2026 Legislative Update

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Pharmacy Forward: Advancing Practice for a Healthier Tomorrow!

OPA Annual Conference & Trade Show April 9-11, 2026

Disclosure Statement

- Michelle Fitzgibbon and Michael Murphy have no relevant financial relationship(s) with ineligible companies to disclose.

  and

- None of the planners for this activity have relevant financial relationships with ineligible companies to disclose.

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Learning Objectives

At the completion of this activity, the participant will be able to:

1. discuss current legislative and policy changes at both the state and federal level that will impact the practice of pharmacy;
2. explain how to effectively advocate for OPA supported legislative changes with state legislators and federal elected officials; and
3. identify issues on OPA's legislative agenda for 2025-26 and what they may mean for pharmacy practice.

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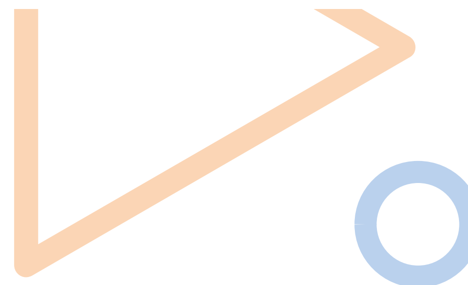

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PBM Reform – 3rd times a charm!

Consolidated Appropriations Act 2026:

- **Included: Require "reasonable and relevant" Medicare Part D pharmacy contracts and payments.**
- **Included: Delink PBM compensation from the cost of medications.**
- **Included: Promote PBM transparency for both employers and patients in their prescription drug plans.**
- Missing: Ban “spread pricing” in Medicaid and move to a transparent system that ensures pharmacies are fairly and adequately reimbursed (NADAC and professional dispensing fee)
- FTC PBM Settlement

Image source: APhA, U.S. House Energy and Commerce Health Subcommittee Hearing, February 26, 2025, FTC

PBM Reform Legislation

The PBM Reform Act (H.R. 4317) would:

- **Ban “spread pricing” in Medicaid and move to a transparent system that ensures pharmacies are fairly and adequately reimbursed (NADAC and professional dispensing fee).**
- Delink PBM compensation from the cost of medications.
- Promote PBM transparency for both employers and patients in their prescription drug plans.
- Require "reasonable and relevant" Medicare Part D pharmacy contracts and payments.

Ensuring Community Access to Pharmacist Services Act (H.R. 3164, S. 2426)

Legislative Hearing

Markup??

ECAPS: Bipartisan Federal Legislation to Ensure Access to Essential Pharmacist Services for Medicare Beneficiaries

ABOUT THE ENSURING COMMUNITY ACCESS TO PHARMACIST SERVICES ACT (ECAPS)

ECAPS allows pharmacists to receive payment from Medicare Part B for providing select services for the flu, RSV, strep throat, and COVID-19 to seniors, who are the most vulnerable to complications from these conditions. Payments would apply only in states where pharmacists are already permitted by state law to deliver these services.

ECAPS PROVIDES REIMBURSEMENT FOR ESSENTIAL PHARMACIST SERVICES IN MEDICARE

ECAPS establishes Medicare Part B reimbursement for select pharmacist services in states where pharmacists are licensed to provide these services.

TESTING: Flu • Respiratory Syncytial Virus (RSV) • Strep Throat • COVID-19

TREATMENT: Flu • Respiratory Syncytial Virus (RSV) • Strep Throat • COVID-19

Image source: Future of Pharmacy Care Coalition

What's next?

U.S. Rep. Pocan: Introduces bill to make it easier to access lifesaving PrEP

January 21, 2026

"The PrEP Access Act ensures Medicare beneficiaries can receive lifesaving HIV prevention services where and when they need them. States already authorize pharmacists to screen and furnish PrEP and PEP—this legislation guarantees Medicare coverage so patients can receive timely pharmacist-provided care, which can mean the difference between preventing HIV or facing lifelong infection. I commend the leadership of Congressional HIV/AIDS Caucus Chair Rep. Mark Pocan (WI-2) and the other caucus members, and I urge Congress to act now and pass this bill to save lives and help end HIV by 2030," **stated Michael D. Hogue, PharmD, FAPhA, FNAP, FFIP, CEO, American Pharmacists Association (APhA).**

Image source: Rep. Pocan U.S. Rep. Pocan: Introduces bill to make it easier to access lifesaving PrEP - WisPolitics

What's next?

