursed only via bona fide service fees (flat, FMV-based, and tied to actual work performed).	• **7/10/25:** Introduced; referred to House Energy & Commerce; Education and the Workforce; and Ways & Means.

Comprehensive				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**
			○ Retained rebates and price concessions must be either transparently passed through or fully disclosed to plan sponsors. • **Transparency & Reporting Requirements.** PBMs serving Medicare plans must annually disclose to CMS and plan sponsors: ○ Detailed drug cost performance and net revenue, including rebates, discounts, and fees. ○ Metrics on percentage of prescriptions filled by affiliated versus independent pharmacies. ○ Any formulary tier changes increasing patient costs, along with justifications. • **Prohibition on Clawbacks & Unfair Pricing Practices** ○ Bans arbitrary clawbacks—retroactive payment rescissions to pharmacies—except in cases of fraud or billing error. ○ PBMs may not unfairly reduce reimbursements to offset federal policy changes. • **Enforcement and Oversight** ○ Grants the FTC and state attorneys general authority to enforce provisions and impose civil penalties. ○ Requires annual reporting to the Comptroller General on PBM business practices, including rebate utilization and pricing structures. ○ Enables CMS to define and enforce reasonable contract standards under Medicare Part D. • **Access & Choice Protections** ○ Ensures any willing pharmacy may participate in Medicare Part D networks if they meet standard contract terms. ○ CMS will enforce that terms and conditions offered by plan sponsors be defined as "reasonable and relevant."	
H.R. 1, *One Big Beautiful Bill Act*	5/20/25	**Rep. Jodey Arrington (R-TX)** No Cosponsors	Among other things, the bill includes the following provisions addressing PBMs: • **Sec. 44123. Ensuring Accurate Medicaid Payments.** Requires participation by retail and applicable non-retail pharmacies in the National Average Drug	• **5/20/25:** Reported by House Budget, H. Rept. 119-106. • **5/22/25:** Passed by House of Representatives, 215 – 214, 1 Present, Roll no. 145.

Comprehensive				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**

			Acquisition Cost (NADAC) survey, which measures pharmacy acquisition costs and is often used in the Medicaid program to inform reimbursement to pharmacies.
			• **Sec. 44124. Banning Spread Pricing in Medicaid.** PBMs participating in Medicaid may not charge health plans more than they reimburse pharmacies and retain the difference. Promotes transparent and fair pass-through of payments.
			• **Sec. 44305. Modernizing and Ensuring PBM Accountability (Medicare Part D)**
			  ○ Requires PBMs to share formulary and coverage data with plan sponsors.
			  ○ Prohibits PBM compensation tied to a drug's list price.
			  ○ Limits PBM payment to bona fide, fair market service fees.
				• **7/3/25:** House passed Senate-passed version of H.R. 1, which **excluded** all three PBM reform; 218 – 214, Roll no. 190.
				• **7/4/25:** Signed into law by President Trump.

H.R. 1, *One Big Beautiful Bill Act* *Senate Version*	6/16/25	**Sen. Mike Crapo (R-ID)** No Cosponsors	Among other things, the bill includes the following provisions addressing PBMs: • **Sec. 71115. Ensuring accurate payments to pharmacies under Medicaid.** Requires participation by retail and applicable non-retail pharmacies in the National Average Drug Acquisition Cost (NADAC) survey, which measures pharmacy acquisition costs and is often used in the Medicaid program to inform reimbursement to pharmacies. • **Sec. 71116. Spread pricing in Medicaid.** PBMs participating in Medicaid may not charge health plans more than they reimburse pharmacies and retain the difference. Promotes transparent and fair pass-through of payments.	• **6/16/25:** Senate Finance releases text and section-by-section summary of their version of H.R. 1, the *One Big Beautiful Bill Act*. • **6/26/25:** Senate Parliamentarian rules that Sec. 71116. Spread pricing in Medicaid, violates the Byrd Rule and would be subject to 60-vote point of order. • **6/28/25:** Senate Finance releases updated text of H.R. 1, which **excluded** Sec. 71115. Ensuring accurate payments to pharmacies under Medicaid, and Sec. 71116. Spread pricing in Medicaid. • **7/1/25:** Passed by Senate; 51–50, Record Vote Number 372. • **7/3/25:** House passed Senate-passed version of H.R. 1; 218 – 214, Roll no. 190. • **7/4/25:** Signed into law by President Trump.
S. 891, *Bipartisan Health Care Act*	3/6/25	**Sen. Ron Wyden (D-OR)** 1 Cosponsor (I)	Among other things, the bill includes the following provisions addressing PBMs: • **Section 901. Oversight of PBM Services** ○ **PBM Reporting Requirements.** PBMs must provide detailed, semiannual (or quarterly)	• **3/6/25:** Introduced; referred to Senate Finance.

