



October 15, 2026

Arkansas Takes Action: 14 PBMs Sign Orders Requiring Fair and Reasonable Pharmacy Payment Models

14 new legal orders signed in September and October 2026. More are coming.

The legal authority for these enforcement actions began in 2018, when the Arkansas General Assembly passed Act 3 of the Second Extraordinary Session, the Arkansas Pharmacy Benefits Manager Licensure Act.

That landmark legislation established state licensure and regulatory oversight of PBMs and specifically authorized the Arkansas Insurance Commissioner to review pharmacy compensation programs to ensure reimbursement is fair and reasonable and sufficient to maintain adequate pharmacy networks.

In 2024, the Arkansas Insurance Department implemented that statutory authority through Rule 128: Fair and Reasonable Pharmacy Reimbursements, establishing a regulatory process to review PBM reimbursement data and determine whether pharmacy compensation adequately supports patient access, professional services, and sustainable pharmacy networks.

This is not a new law or an arbitrary reimbursement mandate. It is the enforcement of legal authority Arkansas established in 2018 and implemented through Rule 128 in 2024.

The Arkansas Insurance Department has issued 14 signed orders under Rule 128, the Fair and Reasonable Pharmacy Compensation Program, addressing a fundamental problem in pharmacy reimbursement.

PBMs were paying Arkansas pharmacies enough to replace the pills on the shelf. They expected the pharmacists, technicians, professional services, patient counseling, operating expenses, and responsibility for patient safety to come free.

Arkansas said otherwise.

After examining reimbursement data submitted by licensed PBMs for 2024 and 2025, the Arkansas Insurance Department put a number on what these reimbursement methodologies had effectively erased: \$10.50 in professional dispensing compensation for every generic prescription.

The PBMs were required to show their homework, justify their reimbursement methodologies, and demonstrate how their payment structures satisfied Arkansas law.

The fundamental question is simple: How can patients and employers pay billions in health insurance premiums and prescription drug benefits while the companies administering those benefits fail to adequately

compensate the healthcare professionals actually delivering the services?

This Is Part of a Much Larger Problem

The PBM business model has evolved into a complex system of financial arrangements, hidden compensation, and conflicts of interest that can drive up healthcare costs while undermining competition and patient access.

These practices include billions in manufacturer rebates and discounts flowing through affiliated entities, including offshore companies, without full transparency or assurances that the savings reach employers and patients.

They also include financial arrangements that can reward insurance brokers and consultants for steering employers toward PBMs rather than securing the best value for the employers they represent.

Hidden effective rate guarantees, reconciliation clawbacks, and spread pricing arrangements further obscure actual prescription drug costs and pharmacy reimbursement.

Perhaps most troubling are reimbursement arrangements that can pay pharmacies under common ownership with PBMs dramatically more than competing independent pharmacies for the same medications, particularly expensive specialty drugs.

The Federal Trade Commission, Tennessee Department of Commerce and Insurance, and West Virginia Insurance Department have documented serious concerns involving PBM affiliate reimbursement practices, conflicts of interest, and financial arrangements that can increase costs for employers, patients, and taxpayers.

When the company setting the price also owns the pharmacy receiving the payment, the conflict of interest should be obvious.

Arkansas Is Investigating PBM Affiliate Reimbursement

The Arkansas Insurance Department currently has active examinations involving five major PBMs:

CVS Caremark, Express Scripts, OptumRx, Navitus, and Prime Therapeutics.

These examinations are reviewing reimbursement practices involving pharmacies under common ownership with PBMs compared with competing, nonaffiliated pharmacies.

Navitus challenged the Insurance Department's examination authority through an administrative appeal and lost. The company has subsequently pursued its challenge in circuit court.

Arkansas is asserting its authority to examine these arrangements and enforce state laws designed to protect patients, pharmacies, employers, and taxpayers.

Paying for the Medication Is Not Paying for Healthcare

For the affected plans, the PBMs reimbursed Arkansas pharmacies at or only slightly above the National Average Drug Acquisition Cost, commonly known as NADAC.

That may cover the ingredient cost of the medication.

It does not cover the professional healthcare services or operating costs necessary to safely dispense that medication.

NADAC buys the medication.

It does not verify the dose, identify dangerous drug interactions, contact the prescriber, resolve insurance rejections, counsel the patient, pay the pharmacy technician, compensate the pharmacist, cover the lease, pay the liability insurance, or keep the doors open while any of that happens.

For years, PBMs have effectively stopped the reimbursement calculation at the wholesaler invoice.