TRICARE Pharmacy Network Reform

- Decrease from 61,027 to 42,457 in-network pharmacies from 2009-2024 (>30% decrease)
- More than 380,000 beneficiaries forced to change pharmacies or pay out-of-pocket
- Many are forced to use mandatory mail-order pharmacies
- DHA has not audited PBM-reported data, despite contractual requirements

Defense Health Care: DOD Should Improve Monitoring of TRICARE Beneficiaries' Access to Prescription Drugs

Image source: Microsoft 360 images

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Executive Order 14297

“Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients,” signed on May 12, 2025

- Aims to lower prescription drug prices, particularly for brand-name drugs without generic or biosimilar competition, by requiring manufacturers to offer their medications **at prices equal to or lower than those paid by comparable developed nations**

Direct-to-Consumer Programs

Encouraged HHS to assist pharmaceutical manufacturers in facilitating DTC purchasing programs for patients, provided that the manufacturers offer their medications at the most-favored-nation price.

Image source: APhA, Trumprx.gov

Principles for Direct-to-Consumer (DTC) Programs

Health care providers and economists agree that pharmaceuticals serve as a cost-effective intervention for improving patient health. Yet, when used incorrectly without a pharmacist's assistance, medications can also result in significant additional health care visits and costly hospital admissions. **In fact, for every $1 spent on drugs in 2017, Americans spent $1.55 on the consequences of drug-related problems.** Most favored nation drug pricing and DTC initiatives hold promise for reducing the cost of medications. Yet these initiatives do not go far enough to ensure Americans receive the full value and effective use of their medications. The American Pharmacists Association (APhA) maintains that any DTC program from pharmaceutical manufacturers must include:

- Adequate payment for the pharmacist's time, from the manufacturer and/or insurer to the pharmacist ***of the patient's choosing***, to provide personal instruction on the appropriate use of medications distributed through the DTC program. This pharmacist's payment may be made to the pharmacy or health system that employs the pharmacist.

To ensure appropriate utilization of medications, certain pharmacist services should be fully covered under Medicare Part B, Medicaid, TRICARE, and commercial health plans, including but not limited to:

- Coverage of an annual comprehensive medication management visit for every American provided by the ***pharmacist of the patient's choosing***. The pharmacist–patient relationship is critical to ensuring optimal drug therapy outcomes and reducing costs. America's seniors, in particular, deserve access to the care services of a personal pharmacist.
- Coverage of the services of the ***patient's personal pharmacist*** during care transitions when being discharged from a hospital, or when transitioning into a new care setting, such as assisted living or skilled nursing care.
- Coverage of the services of the ***patient's personal pharmacist*** for any patient who has not achieved the goals of therapy as established by the patient's physician; for example, controlled blood glucose, blood pressure, asthma, or other chronic or acute conditions.

The Great Healthcare Plan

President Trump’s call to Congress to enact “The Great Healthcare Plan”

- Codify Most Favored Nation (MFN) price deals to lower drug prices
- Expand access to nonprescription drugs
- Replace ACA subsidies with direct payments
- Increase price transparency for providers and insurers

