Bulletin 25-06

To: All Pharmacy Benefit Managers ("PBMs"), Third-Party Payors, and Pharmacies Certified and Licensed to Do Business in the State of Iowa

From: Doug Ommen, Iowa Insurance Commissioner

RE: Prohibited Use of Deceptive and Unfair Practices and Implementation of SF 383

Date: September 24, 2025

PBMs are significant actors in the prescription drug market. Some of the functions PBMs provide include negotiating with drug manufacturers regarding discounts and rebates; designing pharmacy networks; designing and managing drug formularies (formularies list the brand, generic, specialty, and any other drugs that are eligible for coverage under a health benefit plan); contracting with pharmacies to create networks; and administering prescription benefits for health plans.

Three PBMs control approximately 80% of the national market. The largest PBMs have almost total control over the pricing, dispensing, and reimbursement of covered drugs. The Iowa Insurance Division ("Division") is committed to ensuring transparency, fair dealing, and accountability in the marketplace. Sections A, B and C of this advisory bulletin are meant to reinforce existing prohibitions of unfair and deceptive trade practices in the business of insurance and caution against the use of these practices by PBMs, directly or indirectly. Section D addresses the Division's implementation of SF 383, while recognizing the limitations on the Division's enforcement in light of the ongoing litigation challenging the law.

A. Iowa Insurance Trade Practices Act

The Iowa Insurance Trade Practices Act prohibits a person from engaging in any trade practice in Iowa which is defined, or determined pursuant to section 507B.6 to be, an unfair method of competition, or an unfair or deceptive act or practice in the business of insurance. Iowa Code § 507B.3.

While Iowa Code chapter 507B enumerates some acts that are *per se* unfair method of competition, or an unfair or deceptive act or practice, the statute also provides the Commissioner with the authority to determine, after a hearing, that other acts and practices are unfair methods of competition, or unfair or deceptive acts or practices.

Iowa Code § 507B.3 provides:

> A person shall not engage in this state in any trade practice which is **defined** in this chapter as, **or determined** pursuant to section 507B.6 to be, an unfair method of competition, or an unfair or deceptive act or practice in the business of insurance. (Emphasis added).[1]

Iowa Code § 507B.6 provides:

> Whenever the commissioner believes that any person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice whether or not defined in section 507B.4, 507B.4A, or 507B.5 and that a proceeding by the commissioner in respect to such method of competition or unfair or deceptive act or practice would be in the public interest, the commissioner shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing on such charges to be held at a time and place fixed in the notice, which shall not be less than ten days after the date of the service of such notice.

Iowa's Insurance Trade Practices law and its prohibitions of any "unfair method of competition or any unfair or deceptive act or practice" are the result of deliberations in Congress and at the National Association of Insurance Commissioners ("NAIC") dating back to the origins of the McCarran-Ferguson Act. 15 U.S.C. §§ 1011-1015 (2015); Iowa Code § 507B.1.[2]

In 1947, the NAIC adopted the model state unfair trade act, first titled "An Act Relating to Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance."[3] Every state adopted this law.[4] The NAIC model law was specifically drawn from the concepts in Section 5 of the Federal Trade Commission ("FTC") Act, so it carried with it the broad prohibitions of unfairness and deception jurisdiction, and enumerated some unfair and deceptive acts and practices.[5]

The text of Iowa Code §§ 507B.3 and 507B.6, and the declaration of purpose found in Iowa Code § 507B.1 in light of NAIC and Congressional history, makes clear the Iowa Legislature's intent to prohibit enumerated unfair or deceptive acts or practices, but to also broadly prohibit unfair or deceptive acts or practices similar to the FTC Act prohibition. The primary difference between the FTC Act and the Iowa Insurance Trade Practices Act is that chapter 507B was enacted to cover the markets and entities regulated by the insurance commissioner in this state and to vest that consumer protection and market regulation responsibility in Iowa's insurance commissioner.[6]

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[1] See also *In the Matter of Jahvon J. Thompson*, No. 103448, 2020 WL 586720, at 10 (Iowa Ins. Div., Jan. 28, 2020).
[2] *In the Matter of Nathan W. Treibel, and Anthony Peck*, No. 104961, 2023 WL 726758, 10 (Iowa Ins. Div., Jan. 12, 2023) (citing *In the matter of DeVries*, No. 103128, 2021 WL 1202188, 23 (Iowa Ins. Div., March 26, 2021).
[3] Mid Winter Meeting, 1947 Nat'l Ass'n Ins. Comm'rs Proc. 142-143, 383-389, 392-410, 413.
[4] Summer Meeting, 1960 Nat'l Ass'n Ins. Comm'rs Proc. Vol. II, 515.
[5] Mid Winter Meeting, 1947 Nat'l Ass'n Ins. Comm'rs Proc. 142-143, 383-389, 392-410, 413.
[6] *Treibel*, *Id*. at 11.