Comprehensive				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**
			reports to group health plans on drug pricing, rebates, fees, out-of-pocket costs, utilization, and formulary placement. ○ **Transparency.** Reports must include net vs. gross spending, rebate amounts, PBM compensation, and affiliate pharmacy practices. ○ **Participant Access.** Plans must provide summary information and, upon request, specific drug cost data to participants. ○ **Privacy & Compliance.** Reports must follow HIPAA and federal privacy laws. Noncompliance results in civil monetary penalties. ○ **Enforcement.** Enforced by HHS, Labor, and Treasury. Waivers may be granted for good faith compliance efforts. • **Section 902. Full Rebate Pass-Through to Plans** ○ **100% Rebate Remittance.** PBMs must pass all rebates, fees, and discounts from manufacturers or aggregators to the health plan. ○ **Timely Payments.** Rebates must be remitted quarterly and fully disclosed. ○ **Audit Rights.** Plan sponsors may audit PBMs and rebate aggregators; PBMs may not fund these audits. ○ **Fiduciary Protections.** Innocent plan fiduciaries are shielded if they act in good faith and take corrective action upon discovering PBM noncompliance.	
S. 526, *Pharmacy Benefit Transparency Act*	2/11/25	**Sen. Chuck Grassley (R-IA)** 14 Cosponsors (8R, 6D)	• **Prohibition on Unfair or Deceptive Practices** ○ **Spread pricing ban.** PBMs may not charge health plans more than they reimburse pharmacies and retain the difference. ○ **Clawbacks.** PBMs cannot arbitrarily or unfairly reduce or rescind pharmacy reimbursements, except in cases of fraud, billing error, or non-service. ○ **Federal reimbursement manipulation.** PBMs cannot alter pharmacy fees or reimbursements to	• **2/11/25:** Introduced in Senate; referred to Senate Commerce, Science, and Transportation.

Comprehensive				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**
			offset federally mandated rate changes (e.g., in Medicare/Medicaid). ○ Apply to both federal health care programs and commercial market ○ Exceptions ▪ PBM passes 100% of rebates/discounts to health plans or payers. ▪ Provide full disclosure of pricing, fees, markups, and manufacturer remuneration to contracting entities and federal agencies upon request. • **Prohibition on False Information.** Makes it unlawful to knowingly report false PBM-related data to federal agencies if it affects regulatory or market analysis. • **Transparency Requirements** ○ **Requires PBMs to file annual report to HHS and FTC:** ▪ Spread pricing metrics ▪ Fees charged (GER, DIR, clawbacks) ▪ Formulary tier changes and reasons ▪ Discrepancies in reimbursement practices between PBM-owned vs. independent pharmacies ○ **Reports to Congress:** ▪ Annual FTC report on enforcement, complaints, market impact, and competition. ▪ Report on formulary design practices (potential abuse to increase revenue). ○ **GAO Study (within 1 year).** PBM role in supply chain, rebates, formulary structure, prior authorization, step therapy, markup practices, and impact on premiums/drug costs. ○ Apply to both federal health care programs and commercial market • **Whistleblower Protections** ○ Protects individuals (e.g., PBM or pharmacy employees) from retaliation when reporting violations or cooperating with investigations.	

Comprehensive				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**
			○ Allows whistleblowers to sue in federal court with remedies including back pay, reinstatement, and damages • **Enforcement** ○ **FTC Authority.** Treats violations as unfair or deceptive acts under FTC Act. ○ **Expanded FTC jurisdiction.** Covers nonprofit PBMs and insurance activities (overrides McCarran-Ferguson limitations). ○ **Civil Penalties.** Up to $1 million per violation; daily penalties for continuing offenses. • **Effect on State Laws.** The Act does not preempt or override existing State laws or regulations related to pharmacy benefit managers. States retain full authority to enforce their own rules and requirements alongside the provisions of this federal legislation.	

Commercial Market Reforms				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**
S. 3549, *PBM Fiduciary Accountability, Integrity & Reform (FAIR) Act*	12/17/25	**Sen. Roger Marshall (R-KS)** 3 Cosponsors (1R, 2D)	• **Designates PBMs as fiduciaries under ERISA** when they perform core PBM functions for employer-sponsored group health plans, including formulary and network design, rebate negotiation, claims processing, and utilization management. • **Requires PBMs to act solely in the best interests of health plans and beneficiaries**, subjecting them to ERISA's fiduciary duty standards and liability for breaches that cause financial harm to plans or participants. • **Expands ERISA compensation disclosure requirements** to explicitly cover PBM services and third-party administrative services, including disclosure of both direct and indirect compensation related to drug purchasing, rebates, fees, and network or formulary management. • **Clarifies that PBMs may not serve as the "responsible plan fiduciary"** for purposes of ERISA disclosure requirements, except in limited circumstances where a PBM sponsors its own employee health plan. • **Prohibits PBMs from being indemnified for breaches of fiduciary duty**, voiding contractual provisions that shield PBMs from liability for violations of ERISA obligations. • **Applies to plan years beginning at least 12 months after enactment**, giving plans and PBMs time to update contracts and compliance practices.	• **12/17/25:** Introduced; referred to Senate HELP.
H.R. 6837 *House Version*	12/18/25	**Rep. Jake Auchincloss (D-MA)** 1 Cosponsor (R)		• **12/18/25:** Introduced; referred to House Education & Workforce.
H.R. 6610, *Pharmacists Fight Back [in Federal Employee Health Benefit Plans Act]*	12/11/25	**Rep. Jake Auchincloss (D-MA)** 19 Cosponsor (6R, 13D)	• **Applies PBM reforms to the Federal Employees Health Benefits (FEHB) Program**, requiring the Office of Personnel Management (OPM) to withhold approval of any FEHB plan unless the plan's PBM (and PBM affiliates) complies with new pharmacy payment, rebate pass-through, and anti-steering rules. • **Sets minimum pharmacy reimbursement standards** for FEHB plans requiring PBMs to reimburse in-network pharmacies at NADAC (or WAC if NADAC is unavailable) plus a professional dispensing margin (4% or $50, whichever is less).	• **12/11/25:** introduced; referred to House Oversight & Government Reform.