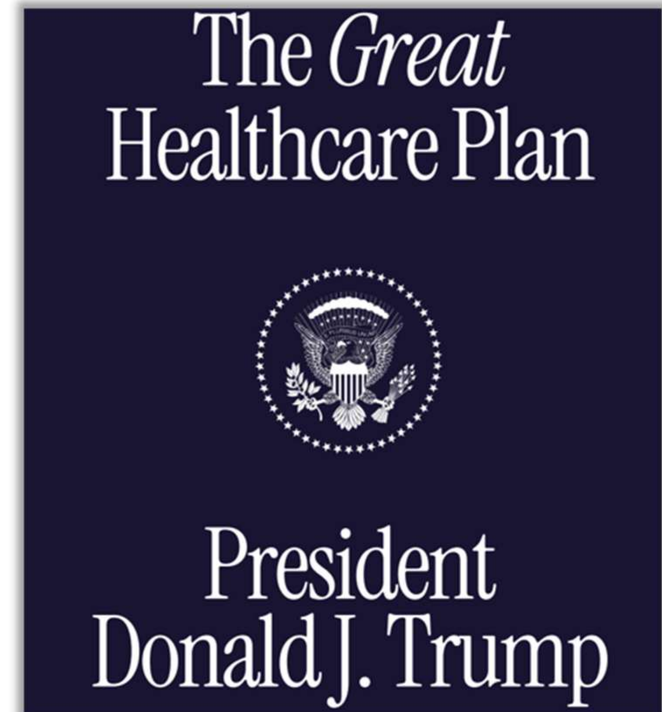


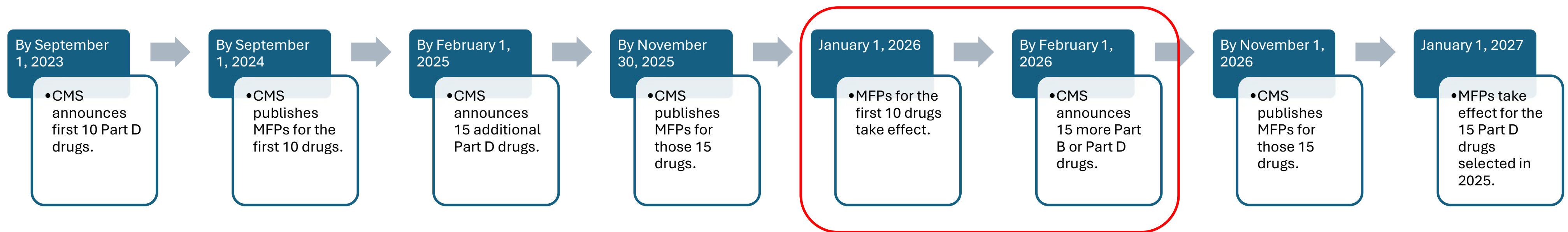
Image source: White House

Where Is MFN Pricing Now?

- **Deals with Pharmaceutical Companies**
  - At least 16 companies signed deals with the President
- **Proposed CMS Drug Payment Models**
  - GUARD, GLOBE, GENEROUS
- **State and Federal Legislation**
  - Potential to codify pricing deals and negotiations

Drug Price Negotiation Program

Implementation and Ongoing Timeline



Drug Price Negotiation Program

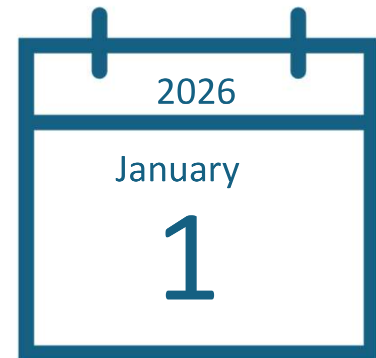
Concerns Raised to CMS Prior to Implementation

- Pharmacies cannot afford to front program costs while waiting for payments.
  - **Response:** CMS offered optional approaches to manage cash flow concerns.
- CMS does not sufficiently allow pharmacies to terminate contracts with Part D PBMs without cause.
  - **Response:** CMS noted the MTF does not obligate pharmacies to dispense selected drugs.
- CMS cannot claim to be powerless to protect pharmacies from under-reimbursement.
  - **Response:** CMS cites the noninterference clause, which bars them from intervening in manufacturer-plan-pharmacy contracting.