Deception is not limited to fraud. The capacity to mislead is closely tied to the concept of deception. Federal decisions under the FTC Act and state consumer protection laws sharing similar principles of deception make clear the legislative intent to prohibit acts or practices that deceive or have the tendency or capacity to mislead consumers and persons transacting in the business of insurance.[7] Therefore, the Division has consistently concluded that the prohibition of deceptive acts and practices in Iowa Code § 507B.3 includes acts or practices that have the tendency or capacity to mislead.[8] Iowa courts, recognizing the broad consumer protection goals of the Iowa Consumer Fraud Act, tend to focus on the likelihood of misleading consumers and the reliance on misrepresentations or omissions, rather than the violator's subjective intent. Similar to the FTC Act, no intent to deceive is required nor must actual deception be demonstrated to find that an unfair or deceptive act occurred.[9]

An act or practice may be both deceptive and unfair, or it may be unfair but not deceptive.[10] Additionally, the Division has concluded that the prohibition of unfair acts and practices in Iowa Code § 507B.3 includes acts and practices that offend public policy as established by law and are likely to cause substantial, unavoidable injury to insurance purchasers.[11] Unfair practices may also be described as an act or practice that causes substantial, unavoidable injury to consumers that is not outweighed by consumer or competitive benefits produced by the act or practice. Iowa Code § 714.16(1)(n).[12]

The Division is concerned with the impact of PBMs' potentially unfair methods of competition and unfair or deceptive practices on the marketplace and Iowa consumers. Approximately 160 pharmacies permanently closed in Iowa over the past decade.[13] These closures can lead to "pharmacy deserts" and Iowans may lose crucial access to easily accessible healthcare. Of the pharmacy closures, less than twenty percent were chain pharmacies.

B. Deceptive Business Practices

The Division, as well as other state and federal agencies, is concerned that some PBMs may be utilizing business practices that are violative of state or federal insurance laws, consumer protection laws, and antitrust principles. The FTC, for example, preliminarily found in its July 2024 FTC Interim Staff Report that the consolidation and vertical integration of the six largest

[7] *Id*.; *DeVries*, *Id*. at 25; *In the matter of Diamond*, No. 96975, 2019 WL 5677529, 38 (Iowa Ins. Div., Oct. 23, 2019); *In the matter of Newman*, No. 91936, 2017 WL 6504574, 9 (Iowa Ins. Div., Jan. 24, 2017); *Montgomery Ward & Co. v. FTC,* 379 F.2d 666 (7th Cir. 1967); Iowa Code § 714.16(1)(c) (2025); *State ex rel. Miller v. Vertrue, Inc.*, 834 N.W.2d 12, 34 (Iowa 2013)).
[8] *Treibel*, *Id*. at 11; *DeVries*, *Id*. at 25; *Diamond*, *Id*. at 38; *Newman*, *Id*. at 9-10; *Vertrue*, 834 at 33-34.
[9] *Montgomery Ward & Co.*, 379 F.2d at 670; *State ex rel. Miller v. Pace*, 677 N.W.2d 761, 770-771 (Iowa 2004); Iowa Code § 714.16(2)(*a*) (2025).
[10] *Vertrue,* 834 at 33-34.
[11] *Treibel*, *Id*. at 12-14; *Diamond*, *Id*. at 38; *Newman*, *Id*. at 10.
[12] *Vertrue,* 834 at 33-34.
[13] This number does not include closures due to ownership transfers, consolidations, or relocations.

PBMs had significant impact on the accessibility and affordability of prescription drugs.[14] Some PBMs may also use their dominant market position to develop and utilize opaque business practices that constitute deceptive practices. The Division is aware of allegations that some PBMs are engaging in the following deceptive practices:

1) Opaque Pharmacy Reimbursement Methods:

Price is typically one of the key terms in a contract between two parties. Price deception can occur in many ways, and the risk of deception is higher when price is a complex term. "In many consumer contracts, price is multidimensional, including multiple, possibly contingent fees and rates, discounts, rebates, add-ons, etc. Price deception might occur when the seller emphasizes one (or more) price dimension(s), while obscuring other price dimensions. An unnecessarily complex and multidimensional pricing scheme designed to conceal the true cost of the product or service can be deceptive in and of itself. Adding nonsalient price dimensions that are likely to be ignored or underestimated by the consumer can also be deceptive."[15]

PBMs may create reimbursement structures for both the initial point-of-sale reimbursement and for later post-sale reimbursement adjustments that are inherently opaque with pharmacies not knowing the amount they will be reimbursed until they actually receive payment. The Division has received information, including but not limited to information obtained through market conduct investigations, that substantiates regulators' concern that reimbursement is not readily understood by pharmacies.