Commercial Market Reforms				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**

			• **Requires PBMs to pay a professional dispensing fee** equal to the dispensing fee paid under the State Medicaid program where the pharmacy is located.
			• **Mandates point-of-sale rebate pass-through for beneficiaries**, requiring PBMs (or affiliates) to apply manufacturer rebates to reduce beneficiary coinsurance/copays based on the net cost of the drug, and to remit remaining rebate amounts to the FEHB carrier.
			• **Prohibits PBM steering and network manipulation**, including directing enrollees to PBM-affiliated pharmacies, marketing/promoting affiliate pharmacies over other in-network pharmacies, creating network rules that exclude or restrict in-network pharmacies, and pressuring manufacturers to limit distribution to preferred/affiliate pharmacies.
			• **Bans DIR-style claim adjustments and unrelated fees**, prohibiting PBMs from lowering reimbursement or imposing fees at or after adjudication (including fees not tied to a specific claim) that reduce pharmacy payment below the statutory minimums.
			• **Requires FEHB carriers to cooperate with OPM inspections**, including producing documents, personnel, and facilities as OPM deems necessary.
			• **Creates a PBM sanctions regime enforced by OPM**, including:
			  ○ **Civil monetary penalties** of **$10,000 per violation** on PBMs (and, after repeated violations, on carriers as well),
			  ○ **Caps on penalties** over a 10-year period (up to $100,000 per carrier for PBMs; up to $50,000 for carriers),
			  ○ A required carrier remediation plan after repeated violations, plus OPM oversight inspections, and
			  ○ **Debarment** of PBMs from FEHB work after 10 penalties in a 10-year period, with restrictions on payments during debarment.	

Commercial Market Reforms				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**
			• **Provides due process protections**, including notice, an opportunity for a hearing, and judicial review of adverse OPM determinations. • **Effective date:** takes effect one year after enactment.	
H.R. 5509, *Safe Step Act*	9/19/25	**Rep. Rick Allen (R-GA)** 47 Cosponsors (8R, 39D)	• Sets a national floor for step-therapy exceptions across commercial and ERISA plans. Requires plans and their PBMs to run a clear, accessible exception process with decisions in 24 hours (urgent) or 72 hours (standard), and to grant exceptions when: a prior step failed/was discontinued; the required drug is expected to be ineffective; it's contraindicated or likely harmful; it would materially impair work/ADLs; or the patient is stable on a current therapy previously covered. • PBMs must provide transparent submission channels (ePA/portal/phone), written decision rationales, specialty clinical review, and timestamped records to demonstrate compliance, and update formulary/UM policies and contracts accordingly.	• **9/19/25:** Introduced; referred to House Education & the Workforce.
S. 2903 *Senate Version*	9/18/25	**Sen. Lisa Murkowski** 32 Cosponsors (9R, 23D)		• **9/18/25:** Introduced; referred to Senate HELP
H.R. 4409, *Fair Pharmacies for Federal Employees Act*	7/15/25	**Rep. Raja Krishnamoorthi (D-IL)** 2 Cosponsors (1R, 1D)	• Prohibits the Office of Personnel Management (OPM) and federal employee health benefit plan contractors from engaging with entities that both operate pharmacies and perform PBM services. • In practice, the bill forbids common ownership or control of PBMs and pharmacies under the Federal Employee Health Benefits Program (FEHBP) to eliminate conflicts of interest and promote fair competition. It is intended to preserve competition, improve transparency, and protect federal employees and retirees from potential anti-competitive practices by vertically integrated PBMs.	• **7/15/25:** Introduced; referred to House Oversight & Government Reform.
H.R. 2214, *Delinking Revenue from Unfair Gouging (DRUG) Act*	3/18/25	**Rep. Mariannette Miller-Meeks (R-IA)** 6 Cosponsors (2R, 4D)	• **Ban on Remuneration Based on Drug Prices or Volume.** PBMs may not receive any payment, fee, rebate, or other remuneration from any entity for PBM-related services if that payment is: ○ Based on the price of a drug (e.g., wholesale acquisition cost or average wholesale price) ○ Tied to the volume or value of rebates, discounts, or other direct/indirect remuneration ○ Contingent on utilization or prescribing patterns.	• **3/18/25:** Introduced; referred to House Education & the Workforce; House Energy & Commerce; House Oversight & Accountability; and House Ways & Means.