Drug Price Negotiation Program

Concerns Raised to CMS Post-Implementation

- Financial strain on pharmacies
- Delays in reimbursement
- Labor-intensive claims filing and tracking
- Extended response times from CMS



FTC Secures Landmark Settlement

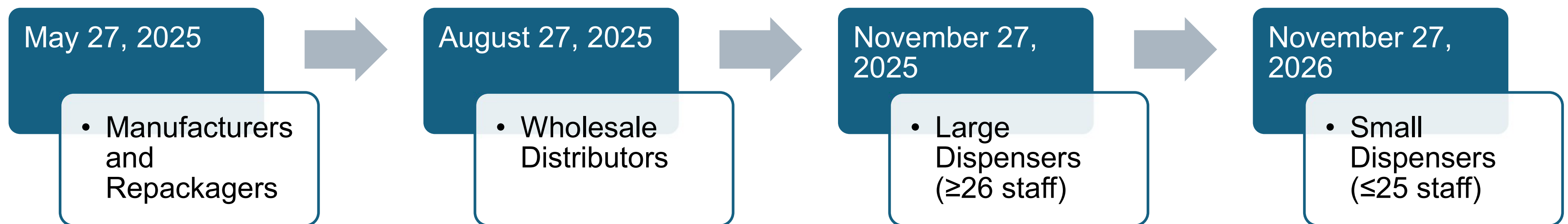
PBM Reform – Federal Trade Commission (FTC)

- Stop preferring on its standard formularies high wholesale acquisition cost (WAC) versions of a drug over identical low WAC versions;
- Provide a standard offering to its plans that ensures that members' out-of-pocket expenses will be based on the drug's net cost, not the inflated list price;
- Provide covered access to TrumpRx;
- Provide full access to its Patient Assurance Program's insulin benefits to all members when a plan sponsor adopts a formulary that includes an insulin product;
- Provide a standard offering that allows the plan to transition off rebate guarantees and spread pricing;
- Delink drug manufacturers' compensation from PBM list prices as part of its standard offering;
- Increase transparency for health plans;
- Transition and promote its standard offering to retail community pharmacies to a more transparent and fairer model based on the actual acquisition cost for a drug product plus a dispensing fee and additional compensation for **non-dispensing services**;
- Reshore its group purchasing organization (GPO) from Switzerland to the United States.

Image source: FTC

Drug Supply Chain Security Act

Compliance Timeline



- FDA's Small Dispensers Assessment December 2025 Notice
- Trading Partner Concerns

Pharmacists Prescribing Controlled Substances

DEA Registration

- Pharmacists reported DEA registration challenges due to outdated DEA website information
- APhA requested DEA update its Mid-Level Practitioners Authorization by State table
- DEA removed the table and agreed to review current state law

U. S. Department of Justice
Drug Enforcement Administration
8701 Morrissette Drive
Springfield, Virginia 22152

www.dea.gov

Michael Baxter
Vice President, Government Affairs
American Pharmacists Association
mbaxter@aphanet.org

Dear Mr. Baxter:

This is in response to your letter dated March 3, 2025, addressed to Derek S. Maltz, former Acting Administrator, Drug Enforcement Administration (DEA). Your letter was forwarded to the DEA Diversion Control Division on May 7, 2025, for response. In addition to the American Pharmacists Association, your letter was submitted to DEA on behalf of the American Association of Colleges of Pharmacy, American Association of Psychiatric Pharmacists, American College of Clinical Pharmacy, American Society of Consultant Pharmacists, American Society of Health-System Pharmacists, Colorado Pharmacists Society, Iowa Pharmacy Association, National Alliance of State Pharmacy Associations, National Association of Chain Drug Stores, National Community Pharmacists Association, Nevada Pharmacy Alliance, North Dakota Pharmacists Association, and Oregon State Pharmacy Association. DEA apologizes for the delay in responding to you and appreciates the opportunity to address your concerns. We are sending an identical response to the associations listed above.

In your letter, you requested, in part, that the DEA update its online registration process and the Mid-Level Practitioners Authorization by State (MLPAS) table to reflect recent changes in state laws and regulations that explicitly grant pharmacists prescriptive authority for controlled substances. Further, you provided information about several states, specifically Colorado, Iowa, Nevada, North Dakota, and Oregon, that you stated have enacted legislation or promulgated regulations that authorize pharmacists to prescribe controlled substances. You requested that DEA update the MLPAS table accordingly.