Many PBMs use a payment method known in the industry as the "lesser of logic pricing methodology" wherein PBMs compare a variety of drug pricing sources (usually listed in the contract or provider manual) to determine which has the lowest drug cost. This is not the amount that is paid to the pharmacy and is typically unrelated to the cost the pharmacy actually paid for a specific drug. The PBM further adjusts the cost of the drug by applying a formula that is set and changed at the sole discretion of the PBM. The reduced amount is what many PBMs reimburse to pharmacies and that amount is not known to the pharmacy when it is making its purchasing decision and dispensing the drug to a consumer. For example, for brand drugs, a pharmacy may know that it will be paid the average wholesale price minus a "discount" that is within a certain percentage range, but the pharmacy will not know what the specific discount percentage will be on any day. The discount can fluctuate at any time, and in the sole discretion of the PBM. Some PBMs apply "discounts" as high as twenty-five (25) percent. To avoid deceptive pricing, the specific discount should be communicated no later than at the time the pharmacy is dispensing the drug. "Discount" by itself may be a misleading term as it is an amount that *reduces* the

[14] OFFICE OF POLICY PLANNING, FED. TRADE COMMISSION, INTERIM STAFF REPORT, PHARMACY BENEFIT MANAGERS: THE POWERFUL MIDDLEMEN INFLATING DRUG COSTS & SQUEEZING MAIN STREET PHARMACIES (July 2024) (https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf).
[15] Restatement of the Law, Consumer Contracts § 6 TD (2019).

reimbursement amount a PBM pays a pharmacy, whereas a reasonable person may believe that discounts benefit the purchaser.

Pharmacies have also expressed uncertainty and concerns about the lack of transparency regarding PBMs' calculations of average wholesale price ("AWP"). A pharmacy can track what it pays its wholesaler to acquire a drug and the average price over a specified period of time, but this is not the price the PBM utilizes in its calculation of AWP. AWP is not a transaction price that is actually paid, but is instead an amount that serves as the starting point from which negotiations and discounts are made to reduce the price. A PBM does not typically publish the AWP for any drug or explain how this number is derived. A significant number of PBMs do not communicate to the pharmacy where they obtain wholesale price information or even if that price is available to a pharmacy in the state where the pharmacy is located.

In the case of generic drugs, PBMs often use maximum allowable cost ("MAC") as the base source price for generic drugs. The MAC list is created by the PBM and is updated on a frequent and unpredictable basis. Pharmacies do not know when the MAC price will change, simply that it often changes. Like the average wholesale price, PBMs do not identify where a drug can be purchased at the listed price. To further obfuscate pricing, some PBMs reduce the drug source price by applying "discounts" that may be as high as ninety (90) percent. Many PBMs neither disclose to the pharmacy the specific "discount" reduction rate nor that it is reducing the drug source price by any amount at all.

Pharmacies are unable to effectively compare point-of-sale reimbursement amounts across PBMs and make informed business decisions under these conditions. The Division is also aware that it is not uncommon for Iowa pharmacies to be reimbursed at an amount below the pharmacy's cost of acquiring the drug it dispenses to Iowa consumers. In addition to opaque reimbursement practices, some PBMs have sole discretion to modify contract reimbursement terms without first obtaining written consent from the pharmacy or providing explicit notice to the pharmacy of the change in terms. Instead, a pharmacy's submission of a claim is deemed acceptance of the new reimbursement terms. This may be a type of negative option contract, which in this context is deceptive and unfair.

The lack of point-of-sale transparency is further exacerbated by PBMs' unpredictable and opaque post-sale reimbursement adjustments. Some examples of post-sale adjustments to reimbursement amounts include effective rate reconciliation, performance rebates or payments, direct and indirect remuneration ("DIR") fees, network fees, and claims processing fees. These post-sale price adjustments often occur at the end of the calendar year, months after the point-of-sale reimbursements have occurred. The timing of the adjustments makes it difficult for a pharmacy to determine if it has been underpaid on any particular drug.

Effective rate reconciliation ("ERR") is a process utilized by PBMs to retroactively adjust reimbursements paid to pharmacies the prior year. Typically, this process involves the PBM reviewing all reimbursements paid to all pharmacies in a chain or all pharmacies associated with a specific pharmacy service administrative organization ("PSAO"), across all non-Medicare lines

of business, nationwide and then retroactively adjusts the reimbursement payments in order to meet an aggregate payment that is not more or less than a contracted amount. Effective rates can apply to both generic and brand drugs.

As part of the ERR process, the PBM reviews every claim reimbursement paid to every pharmacy in a chain or PSAO during the previous calendar year and aggregates this information. The PBM determines the average discount percentage after reviewing the pooled information. Once the PBM determines the difference between the average annual discount percentage and the effective rate reimbursement amount percentage, the PBM will either make a payment to the pharmacy chain or PSAO, or demand payment from the pharmacy chain or PSAO. In turn, the pharmacy chain or PSAO, must distribute funds or seek funds from the individual pharmacies that make up the pharmacy chain or PSAO.

Overpayments and underpayments can be difficult for even the most sophisticated pharmacies to predict and track. Pharmacies are put in the position of having point-of-sale reimbursements they received over a year ago, and presumably spent or otherwise accounted for, decreased and clawed back. Reimbursements could also later be increased if a pharmacy was underpaid at the point-of-sale. This prolonged uncertainty poses a significant financial challenge, making it difficult, if not impossible, for pharmacies to make informed purchasing and general business decisions.