Commercial Market Reforms				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**

			• Applies to:
			  ○ Group health plans
			  ○ Group or individual health insurance coverage regulated under the Public Health Service Act and ERISA
			• **Exception:** Bona Fide Service Fees.PBMs may charge flat-dollar, fair-market-value service fees for specific, itemized services if:
			  ○ The fee is not based on drug price or utilization;
			  ○ The service would otherwise need to be performed by the plan or insurer;
			  ○ A written agreement sets forth the nature and amount of the fee.
			• **Penalties and Remedies**
			  ○ **Disgorgement.** PBMs must return any impermissible payments to the group health plan or issuer.
			  ○ **Civil Monetary Penalty.** Up to $10,000 per day for each day of noncompliance. Applies to PBMs and their affiliates.
			• **Effective Date.** Provisions take effect on January 1, 2027.	

Medicaid				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**

S. 927, *Protecting Pharmacies in Medicaid Act*	3/11/25	**Sen. Peter Welch (D-VT)**
		3 Cosponsors (2R, 1D)
			• **Accurate Pharmacy Payments**
			  ○ Requires monthly surveys of drug acquisition costs for retail and non-retail pharmacies.
			  ○ Pharmacies must report all Medicaid-related payments, rebates, and fees—whether from the state, MCOs, or PBMs.
			  ○ Survey data (including price concessions and noncompliant pharmacies) will be made public.
			  ○ Penalties up to $100,000 per violation for failing to comply.
			  ○ HHS OIG to conduct oversight studies, especially on affiliated entities.
			  ○ Implementation: 6 months after enactment for retail; 18 months for non-retail.
			• **Ban on Spread Pricing**
			  ○ PBMs and MCOs must use a pass-through pricing model:
			  ○ Only pay pharmacies for ingredient cost + dispensing fee.
			  ○ No markup or retention of spread allowed.
			  ○ PBMs allowed fair-market admin fees only.
			  ○ Must disclose all drug cost and payment data to states and HHS.
			  ○ Allows limited exception for 340B drugs with annual reporting.
			• **Effective Date.** Applies to contracts effective 18 months after enactment.
				• **3/11/25:** Introduced; refered to Senate Finance.

Medicare				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**
H.R. 6609, *Pharmacists Fight Back in Medicare & Medicaid Act*	12/11/25	**Rep. Jake Auchincloss (D-MA)** 22 Cosponsors (7R, 15D)	• **Imposes new federal requirements on PBMs in Medicare Part D and MA-PD plans**, effective for plan years beginning on or after January 1, 2027, conditioning plan participation on PBM compliance. • **Establishes minimum pharmacy reimbursement standards** requiring PBMs and plan sponsors to reimburse in-network pharmacies at NADAC (or WAC if NADAC unavailable) plus a professional dispensing margin (4% or $50, whichever is less), and to pay dispensing fees equal to those paid under the State Medicaid program—without shifting those fees to patients. • **Prohibits PBMs from imposing post-adjudication fees or other charges** that would reduce pharmacy reimbursement below the amounts specified in statute (effectively banning DIR-style clawbacks). • **Mandates full manufacturer rebate pass-through at the point of sale**, requiring rebates to be applied to reduce beneficiary cost-sharing and remitted to plan sponsors (and ultimately CMS or States for low-income subsidy enrollees). • **Bans PBM "steering" practices**, including directing patients to PBM-affiliated pharmacies, creating preferred or narrow networks that disadvantage independent pharmacies, or encouraging manufacturers to limit drug distribution to certain pharmacy types. • **Requires annual PBM reporting and certification** to CMS and plan sponsors confirming compliance with reimbursement, rebate pass-through, and anti-steering requirements. • **Requires Part D and MA-PD plans to account for expected rebate remittances** in plan bids, reducing plan actuarial value assumptions beginning in 2027. • **Extends parallel PBM requirements to Medicaid managed care**, mandating NADAC-based reimbursement, Medicaid-equivalent dispensing fees,	• **12/11/25:** Introduced; referred to House E&C and W&M.

Medicare				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**

			full rebate pass-through to States, and anti-steering protections.
			• **Creates strong enforcement mechanisms**, including:
			  ○ Felony criminal penalties (up to $1 million in fines and/or 10 years imprisonment) for knowing and willful PBM violations; and
			  ○ Civil monetary penalties of up to $1 million per violation.
			• **Expands Medicaid drug price transparency**, requiring pharmacies to report acquisition costs net of all price concessions and directing CMS to publicly release national acquisition price data, while prohibiting States from using non-retail pharmacy pricing to set retail pharmacy reimbursement.	