As part of DEA's ongoing effort to ensure our resources reflect the most up-to-date information available, the MLPAS table has been removed from the DEA Diversion Control Division website and is in the process of being reviewed. During this review, DEA will consider the information you provided about the legislation and regulations in Colorado, Iowa, Nevada, North Dakota, and Oregon. Once DEA has completed its review, the DEA Form 224, Application for Registration, will be updated appropriately.

Image source: APhA

Extension of COVID-19 Telemedicine Flexibilities

Flexibilities remain in effect through December 31, 2026

- Remote prescribing of Schedule II-V controlled substances through real-time audio-video telemedicine without a prior in-person medical evaluation
- Audio-only prescribing of Schedule III-V narcotic medications approved for opioid use disorder maintenance or withdrawal management through telemedicine

Impact of the "Two Final Rules"

- Expansion of Buprenorphine Treatment via Telemedicine Encour
- Continuity of Care via Telemedicine for Veterans Affairs Patients

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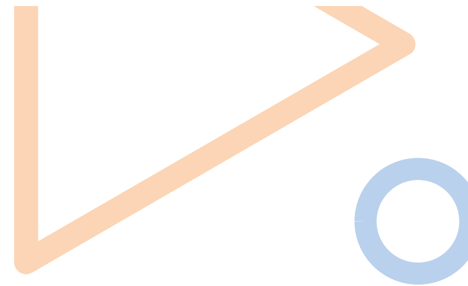


2025 Recap: PBM Reform

- Widespread enactment of PBM reform laws
- Establishment of reimbursement floors
- Elimination or restriction of spread pricing
- Enhanced PBM transparency and reporting requirements
- Strengthened protections against patient steering and pharmacy discrimination
- Expanded PBM licensure, enforcement authority, and audit protections
- Parallel rise in litigation challenging state PBM authority

Examples of 2025 Policy Advancements

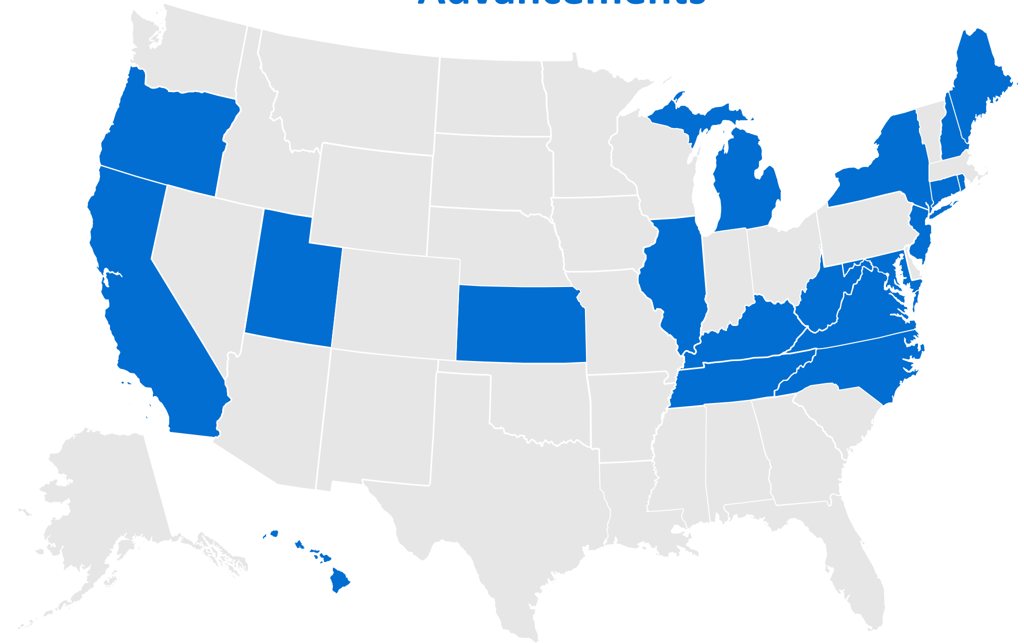
Source: APhA analysis of state policy

*Examples of legislative, regulatory, or policy advancements and not intended to be a comprehensive representation

2025 Recap: Coverage for services & scope of practice

- Shift toward a standard-of-care regulatory model
- Expansion of pharmacist prescribing and test-and-treat authority, particularly for infectious diseases, HIV prevention, contraception, vaccines, and medications for opioid use disorder.
- Growing recognition of pharmacists as health care providers
- Medicaid coverage gains through State Plan Amendments
- Commercial insurance alignment with scope expansions
- Federal policy signals reinforcing state action

Examples of 2025 Policy Advancements



Source: APhA analysis of state policy

*Examples of legislative, regulatory, or policy advancements and not intended to be a comprehensive representation

State RHTP – Pharmacist Wins!