In addition to the unpredictable reimbursement amounts and unreasonable post-sale adjustment periods, the ERR data provided to the pharmacies and PSAOs is often opaque. The ERR data provided to pharmacies and PSAOs should contain sufficient information to enable a pharmacy chain or PSAO to determine if the PBM's ERR calculations are correct. PBMs may implement the ERR process in a manner that is inconsistent with the terms of the ERR contract and the complexity of the ERR process may allow this practice to occur unnoticed by a pharmacy. For example, if an ERR contract requires all commercial claims to be part of the ERR process, but the PBM unilaterally excludes certain commercial claims without consent or even notification to the impacted pharmacies, the action may be a deceptive business practice. A one-page report listing claims on an aggregate level across a PSAO and with the total number of claims excluded from the ERR process, but without listing the specific excluded claims, does not contain sufficient information for a reasonable person to understand, let alone verify, the accuracy of the PBM's ERR calculations.

Post-sale adjustments also violate Iowa's clean claim statute if a PBM, directly or indirectly, retroactively reduces the payment of a clean claim submitted by a pharmacy. Iowa Code § 510B.8C.

2) Deception of Payors by Omissions or Misrepresentations of Manufacturer Payments:

Similar to deceptive practices under the FTC Act, deception under Iowa's Insurance Trade Practices Act includes not only misrepresentations, but also omissions of material facts.[16] PBMs may receive and retain additional payments from drug manufacturers, or other parties, that are not disclosed to the third-party payor, which may be an insurer or an employer group. PBMs may receive money from drug manufacturers in the form of administration fees, service fees, volume discounts, inflation fees, enterprise fees, incentives, educational grants, allowances, data fees, and so forth. These payments are rebates in disguise, renamed by PBMs or drug manufacturers to enable the PBM to retain the monetary funds without passing them through to the payor.

Texas has an ongoing case[17] which alleges, in part, that drug manufacturers pay PBMs an "inflation fee" if the manufacturer raises its price by more than a set percentage. The PBM in turn has contracted a "price protection guarantee" with the payor that requires the PBM to pay a certain amount back to the payor in the event that a drug price increases by more than a specified amount. However, if a manufacturer increases a drug price above the set inflation fee rate but less than the price protection guarantee rate set by the PBM, the PBM retains the entire "inflation fee" payment.[18]

Illinois previously alleged that a PBM was receiving numerous payments that constituted rebates even though they were not categorized as such. Illinois also alleged that these rebate payments were not disclosed or passed through to the Illinois Department of Central Management Services, as required by contract.[19] In 2024, CaremarkPCS Health, LLC and Illinois entered a settlement agreement following an investigation by the Illinois Office of Attorney General into certain manufacturer payments. Illinois alleged that Caremark, CVS Pharmacy, Inc., Zinc Health Services, LLC, and Zinc Health Ventures, LLC, collected payments that constituted rebates without proper disclosure to the state and unlawfully retained such payments. Caremark denied the allegations but entered into the settlement and agreed to pay Illinois $45 million dollars.

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[16] See Sec 5 of FTC Act (15 U.S.C. § 45); see also Federal Trade Commission's Policy Statement on Deception (1983) which states that deception occurs when a material representation of omission is likely to mislead reasonable consumer and that omissions are deceptive if information necessary to prevent a practice, claim, representation, or reasonable expectation or belief from being misleading is not disclosed, https://www.ftc.gov/system/files/documents/public_statements/410531/831014deceptionstmt.pdf

[17] *State of Texas v. Eli Lilly and Co.*, No. D-1-GN-24-007940 (Tex. Dist. Oct. 3, 2024).

[18] *Id*.

[19] Press Release, State of Illinois, Illinois Recovers $45 Million Settlement from CVS Caremark (May 14, 2025) (https://www.illinois.gov/news/release.html?releaseid=31292#:~:text=The%20agreement%20settled%20claims%20related,under%20a%20contract%20with%20CMS). The State of Oklahoma also recently alleged that CVS Caremark did not pass through rebates to Oklahoma's state employee health plan. The parties entered into a settlement which requires CVS Caremark to pay $32.1 million to Oklahoma. See Press Release, State of Oklahoma, Drummond Secures $32M in Settlement with CVS Caremark (Sept. 9, 2025) (https://oklahoma.gov/oag/news/newsroom/2025/september/drummond-secures-32m-in-settlement-with-cvs-caremark.html).

Also in 2024, the Inspector General of the U.S. Office of Personnel Management issued an audit report which found that Express Scripts did not pass through all of the manufacturer payments it received while acting as the PBM for the American Postal Workers Union Health Plan.[20] Although the contract required the PBM to pass-through manufacturer payments, defined as "any and all compensation, financial benefits, or remuneration the PBM [or any Third Party] receives from a pharmaceutical manufacturer . . . , including but not limited to, discounts, credits, rebates regardless of how categorized), market share incentives, chargebacks, commissions, [and] administrative or management fees . . . ," the audit found that the PBM overcharged the American Postal Workers Union and the Federal Employees Health Benefits Program nearly 45 million dollars by not passing through all discounts and credits, including almost 16 million dollars in manufacturer rebates withheld by the PBM's sister company.[21]

Recently, some PBMs have utilized "rebate aggregators" to conceal and retain payments they receive from manufacturers. It is an omission of material fact and a deceptive practice if a PBM represents to payors that it is passing through the entire rebate amount, without disclosing the existence and amount of all other payments the PBM is receiving and retaining from drug manufacturers.