S. 3345, the *PBM Price Transparency and Accountability Act*	12/4/25	**Sen. Mike Crapo (R-ID)**
		24 Cosponsors (13R, 11D)
			• **Section 2. Arrangements PBMs with Respect to Prescription Drug Plans and MA-PD Plans.** for plan years beginning on or after January 1, 2028.
			  ○ **Delinks PBM income from Rx drug prices.** Prohibits PBMs and their affiliates from deriving income or remuneration related to covered Part D drugs based on a drug's price or manufacturer-linked price benchmarks. PBM compensation must be limited to "bona fide service fees" that: (1) reflect fair market value for services actually performed; and (2) are structured as flat dollar amounts, not contingent on drug price, rebates, or volume. Rebates, discounts, and price concessions from manufacturers may continue so long as they are fully passed through to the Part D plan sponsor and comply with DIR requirements.
			  ○ **Consistency in terms for pricing guarantees & cost performance evaluations.** Requires PBMs to define and apply key pricing and drug-classification terms (e.g., generic, brand, specialty drug, rebate, discount) in a transparent and consistent manner when calculating pricing guarantees or evaluating PBM cost-performance commitments. PBMs must clearly identify any exclusions from pricing guarantees and provide
				• **12/4/25:** Introduced; referred to Senate Finance.

Medicare				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**
			WAC-based equivalents where alternative benchmarks are used. ○ **Enhanced PBM reporting requirements.** Requires PBMs to submit **detailed annual reports** to Part D plan sponsors and the HHS Secretary, including drug-level and aggregate information on: ▪ Covered Part D drugs, utilization, and dispensing channels; ▪ Drug prices, costs, rebates, DIR, pharmacy reimbursement, and NADAC comparisons; ▪ Generic and biosimilar formulary placement decisions and justifications; ▪ PBM ownership interests and pharmacy affiliations; ▪ Financial arrangements with consultants, brokers, and auditors; ▪ Potential conflicts of interest and steering toward affiliated pharmacies. Information disclosed to HHS is protected from public release, except in limited circumstances, and may not be disclosed in a manner that identifies specific entities or drug-specific pricing. ○ **Audits & enforcement.** Permits Part D plan sponsors to audit PBMs annually to ensure compliance with contractual and statutory requirements. If a PBM is found non-compliant, it must: (1) Disgorge impermissible remuneration to the plan sponsor; (2) reimburse the plan sponsor for any civil monetary penalties imposed by HHS due to PBM violations; (3) be subject to punitive contractual remedies for breach of contract. Plan sponsors must submit annual certifications of compliance to the HHS Secretary. • **Section 3. Assuring Pharmacy Access and Choice under Medicare Part D.** Effective beginning plan year 2028: ○ **Any willing pharmacy requirement.** Requires Part D plan sponsors to allow any pharmacy that meets	

Medicare				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**
			standard contract terms to participate in plan networks. ○ **Reasonable and relevant contract standards.** Directs the HHS Secretary to establish standards ensuring that pharmacy contract terms are reasonable and relevant, based on pharmacy-impactable factors such as reimbursement practices, dispensing fees, audits, quality measures, and utilization restrictions. Standards must be informed by stakeholder input via an HHS request for information. ○ **Enforcement and protections.** Establishes a formal HHS process allowing pharmacies to submit allegations of violations of network contracting standards, with: (1) Anti-retaliation and anti-coercion protections; (2) investigation and enforcement authority for HHS; and (3) civil monetary penalties and sanctions for non-compliant plans. • **Section 4. Essential Retail Pharmacies (Medicare Part D).** ○ **Designation of "essential retail pharmacies."** Defines essential retail pharmacies as non-affiliated retail pharmacies located in areas with limited pharmacy access (rural, suburban, or urban distance thresholds). ○ **Data collection and public reporting.** Requires HHS to publish biennial reports analyzing: ▪ Reimbursement trends, fees, incentive payments, and pharmacy participation in preferred networks; ▪ Cost-sharing and dispensing patterns at essential versus non-essential pharmacies; ▪ Geographic access trends over time. HHS must also publish an annual public list of essential retail pharmacies. • **Section 5. Prohibiting spread pricing in Medicaid.** Prohibits PBMs from engaging in spread pricing in the Medicaid program. Requires pass-through pricing for	

Medicare				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**

			covered outpatient drugs reimbursed under Medicaid, including when services are provided under contract with managed care organizations. Payment for PBM services would be limited to the ingredient cost for the drug (i.e., an amount that approximates pharmacy acquisition costs) and a professional dispensing fee. Amount must be passed through in its entirety from the PBM to the pharmacy. Would take effect 18 months after enactment.
			• **Section 6. Ensuring accurate payments to pharmacies under Medicaid.** Requires participation by retail community pharmacies in the National Average Drug Acquisition Cost (NADAC) survey 18 months after enactment.
			• **Section 7. GAO and MedPAC Studies and Reports.**
			  ○ **GAO study on price-based compensation.** Requires GAO to examine the prevalence and impact of price-linked compensation structures across the prescription drug supply chain under Medicare Part D, including effects on costs, competition, generic and biosimilar utilization, and potential conflicts of interest.
			  ○ **MedPAC reporting.** Requires MedPAC to issue reports analyzing how PBM agreements affect beneficiary cost-sharing, pharmacy reimbursement, and overall program spending.
			• **Section 8. Funding and Implementation Provisions.**
			  ○ **Appropriations.** Provides dedicated funding in FY 2026 for CMS program management, HHS OIG oversight, and MedPAC activities tied to implementation and enforcement.
			  ○ **Implementation flexibility.** Authorizes the HHS Secretary to implement provisions via program instruction and exempts implementation from the Administrative Procedure Act and Paperwork Reduction Act where specified.	