Everything that happens after the medication arrives at the pharmacy is treated as though it requires no professional labor, clinical judgment, or operating expense.

Then the PBM sends back a paid claim and calls the pharmacy reimbursed.

Arkansas used the PBMs' own data and refused to call that fair or reasonable.

What Changes January 1, 2027?

Beginning January 1, 2027, the affected plans administered by these PBMs must reimburse Arkansas pharmacies at least NADAC plus \$10.50 for each generic prescription.

Importantly, PBMs cannot simply shift this professional dispensing compensation directly onto patients through a new charge outside the plan's existing copayment, coinsurance, or deductible obligations.

The PBMs signed the orders and agreed to identify the affected plans, BINs, and PCNs to participating Arkansas pharmacies.

The \$10.50 Is an Established Cost Benchmark, Not an Arbitrary Number

The \$10.50 professional dispensing fee is based on an accounting firm cost of dispensing analysis previously established for the Arkansas Medicaid program, using data collected before the significant inflation in pharmacy labor, operating expenses, and other healthcare delivery costs.

Yet some PBMs were reportedly reimbursing Arkansas pharmacies for professional dispensing services at amounts equivalent to as little as 5% of the Medicaid dispensing fee.

These reimbursement practices raise serious antitrust and competition concerns. When PBMs reimburse independently owned pharmacies at rates that may be insufficient to sustain operations, while simultaneously directing prescription volume to pharmacies under their own common ownership, it raises a legitimate question: Are these reimbursement methodologies being used to financially weaken competing pharmacies, force them out of business, and shift market share to PBM owned pharmacies where the PBMs can pay their own affiliates substantially higher amounts?

That possibility deserves serious regulatory and antitrust scrutiny.

The \$10.50 benchmark is also substantially below more recent pharmacy cost of dispensing findings in neighboring states.

Kentucky's 2026 cost of dispensing study established a professional dispensing fee of \$16.31, which the state has adopted through an emergency regulation for applicable commercial health plans beginning January 1, 2027.

That means Arkansas's \$10.50 requirement is approximately 35.6% lower than Kentucky's \$16.31 fee, even before accounting for inflation since the earlier Arkansas Medicaid cost study.

Arkansas is not requiring an excessive professional dispensing fee. It is establishing a minimum reimbursement benchmark based on historical pharmacy operating costs, while a neighboring state's more recent analysis

demonstrates that the actual cost of providing pharmacy services may be considerably higher.

The \$10.50 is not a bonus, a windfall, or an arbitrary payment. It is recognition of a real cost that PBMs have spent years treating as though it does not exist.

Federal Courts Have Recognized States' Authority to Regulate Pharmacy Reimbursement

A self funded health plan challenged state pharmacy reimbursement requirements under ERISA.

In September 2026, the Seventh Circuit upheld the relevant state cost regulation against the ERISA preemption challenge, consistent with the principles established by the United States Supreme Court in *Rutledge v. Pharmaceutical Care Management Association* in 2020.

That unanimous Supreme Court decision upheld Arkansas's authority to regulate PBM pharmacy reimbursement costs.

Arkansas continues to lead efforts to defend states' authority to regulate PBMs, protect competition, preserve pharmacy access, and ensure public health and safety.

14 PBMs Signed Final Determination Orders

Arkansas Insurance Department

Rule 128: Fair and Reasonable Pharmacy Compensation Program

October 14, 2026

TrueScripts

October 12, 2026

MedImpact and Smith Health

October 9, 2026

CarelonRx, MedOne, Navitus, Prescriptive Health, Prime Therapeutics, SavRx, and Ventegra

October 8, 2026

MaxorPlus

October 7, 2026

VeracityRx

October 6, 2026

BeneCard

September 17, 2026

TrueRx

14 licensed PBMs. 14 signed orders. More enforcement actions expected.

Arkansas Insurance Department orders:

<https://insurance.arkansas.gov/industry-regulation/legal/orders/>

The Bottom Line

Arkansas is confronting a reimbursement system that has too often treated pharmacy professionals, patient safety services, and the infrastructure necessary to deliver prescription medications as though they have no value.

Patients and employers pay for prescription drug coverage expecting their benefits will support access to actual healthcare, not merely the acquisition cost of a bottle of pills.

The professional services required to dispense medications safely are not optional, and they are certainly not free.

The \$10.50 is not a bonus. It is the part of the prescription PBMs have spent years pretending happens for free.

The drug was paid for. The pharmacy was not.