C. Unfair Practices and Unfair Methods of Competition

1) Reimbursements for Unaffiliated and Affiliated Pharmacies:

There have been reported concerns that PBM-affiliated pharmacies may receive higher reimbursement rates for drugs than unaffiliated pharmacies dispensing the same drug. Both the FTC Interim Report and the Second Interim Report found that for prescription drug plans managed by the three largest PBMs, specialty generic drugs had reimbursement rates substantially higher (majority of drugs had markups more than 100-1000%) than the National Average Drug Acquisition Cost ("NADAC") for PBM-affiliated pharmacies and that PBM-affiliated pharmacies were reimbursed more than unaffiliated pharmacies for almost every drug examined as part of the case study.[22]

In 2022, the Iowa legislature also expressed concern about this unlawful practice and made its intent clear by enacting a law prohibiting PBMs from reimbursing a pharmacy located in Iowa

[20] U.S. OFFICE OF PERSONNEL MANAGEMENT OFFICE OF THE INSPECTOR GENERAL OFFICE OF AUDITS, OPM-OIG REPORT NO. 2022-SAG-029, AUDIT OF THE AMERICAN POSTAL WORKERS UNION HEALTH PLAN'S PHARMACY OPERATIONS AS ADMINISTERED BY EXPRESS SCRIPTS, INC. FOR CONTRACT YEARS 2016 THROUGH 2021. (March 27, 2024) (https://www.oversight.gov/sites/default/files/documents/reports/2024-10/2022-SAG-029.pdf).
[21] *Id*.
[22] FED. TRADE COMMISSION, INTERIM STAFF REPORT, (July 2024); FED. TRADE COMMISSION, SECOND INTERIM STAFF REPORT, SPECIALTY GENERIC DRUGS: A GROWING PROFIT CENTER FOR VERTICALLY INTEGRATED PHARMACY BENEFIT MANAGERS (January 2025) (https://www.ftc.gov/system/files/ftc_gov/pdf/PBM-6b-Second-Interim-Staff-Report.pdf).

in an amount lower than the amount the PBM reimburses an affiliate dispensing the same drug. Iowa Code § 510B.8B.

The practice of PBMs reimbursing unaffiliated pharmacies less than affiliated pharmacies is also an opaque practice because an unaffiliated pharmacy has no ability to determine whether or not it is being reimbursed the same, more, or less than an affiliated pharmacy for dispensing the same drug. It is also deceptive practice if a PBM represents that it reimburses unaffiliated pharmacies the same as affiliated pharmacies but does nothing to verify the accuracy of its representation.

There have been reported concerns that PBMs have created networks available only to affiliated pharmacies. It is a deceptive omission if a PBM represents that it pays all pharmacies within the same network at the same rate, but does not disclose that the PBM has created networks that prohibit unaffiliated pharmacies from joining. Additionally, it would be an unfair and deceptive practice and unfair method of competition for a PBM to create affiliate-only networks as a means to pay affiliated pharmacies more than unaffiliated pharmacies.

2) Integrated Discount Programs:

Some PBMs, including the three largest PBMs, contract with unaffiliated third-parties to administer discount programs. If a claim is submitted to the discount program, the third-party finds the lowest network rate cost available anywhere. If the third-party's network rate cost is lower than the consumer's cost sharing obligation under the consumer's healthcare plan, the third-party will adjudicate the claim, and the pharmacy is directed to collect the amount provided by the third-party from the consumer. Pharmacies are typically charged a fee for any claim submitted through the discount program. The third-party discount program, in turn, pays the PBM significant sums of money in "development fees" and "per-paid claim administrative fees."

At least one of the largest PBMs does not notify a pharmacy before a claim is submitted to the discount program for adjudication and the pharmacy has no option to opt out. Other PBMs will prompt a pharmacy to submit certain claims to the discount program for adjudication, but the pharmacy may decline to do so. PBMs may also differ in the types of claims submitted to a discount program. At least one large PBM retains authority to submit *any claim* to a discount program, whereas other PBMs may only submit claims after they have been denied under the covered person's health plan.

The Division's preliminary review of limited claim information indicates that pharmacies are reimbursed well below acquisition cost for generic drugs when a claim is processed through a discount card program. As part of the Division's ongoing investigation into PBM market practices, the Division has received comments from pharmacies stating the pharmacies have no ability to negotiate regarding the use of discount programs for claim adjudications. Even if a pharmacy makes the business decision not to enter into a direct contract with a discount program, some

pharmacies are forced into the practice of discount program claims adjudication because the PBM the pharmacy contracts with has its own agreement with the third-party administering the discount program.

The use of integrated discount programs described above is both an opaque, deceptive practice and an unfair practice or method of competition if:

- the pharmacy does not know when a PBM will submit a claim to a discount program;
- the pharmacy does not have an option to opt out of the claim being submitted to the discount program;
- the pharmacy is not notified what the reimbursement price and/or fee associated with use of the discount program will be at the point of sale;
- the pharmacy is reimbursed by the discount program using rates which are often not available in the covered person's network, networks that are not associated with the relevant PBM, or networks that are not available in this state; and
- the pharmacy contracts with a PBM that does not allow the pharmacy to negotiate the contract term permitting the submission of claims through a discount program, a pharmacy is forced into a situation whereby the *PBM's* agreement with the discount program allows claims to be submitted to the discount program, which in turn reimburses pharmacies well below acquisition cost.