Medicare				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**
S. 2800, *Pharmacy and Medically Underserved Areas Enhancement Act*	9/15/25	**Sen. Chuck Grassley (R-IA)** 1 Cosponsor (D)	• Adds pharmacist services to Medicare Part B when provided in Health Professional Shortage Areas, Medically Underserved Areas, or to Medically Underserved Populations. • Services must be within state scope of practice and ones that would be covered if furnished by a physician or incident to a physician's service. • **Payment:** Medicare pays 80% of the lesser of the actual charge or 85% of the physician fee schedule amount (standard 20% coinsurance applies). • **Effective** Jan 1, 2027; HHS must create pharmacist-specific billing codes under the physician fee schedule.	• **9/15/25:** Introduced; referred to Senate Finance.
H.R. 5197, *Protect Beneficiaries from Middlemen Act*	9/8/25	**Rep. Nicole Malliotakis (R-NY)** No Cosponsors	• **Delinking.** Prohibits Part D PDPs and PBMs in Medicare Part D or Medicare Advantage from charging patients more in drug cost-sharing than the net price of the drug.	• **9/8/25:** Introduced; referred to House Energy & Commerce and House Ways & Means.
H.R. 5031, *Preserving Patient Access to Long-Term Care Pharmacies Act*	8/22/25	**Rep. Beth Van Duyne (R-TX)** 32 Cosponsors (22R, 10D)	• **Temporary LTC supply fee (Part D):** For plan years 2026–2027, Part D plans must pay long-term care (LTC) pharmacies a supply fee per "specified prescription." Amount: $30 in 2026; 2027 = 2026 amount indexed (per §1860D-2(b)(6)). Applies when an LTC pharmacy dispenses a covered Part D drug at the Medicare Maximum Fair Price (MFP) to an MFP-eligible enrollee. • **Additional to existing payments:** Supply fee is paid at the same time and cannot reduce ingredient cost, dispensing fee, or other contracted payments. • **Enforcement:** Plans that fail to pay face a civil money penalty of at least $10,000 per instance. • **Plan reimbursement:** HHS will reimburse plans for the aggregate supply fees (subsidy paid within 18 months after each plan year). • **GAO study:** Within 12 months of enactment, GAO must report on LTC pharmacy payment sustainability in Part D and recommend steps to	• **8/22/25:** Introduced; referred to House Energy & Commerce and House Ways & Means.
S. 3159 *Senate version*	11/7/25	**Sen. James Lankford (R-OK)** 1 Cosponsor (R)		• **11/7/25:** Introduced; referred to Senate Finance.

Medicare				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**
			ensure beneficiary access, including in rural markets.	
H.R. 3164, *Equitable Community Access to Pharmacist Services (ECAPS) Act*	5/1/25	**Rep. Adrian Smith (R-NE)** 94 Cosponsors (47R, 47D)	• Improves access to care, especially in rural and underserved communities, by making permanent some of the pharmacist authorities granted during the COVID-19 pandemic. • Allows Medicare Part B to reimburse pharmacists for providing certain healthcare services—such as testing, treatment, and vaccinations—for respiratory illnesses like COVID-19, flu, RSV, and strep throat. • Formally recognizes pharmacists as providers under Medicare for these services, provided they are authorized to deliver them under state law.	• **5/1/25:** Introduced; referred to House Energy & Commerce and House Ways & Means.
S. 2426 *Senate version*	7/24/25	**Sen. John Thune (R-SD)** 27 Cosponsors (13R, 14D)		• **7/24/25:** Introduced; referred to Senate Finance.
H.R. 2484, *Seniors' Access to Critical Medications Act*	3/31/25	**Rep. Diana Harshbarger (R-TN)** 22 Cosponsors (13R, 9D)	• **Creates a Temporary Stark Law Exception (2026–2030).** Allows physicians to dispense certain Part D drugs in-office if all of the following conditions are met: 1. **Patient Relationship Requirement**. Patient has an established, ongoing relationship with the prescribing physician (or another in the same group). 2. **Recent In-Person Visit**. Patient had at least one in-person, face-to-face visit with the physician or group within the past 12 months for a non-designated health service billed under Medicare. 3. **Onsite Dispensing Conditions** ○ Drug is dispensed by: ▪ The referring physician ▪ A group member physician, or ▪ A supervised individual in the same practice ○ Dispensing occurs on-site or via delivery, courier, or mail. **4.** **Billing Restrictions**. Physician or group must bill directly, or through an entity they wholly own.	• **3/31/25:** Introduced; referred to House Energy & Commerce and House Ways & Means. • **4/29/25:** Passed by House Energy & Commerce; 38 – 7.