At least 38 State Rural Health Transformation Programs explicitly mention pharmacists, and many detail how they will pay pharmacists for services to rural communities!

Inclusion of Pharmacists in Rural Health Transformation Program

This resource provides an initial, state-by-state summary of how pharmacists and pharmacies are referenced in applications submitted under the Rural Health Transformation Program (RHTP) administered by the Centers for Medicare & Medicaid Services (CMS). The table below reflects APhA's review of publicly available state project narratives and identifies whether specific pharmacy-related themes are explicitly mentioned in each application. Categories distinguish between states that propose policy levers to expand pharmacists' scope of practice, reference existing authority without proposing change, and address related issues such as payment for pharmacists' services, workforce development, rural access, and health information technology access for pharmacists. Inclusion indicates the topic was referenced in a state's application and does not imply that CMS has approved, endorsed, or will fund any specific policy proposal or activity. Indicators reflect explicit language contained in the state applications and are not intended to assess implementation. Absence of an indicator does not imply absence of authority or activity within a state.

State	Planned Scope Expansion (Policy Lever)[a]	Existing Scope Referenced (Descriptive Only)[b]	Scope is Incorrectly Implied as Broad[c]	Payment for Pharmacist Services[d]	Workforce / Training Strategy[e]	Pharmacies as Rural Access Points[f]	Health Information Technology Access for Pharmacists[g]
Alabama[1]		X			X		
Alaska[2]	X			X	X	X	X
Arizona[3]							
Arkansas[4]	X			X			
California[5]		X			X		
Colorado[6]							

Source: APhA
Image source: APhA

136th General Assembly Priorities

STATE UPDATE

SB230 -Test and Treat Authority for Pharmacists

Sponsor: Senator Mark Romanchuk
Status: Senate Health – Second Hearing 02/18/26

This legislation would allow pharmacists to Test and Treat for:

1. Influenza
2. Strep
3. COVID-19
4. RSV

SB230 -Test and Treat Authority for Pharmacists

Sponsor: Senator Mark Romanchuk

Status: Senate Health – Second Hearing 02/18/26

Other key provisions of the legislation:

- State Board of Pharmacy will create a Statewide Protocol
- Requires payment that is equivalent to other health care service providers.
- Allows the State Board of Pharmacy to create rules to add other respiratory conditions

HB276 & SB198 – 340B Pharmacy Access Act

Sponsor: Rep. John, Rep. Holmes and Sen. Koehler

Status: HB276 (House Insurance – 4th Hearing 11/4/25); SB198 (Senate Health – 3rd Hearing 11/12/25)

- The 340B program is a critical lifeline for patients served by federally qualified health centers, community clinics, and nonprofit hospitals
- Recent manufacturer-imposed restrictions limit access to discounted drugs through contract pharmacies
- These restrictions threaten patient access—especially in rural and underserved communities

HB229 & SB210 – PBM Regulation

Sponsor: Rep. Deeter and Sen. Blessing
Status: HB229 (Senate Financial Institutions – 4th Hearing 02/11/26); SB210 (Referred to Senate Health – 6/4/25)

- Established a stand-alone licensing process for PBMs under the Ohio Department of Insurance (ODI).
- Requires transparent contracts with pharmacies and plan sponsors.
- Grants ODI clear enforcement authority.