Some market participants have recognized the need for a functioning price-based market and acknowledge that the current market is opaque. In June 2025, GoodRx announced that starting July 1, independent pharmacies would be opted-out of GoodRx's integrated savings program. GoodRx launched a new program "[d]esigned to address the industry challenges that independent community pharmacies face around complex reimbursement models and competitive pressures, Community Link leverages a cost-plus pricing model based on NADAC to provide predictable pricing and favorable economics." This new program includes a direct contact between the pharmacy and GoodRx, without the involvement of a PBM.

3) Exclusionary Formulas and Formulary Manipulation:

PBMs, on behalf of their payor clients, often both design and maintain drug formularies. A drug will not be covered by insurance or even offered to covered individuals, if it is not a drug listed on the relevant health plan's formulary. Formularies often have different drug tiers, and the tier impacts the cost-sharing amount paid by the covered individual.

Several regulatory agencies have alleged that if a manufacturer's drug is excluded from a formulary, the manufacturer is unable to sell that drug to anyone covered by that formulary. PBMs can, effectively, use formularies to boycott certain brand and generic drugs and limit consumers'

access to covered drugs. Regulatory agencies have also alleged that PBMs use this market power to induce drug manufacturers into paying higher rebates for inclusion of their drugs on the formulary. Not only does this raise anticompetitive concerns, the drive for increased rebate payments may also lead to inflated drug list prices that are untethered from the price that any entity actually pays for the drug.

Further, PBMs' formulary designs directly impact the out-of-pocket costs for covered individuals. Typically, generic drugs are placed on the lowest cost-sharing tier with more expensive brand and specialty drugs being placed in higher cost-sharing tiers. When a PBM's formulary excludes lower cost generic drugs, which do not receive manufacturer rebates, in favor of brand drugs that will provide rebates from a manufacturer, the PBM's action may result in covered individuals paying more for their prescription drugs so it may obtain rebates from drug manufacturers.

4) Non-Negotiable Contract Terms:

Pharmacists have told the Division, and other regulators, that they have no, or very limited, ability to negotiate terms when contracting with PBMs. Pharmacies report that contract terms are commonly offered to pharmacies on a "take it or leave it" basis. Such unequal bargaining power can result in contracts of adhesion.

Unaffiliated pharmacies enter into a network contract with the PBM in order to have access to individuals covered by the plan. If a pharmacy does not agree to the PBM's terms, the pharmacy will lose access to a large portion of the market. The Division has heard from Iowa pharmacies that not only are they unable to negotiate certain contract terms, some PBMs also unilaterally change the contract terms after the contract is entered into by the parties.

The use of discount programs to the financial detriment of pharmacies, described above, is one example of a contract term that pharmacies report having no ability to negotiate. Another example is a PBM's contract requirement to use arbitration as the exclusive, and binding, method to appeal a PBM's audit findings, decisions to terminate or suspend a pharmacy, and any other dispute. The Division has observed some PBMs including very restrictive arbitration requirements in contracts with pharmacies. For instance, requiring a pharmacy to place $50,000 in an escrow account as a condition of requesting arbitration; limiting discovery to the exchange of witness and exhibit lists; limits on relief available; and requiring the PBM and pharmacy to equally share the cost of arbitration, regardless of who prevails. Non-negotiable contract terms which have the practical effect of discouraging arbitration requests or opportunity for a meaningful and fulsome resolution of disputes may be an unfair practice or method of competition.

A PBM may be using an unfair practice or method of competition if it uses its market power to mandate contract terms that are detrimental to the pharmacy and does not provide the pharmacy with any meaningful opportunity to negotiate.

D. New Legislative Provisions

SF 383 was passed by the Iowa Legislature and signed by Governor Reynolds on June 11, 2025. As Governor Reynolds noted, the issues regarding PBMs are "complex" and it is important to address "PBM practices that harm both patients and independent pharmacies" and implement SF 383 in a way "to mitigate and ensure that any unintended consequences for private employers are addressed."

Since SF 383 was passed, the Division has received many requests for guidance about the bill and about the impact of the preliminary injunction ordered by the court in *Iowa Association of Business and Industry (ABI) et al. v. Ommen*. SF 383 is enforceable in its entirety against all entities that are not plaintiffs in *ABI v. Ommen*. For those employer groups who are plaintiffs in that lawsuit, and the contractors and agents those plaintiffs use for plan administration, some sections of SF 383 remain enforceable.[23] PBMs, contractors and agents are expected to implement SF 383 for all of their third-party payor clients who are not subject to the court's order in *ABI v. Ommen*.