Medicare				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**
			• **GAO Study Requirement.** Directs GAO to study physician-dispensing arrangements, including: ○ Changes in Part D dispensing patterns post-enactment. ○ Whether such arrangements are linked to physician-owned or integrated pharmacies. ○ Prevalence by specialty, and relationships with PBMs, insurers, wholesalers, or others. ○ Contractual structures and potential conflicts of interest. ○ Measures taken to address or disclose such conflicts. ○ Report due within 3 years of enactment.	
S. 882, *Patients Before Middlemen (PBM) Act*	3/6/25	**Sen. Marsha Blackburn (R-TN)** 7 Cosponsors (3R, 4D)	• **Delinking.** For Medicare Part D and MA-PD plans, PBMs may only receive flat, bona fide service fees for services rendered. Fees must: ○ Be disclosed in contracts with plan sponsors ○ Reflect fair market value for itemized services, and ○ Cannot be based on: ▪ Drug prices (e.g., WAC or AWP) ▪ Rebates, discounts, fees, or other remuneration ▪ Other amounts prohibited by the Secretary of HHS • **Definition of PBM. Broadly includes any entity (including affiliates or agents) that:** ○ Negotiates drug prices ○ Manages Part D benefits (claims, prior auth, formularies, pharmacy contracting, etc.) ○ Acts on behalf of a PDP sponsor or plan, regardless of whether it calls itself a PBM. • **Clarifications** ○ Does not prohibit reimbursement for drug ingredient costs or pharmacy dispensing fees. ○ PDP sponsors acting as PBMs may still retain rebates or discounts if they reduce net costs for Part D drugs.	• **3/6/25:** Introduced; referred to Senate Finance

Medicare				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Actions**
			○ Applies to all PBM roles—whether direct, affiliate, or subcontractor. • **Oversight & Enforcement** ○ PBMs and PDP sponsors must annually certify compliance to CMS. ○ PBMs must disgorge any prohibited payments to the Secretary. ○ Applies regardless of the PBM's position in the plan's contracting chain (first-tier, downstream, or related entity).	
H.R. 950, *Saving Seniors Money on Prescriptions Act*	2/4/25	**Rep. Greg Landsman (R-OH)** 1 Cosponsor (R)	• **PBM Reporting Requirements (Medicare Part D & MA-PD Plans)** ○ PBMs must report detailed drug-level data, including: ▪ Utilization, pricing, rebates, out-of-pocket costs, and pharmacy reimbursements. ▪ Retained revenue and payments to affiliate pharmacies. ▪ Justifications for coverage of brand-name drugs or reference biologics over cheaper generics or biosimilars. ▪ Benefit design features favoring PBM-affiliated pharmacies. ▪ Lists of affiliated entities and compensated consultants or brokers. ○ Data must be submitted to plan sponsors (at no cost) and made available to CMS, GAO, CBO, MedPAC, and the Attorney General, subject to strict confidentiality protections. ○ PBMs must allow annual audits by plan sponsors and provide access to necessary data, including data held by affiliates. ○ PBMs are liable for civil penalties or contractual damages resulting from noncompliance. • **Certification.** PDP sponsors must annually certify compliance with reporting rules to CMS. • **Effective Date.** Applies to plan years beginning on or after January 1, 2028.	• **2/4/25:** Introduced; referred to House Energy & Commerce and House Ways & Means.

Transparency				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Status**

S. 527, *Prescription Pricing for the People Act*	2/11/25	**Sen. Chuck Grassley (R-IA)**
		13 Cosponsors (7R, 6D)
			• **FTC Study.** Requires the Federal Trade Commission (FTC) to study whether anticompetitive practices exist within the pharmaceutical supply chain, especially as carried out by pharmacy benefit managers or intermediaries. Under the bill, the FTC would:
			  ○ Research potential legal or regulatory barriers that prevent the commission from effectively enforcing violations of the antitrust and consumer protection laws in the pharmaceutical supply chain.
			  ○ Study any legal or regulatory obstacles that contribute to the cost of prescription drugs.
			  ○ Identify methods that payers and companies use to assess the costs and benefits of contracting with intermediaries.
			  ○ Formulate policy or legislative recommendations to deter anticompetitive behavior in the pharmaceutical supply chain and report its findings to Congress.
			• **Report to Congress** on the number and nature of complaints about sole-source drug manufacturers, the commission's ability to engage in enforcement against such manufacturers, and recommendations to strengthen its ability to prosecute anticompetitive behavior.
				• **2/11/25:** Introduced; referred to Senate Judiciary.
				• **4/3/25:** Passed by Senate Judiciary by voice vote.
				• **4/10/25:** Placed on Senate Legislative Calendar.