HB192– Community Pharmacy Protection Act

Sponsor: Rep. Barhorst

Status: House Insurance – 5th Hearing 11/18/25

- Prevents health plans and PBMs from imposing unnecessary accreditation or certification requirements beyond what Ohio law requires.
- Requires PBMs to report drug cost data, providing transparency for plan sponsors and pharmacies.
- Protects pharmacies from retaliation or exclusion for reporting violations advocating for fair practices.

HB629– Pharmacists Prescribing Authority Act

Sponsor: Rep. Barhorst and Rep. Gross
Status: Introduced 12/11/25

- Authorizes pharmacists to prescribe for select minor and self-limiting health conditions.
- Builds on pharmacists’ extensive education, clinical training, and medication expertise.
- Establishes clear parameters to ensure safe and appropriate patient care.

HB324– Patient Protection Act

Sponsor: Rep. Mathews and Rep. Craig
Status: Passed by House 11/19/25

- Directs the Ohio Director of Health to determine when a prescription drug causes severe adverse effects in more than 5% of users
- Requires consultation with the Superintendent of Insurance, State Board of Pharmacy and State Medical Board
- Defines severe adverse effects as: death, infection or hemorrhaging requiring hospitalization, organ failure or Sepsis
- Establishes additional prescribing requirements for drugs meeting the threshold
- Requires a publicly available list of identified drugs on the Department of Health website

HB324– Patient Protection Act

Sponsor: Rep. Mathews and Rep. Craig
Status: Passed by House 11/19/25

OPA's concerns with the legislation:

1. Pharmacists are often the last healthcare professional to review a medication before a patient uses it
2. The bill introduces new prescribing requirements that may impact access and workflow without clear implementation guidance
3. Public drug lists, if not carefully communicated, may confuse patients or discourage appropriate therapy
4. Pharmacists need clarity on their role and responsibilities once a drug appears on the severe adverse effects list
5. Any changes must ensure patient safety without creating unnecessary barriers to care

HB374 – Prescription Drug Readers

Sponsor: Rep. Sigrist and Rep. Abrams
Status: House Insurance – 2nd Hearing 10/28/25

- Requires pharmacies to notify patients that a prescription drug reader is available
- Requires pharmacies to provide a reader upon request
- Requires health plans and Medicaid to cover prescription drug readers

HB374 – Prescription Drug Readers

Sponsor: Rep. Sigrist and Rep. Abrams

Status: House Insurance – 2nd Hearing 10/28/25

OPA's concerns with this legislation:

- Pharmacies would need clear guidance on how notification must occur, what devices qualify, and how reimbursement would work in practice.

- This is a good example of legislation that aims to improve patient access and safety, while also raising practical questions about workflow, technology, and operational impact in a pharmacy setting.

SB207– Co-Pay Accumulators

Sponsor: Sen. Manchester and Sen. Liston
Status: Senate Financial Institutions, Insurance and Technology – 3rd Hearing 11/4/25

- Patient payments must count toward deductibles and out-of-pocket costs
- Plans may require generics when appropriate
- Cost-sharing cannot exceed federal limits
- Coverage decisions cannot be based on drug assistance programs

SB249– Dispensing Ivermectin without Prescription

Sponsor: Sen. Lang and Sen. Johnson
Status: Referred to Senate Health 10/1/25

- Allows a pharmacist or pharmacy intern to dispense ivermectin without a prescription
- Must be done under a protocol established by a prescriber
- Prescriber may authorize one or more pharmacists to use the protocol

SB249– Dispensing Ivermectin without Prescription

Sponsor: Sen. Lang and Sen. Johnson

Status: Referred to Senate Health 10/1/25

OPA's concerns with this legislation:

- OPA's concerns are centered on patient safety, clinical appropriateness, and the way this authority is structured. Unlike other scope expansions that are based on well-established evidence, standardized statewide protocols, and clear reimbursement pathways, this bill raises concerns about inconsistent application and potential misuse.
- Additionally, placing pharmacists and interns in the position of dispensing a highly controversial medication without a patient-specific prescription may create ethical, clinical, and professional challenges.
- Not all scope expansion proposals are good policy. OPA evaluates legislation based on patient safety, evidence-based practice, and how it impacts pharmacists in real-world settings—not simply whether it expands authority.

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Need More Information?

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