1) Effective Date and Enforcement:

Pursuant to Section 9 of SF 383, the bill "applies to pharmacy benefits managers, health carriers, third-party payors, and health benefit plans that manage a prescription drug benefit in the state on or after July 1, 2025." This includes the new sections and subsections of the Iowa Code as follows:

- 510B.1 that provides new definitions to be utilized;
- 510B.4(4) prohibiting discriminatory practices against pharmacies and pharmacists acting within the scope of their license;
- 510B.4B that prohibits a PBM from engaging in certain practices such as limiting a consumers' choice of pharmacy, restricting similarly classified pharmacies' participation with a health benefit plan and unreasonably designating a drug to be a specialty drug;
- 510B.8(3)-8(7) relating to rebates and consumer cost-sharing for their prescription drug benefit;

[23] The following provisions may not be enforced against plaintiffs in the *ABI v. Ommen* lawsuit or the PBMs, contractors, and agents when acting on behalf of those plaintiffs: Iowa Code § 510B.4(4), 510B.4B(1)(b), (1)(d), (1)(f), 510B.4B(2)(a), 510B.4B(4), 510B.8(3), 8(6), 510B.8B(3), 510B.8D(1), 8D(2), See: *Iowa Ass'n of Bus. and Indus. v. Ommen*, No. 4:25-cv-00211, Docket No. 54 at *86 (S.D. Iowa July 21, 2025).

- 510B.8B (as amended) requires PBMs to reimburse all retail pharmacies located in Iowa at the NADAC rate and to pay a dispensing fee of $10.68; and

- 510B.8E relating to pharmacy appeals.

SF 383 is effective and shall be complied with as of July 1, 2025. The Division will consider a good faith implementation plan and compliance efforts should the need to determine any enforcement action become necessary.

Additionally, all contracts that apply to prescription drug benefits on or after January 1, 2026, between a PBM and a third-party payor, or between a person and a third-party payor, are expected to comply with the new requirements of Iowa Code § 510B.8D no later than January 1, 2026.

2) Guidance Related to the Implementation of SF 383:

Consumer Steering: Iowa Code §§ 510B.4B(1)(a), (e), and (f) prohibit a PBM from engaging in certain practices that have the effect of steering consumers to one pharmacy over another. Prohibited actions include but are not limited to:

- Limiting a consumer's choice of pharmacy;

- Imposing cost-sharing variations among pharmacies that would affect a consumer's choice; and

- Limiting the daily amounts that a prescription can be filled in certain pharmacies. For example, allowing a 60-day supply at a retail pharmacy and a 90-day supply at a mail order pharmacy for the same cost-sharing amount.

Iowa Code § 510B.8(3) prohibits a PBM from imposing "different cost-sharing or additional fees on a covered person based on the pharmacy at which the covered person fills a prescription drug order."

To comply with Iowa Code §§ 510B.4B(1)(a), (e), (f) and 510B.8(3), a PBM may not solicit, offer, or recommend that a third-party payor take any actions that may have the effect of steering a consumer to certain pharmacies such as a mail order or PBM affiliated pharmacy. A third-party payor may, however, make an unsolicited and unilateral decision regarding such cost-sharing and pharmacy network decisions in designing its benefit plans.

Pharmacy Participation in PBM and Third-Party Payor Networks: As described in Iowa Code §§ 510B.4B(1)(b) and (c), PBMs must allow a pharmacy or pharmacist to participate in a network if the pharmacy or pharmacist agrees to provide pharmacy services that meet the

terms and other requirements, including reimbursement, of the third-party payor. Further, as a condition of participation, PBMs may not impose more stringent requirements than would otherwise be required for pharmacy licensure, certification or as described in the administrative rules adopted by the board of pharmacy.

These sections of SF 383 shall not be construed to mean that a PBM or third-party payor must allow unqualified pharmacies to participate in any network of the pharmacy's choosing. For example, if a pharmacy does not have the ability to refrigerate a drug that has temperature control requirements, that pharmacy would not be qualified to be in a network that requires such drugs to be dispensed. Iowa Code § 510B.4B(2) describes the required actions a third-party payor must take when it restricts pharmacy participation in a network. Rather these sections are meant to prevent PBMs and third-party payors from imposing unreasonable, or unequal, restrictions on those qualified pharmacies as a means of preventing network participation.

Rebates: As described in Iowa Code § 510B.8(4), for the purpose of reducing premiums, one hundred percent of all rebates received by a PBM, must be passed through to the third-party payor.

Iowa Code § 510B.1 defines "rebate" as "all discounts and other negotiated price concessions paid directly or indirectly by a pharmaceutical manufacturer or other entity, other than a covered person, in the prescription drug supply chain to a pharmacy benefits manager. . ." Directly or indirectly includes but is not limited to any "rebates" paid by a pharmaceutical manufacturer to a PBM, an affiliated entity, group purchasing organization, rebate aggregator or any of the PBM's contracted agents. As discussed above in Section B(2), PBMs are prohibited from using practices, such as using different terms for rebates, to evade compliance with the law. Iowa Code § 510B.1 will be interpreted under the prohibition of deception found in Iowa Code chapter 507B.