TRICARE				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Status**
H.R. 6400, the *Rx Access, Choice, Cost Equity, and Supply Stability (Rx ACCESS) Act.*	12/3/25	**Rep. Jen Kiggans (R-VA)** 3 Cosponsors (1R, 2D)	• Updates the TRICARE pharmacy program to strengthen patient access and bring greater transparency to PBM operations. • Beginning in 2026, TRICARE beneficiaries will regain the ability to receive non-generic maintenance medications through any approved pharmacy channel, including retail. • Requires TRICARE's PBM to reimburse retail pharmacies based on their actual acquisition costs plus a fair Medicaid-based dispensing fee, while banning hidden or retroactive fees. • Requires annual GAO audits of reimbursement practices, PBM price concessions, and the adequacy of the retail pharmacy network—especially in rural and underserved areas. The Department of Defense must support these audits and provide Congress with an implementation plan within 90 days.	• **12/3/25:** Introduced; referred to Armed Services.

Miscellaneous				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Status**
H.R. 5316, *Drug Shortage Compounding Patient Access Act*	9/11/25	**Rep. Diana Harshbarger (R-TN)** 3 Cosponsors (R)	• **Urgent-use 503A compounding for shortages:** Permits licensed pharmacists/physicians to compound limited quantities without a patient-specific Rx for urgent hospital/clinic use when the drug was on FDA's shortage list within 60 days and the prescriber certifies a 503B product isn't obtainable (same API/route). • **Safeguards & traceability:** Requires USP-compliant beyond-use dating; special "urgent administration" packaging; hospitals must send patient identifiers back within 7 days of administration/discharge; compounders must link records and report adverse events to FDA MedWatch within 15 days. • **Clarifies "essentially a copy" exception:** Compounded drug is not "essentially a copy" if (a) there's a prescriber-determined, patient-specific difference, or (b) the drug was on the shortage list in the prior 60-days and the product meets the same labeling/documentation safeguards above. • **Strengthens FDA shortage reporting (FD&C §506C):** Explicitly covers surges in demand (not just discontinuations/interruptions); requires notice 6 months in advance when possible—or ASAP if not—and ASAP for demand surges; updates the drug shortage definition (demand exceeds supply), extends scope to APIs, and adds outsourcing facilities to stakeholder engagement. • **503B updates:** Extends shortage lookback to 180 days for qualifying compounding; FDA to issue annual public updates on bulk drug substances; standardizes 503A patient label language.	• **9/11/25:** Introduced; referred to House Energy & Commerce.
H.R. 5256, *340B Affording Care for Communities and Ensuring a Strong Safety-net (ACCESS) Act*	9/10/25	**Rep. Buddy Carter (R-GA)** 1 Cosponsor (R)	• Protects health centers' ability to serve all patients, regardless of their ability to pay by increasing access to affordable medications and health services for medically underserved communities. • **Restores access to unlimited contract pharmacies**, including access to mail order and specialty pharmacies, enabling greater access for health center patients.	• **9/10/25:** Introduced; referred to House Energy & Commerce and House Ways & Means.

Miscellaneous				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Status**
			• Ensures that health centers and their patients have access to affordable medications for prescriptions written by specialty providers. • Increases transparency and accountability for all stakeholders in the program. • **Limits on administrator service fees and contractor pharmacy fees.** Contract pharmacy fees charges to covered entities would be limited to flat fair-market value fees that could not exceed 125% of the average per-prescription fee paid to pharmacies by all third-party payers. Imposes civil monetary penalties on PBMs, TPAs, and contract pharmacies that do not comply. • **Prohibits discriminatory contracts.** Prohibits PBMs from imposing specified discriminatory contract terms (e.g., fees or chargebacks) due to a covered entity's or pharmacy's participation in 340B. • **Prohibits interference with pharmacy choice.** Prohibits health plans, insurers and PBMs from interfering with identifying 340B claims or allowing an individual to choose to receive a 340B drug from a covered entity or contract pharmacy.	
H.R. 4581, *340B Pharmaceutical Access to Invest in Essential, Needed Treatments & Support (PATIENTS) Act*	7/22/25	**Rep Doris Matsui (D-CA)** 16 Cosponsors (16D)	• **Manufacturer obligations clarified:** Drug makers must offer 340B ceiling prices regardless of where or how a drug is dispensed, including via contract pharmacies. They may not impose conditions (e.g., limiting delivery sites/mechanisms, demanding claims data/extra attestations, or other non-customary hurdles) unless pre-approved by HHS. • **Contract pharmacies codified:** Covered entities may use one or more contract pharmacies to dispense 340B drugs; all manufacturer requirements apply equally when entities choose this model. • **Enforcement strengthened:** Adds civil monetary penalties (for non-overcharge violations of these provisions) of up to $2,000,000 per day for intentional violations, accruing until cured; existing overcharge penalties remain.	• **7/22/25:** Introduced; referred to House Energy & Commerce.
S. 2372 *Senate version*	7/22/25	**Sen. Peter Welch (D-VT)** 2 Cosponsors (2D)		• **7/22/25:** Introduced; referred to Senate HELP.

Miscellaneous				
Bill Name & Number	**Date Introduced**	**Lead Sponsor/Cosponsors**	**Summary**	**Status**
			• **HHS rulemaking & remedies:** HHS must issue regulations within 180 days to set CMP standards and enable covered entities to bring claims of violations (including contract-pharmacy restrictions) through the existing administrative dispute process.	