Cost-Sharing Requirements: As described in Iowa Code §§ 510B.8(5) and 510B.8(6), when calculating the covered person's total contribution toward the covered person's cost-sharing at the point of sale, a PBM shall include any amount paid by the covered person or on behalf of the covered person. However, only the amount paid directly by the covered person shall be applied to the deductible and out-of-pocket maximum set by the covered person's health benefit plan unless the health benefit plan's coverage documents would allow the total amount to apply toward the covered person's out-of-pocket maximum. The following is an example:

> John Doe visits a local pharmacy to purchase a prescription that has a cash price of $500. According to John Doe's prescription drug benefit, the total amount of cost-sharing required to be paid by the covered person is $200. John has a manufacturer's coupon that provides $150 off this type of prescription. The pharmacy will subtract $150 from John's original cost-sharing amount of $200, lowering his out-of-pocket responsibility for this prescription to $50. The third-party payor will apply $50 toward John Doe's deductible

and out-of-pocket maximum from the transaction as that was the amount paid by the covered person.

National Average Drug Acquisition Cost (NADAC) Reimbursement Requirements: Pursuant to Iowa Code § 510B.8B(2), a PBM shall not reimburse any retail pharmacy located in the state an amount less than the most recently published NADAC price for a prescription drug on the date that the prescription drug is administered or dispensed.

A PBM must utilize the most recently published monthly NADAC price for a pharmacy's drug reimbursement price per unit of drugs dispensed. The Division has published and will continually update a Pharmacy List identifying pharmacies that meet the definition of a retail pharmacy located in Iowa. The Pharmacy List shall be used by all parties as the determination of whether the licensed pharmacy is a retail pharmacy located in Iowa. Any party may contact the Division if they believe the Pharmacy List is no longer accurate and needs to be updated. The Pharmacy List is available at: https://iid.iowa.gov/regulated-entities/insurance-related/service-providers/pbm

Dispensing Fees: Iowa Code § 510B.8B(3) requires PBMs to reimburse retail pharmacies located in Iowa a dispensing fee of $10.68 for each claim it is required to reimburse at the NADAC rate.

Pass-Through Pricing: Iowa Code § 510B.8D(1)(a) requires a PBM to use a pass-through pricing model, as defined in SF 383. Under Iowa Code § 510B.1(11B) pass-through pricing means a model of prescription drug pricing in which payments made by a third-party payor to a pharmacy benefits manager for prescription drugs are equal to the payments the pharmacy benefits manager makes to the dispensing pharmacy or dispensing health care provider for the prescription drugs, including any professional dispensing fee.

Appeals and Disputes: Iowa Code § 510B.8E implements requirements for how a PBM must address pharmacy appeals including but not limited to how the PBM must respond when appeals are granted and when they are denied.

Specifically, when a PBM grants a pharmacy's appeal, it must adjust the reimbursement rate for:

- Each pharmacy that is under common ownership with the pharmacy that submitted the appeal; and
- Each pharmacy in the state that demonstrates the inability to purchase the prescription drug for less than the established reimbursement rate.

Additionally, when a PBM denies a pharmacy's appeal, it must provide the pharmacy with the name of a wholesaler from which the pharmacy can obtain the drug at or below the PBM's

reimbursement rate. If the pharmacy demonstrates that its acquisition cost from the wholesaler from "whom the pharmacy purchases the majority of its prescription drugs" is higher than the PBM's reimbursement rate, the PBM must adjust its reimbursement rate above the appealing pharmacy's acquisition cost.

The Division expects PBMs to use good faith and reasonable efforts to comply with these requirements when it grants or denies a pharmacy's appeal. Although the Division does not intend to dictate these business decisions for PBMs, the Division would expect PBMs to implement these requirements in a manner that is not overly burdensome for pharmacies. PBMs should not implement policies or requirements that prevent pharmacies from receiving the required reimbursement amount.

An example of a problematic PBM policy would be having excessive and unnecessary documentation requirements for pharmacies to verify their "common ownership" or wholesaler information. An example of a reasonable PBM policy would be to record all "common ownership" and wholesaler information from one appeal and allow it to be automatically applied if the same pharmacy makes another appeal so long as the pharmacy agrees to the policy. This would eliminate the requirement to resubmit the same information and would streamline the appeal process for both the PBM and the pharmacy.

3) Continuation of Work to Implement SF 383:

Section D of Bulletin 25-06 is issued to provide guidance to all parties as soon as possible following the signing of SF 383 to help facilitate the fastest and smoothest implementation possible for all Iowans, pharmacies, PBMs, and third-party payors. The Division may issue additional bulletin(s) or administrative rules as necessary to implement SF 383. The Division looks forward to working with all parties to take, as Governor Reynolds stated, "a meaningful step toward a fairer, more transparent and accessible healthcare system for all."

Such practices as described in Sections B and C above, if utilized, would violate the Iowa Insurance Trade Practices Act. The practices described in Sections B and C above are illustrative examples and not an exhaustive list of every practice which may constitute an unfair or deceptive practice or method of competition. Violations of SF 383 would also constitute violations of the Iowa Insurance Trade Practices Act. The Division takes these possible violations seriously and will continue to investigate and take enforcement actions where necessary to protect Iowa consumers. Any consumers or industry participants aware of these practices should report them directly to the Division.

Questions or reports may be submitted to: Iowa Insurance Division Market Regulation Bureau pbm.market.conduct@iid.iowa.gov or 515-654-6600.

Bulletins are the Division's interpretations of existing insurance law or general statements of Division policy. Bulletins themselves do not establish binding precedents nor determine facts or violations of law.