THE SENATE
THIRTY-THIRD LEGISLATURE, 2026
STATE OF HAWAII

S.B. NO. 2208

JAN 21 2026

A BILL FOR AN ACT

RELATING TO PHARMACY BENEFIT MANAGERS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that prescription drug costs continue to rise in the State and across the nation, in part due to the opaque business practices of pharmacy benefit managers (PBM), which are companies that manage prescription drug benefits on behalf of health insurers and other payors. The legislature further finds that states such as Kentucky and Ohio have implemented substantial reforms by creating a single, state-controlled pharmacy benefit manager. These reforms were designed to replace fragmented PBM contracts with a transparent, accountable model operating under state oversight.

The legislature also finds that Kentucky and Ohio both initiated their statewide transition by adopting a state-contracted PBM model that limited the responsibility of the state PBM to administering the pharmacy benefits for medicaid recipients enrolled with a managed care organization contracted by the state. In both states, these reforms served as pilot frameworks that exposed spread-pricing, improved

pharmacy reimbursements, and returned savings to medicaid programs. Over time, the transparency and data gained through these models informed broader legislative reforms applicable to commercial PBMs and strengthened overall consumer protection.

The legislature additionally finds that establishing a state PBM in the State similar to Kentucky and Ohio's initial model will promote transparency, consistent drug pricing, and fair pharmacy reimbursement within the State's medicaid programs. This structure will also create a regulatory foundation to guide future statewide PBM oversight for commercial markets.

Accordingly, the purpose of this Act is to:

(1) Require the department of human services to establish or select and contract with a third-party administrator to serve as the state PBM who shall be responsible for administering all pharmacy benefits for medicaid beneficiaries enrolled with a medicaid managed care organization;

(2) Require all medicaid managed care organizations to contract with and utilize the state PBM;

(3) Establish requirements for the procurement of the state PBM in addition to the requirements under chapter 103F, Hawaii Revised Statutes;

(4) Establish requirements and prohibitions to be included in the contract between the department of human services and state PBM;

(5) Require the department of human services to establish a single-preferred drug list to be used by the state PBM; and

(6) Require the department of human services to consult with the med-QUEST healthcare advisory committee on the development, implementation, and oversight of the state PBM program.

SECTION 2. The Hawaii Revised Statutes is amended by adding a new chapter to be appropriately designated and to read as follows:

"CHAPTER

STATE PHARMACY BENEFIT MANAGER PROGRAM

§ **-1 Definitions.** As used in this chapter:

"Department" means the department of human services.

"Medicaid managed care organization" means an entity with which the department has contracted to serve as a managed care organization as defined in title 42 Code of Federal Regulations section 438.2.

"Pharmacy benefit manager" has the same meaning as defined in section 431S-1.

"Spread pricing" means any technique by which a pharmacy benefit manager or other administrator of pharmacy benefits charges or claims an amount from an insurer or managed care organization for pharmacy or pharmacist services, including payment for a prescription drug, that is different than the amount the pharmacy benefit manager or other administrator pays to the pharmacy or pharmacist that provided the services.

"State pharmacy benefit manager" means the pharmacy benefit manager established or contracted by the department pursuant to section -2 to administer pharmacy benefits for all medicaid beneficiaries in the State.

§ **-2 State pharmacy benefit manager; procurement; master contract.** (a) No later than December 31, , the department shall establish or select and contract with a third-party administrator pursuant to chapter 103F, to serve as the state

pharmacy benefit manager for every medicaid managed care organization.

(b) The state pharmacy benefit manager shall be responsible for administering all pharmacy benefits for medicaid beneficiaries enrolled with a medicaid managed care organization.

(c) Each contract entered into or renewed by the department with a managed care organization to deliver medicaid services after the department has established or selected and contracted with a third-party administrator to serve as the state pharmacy benefit manager shall require the managed care organization to contract with and utilize the state pharmacy benefit manager for the purpose of administering all pharmacy benefits for medicaid beneficiaries enrolled with the managed care organization.

(d) In coordination with the attorney general, the department shall establish a standard contract form to be used when contracting with the state pharmacy benefit manager. In addition to the contract provisions required pursuant to chapter 103F, the standard contract form shall include provisions that:

(1) Establish the state pharmacy benefit manager's fiduciary duty owed to the department;

(2) Require the state pharmacy benefit manager to comply with the provisions of section -3, as applicable;

(3) Require:

(A) The use of pass-through pricing; and

(B) The state pharmacy benefit manager to use the preferred drug list, reimbursement methodologies, and dispensing fees established by the department pursuant to section -3; and

(4) Prohibit:

(A) The use of spread pricing; and

(B) The state pharmacy benefit manager from:

(i) Reducing payment for pharmacy or pharmacist services, directly or indirectly, under a reconciliation process to an effective rate of reimbursement. This prohibition shall include without limitation, creating, imposing, or establishing direct or indirect remuneration fees, generic effective rates, dispensing effective rates, brand effective

rates, any other effective rates, in-network fees, performance fees, pre-adjudication fees, post-adjudication fees, or any other mechanism that reduces, or aggregately reduces, payment for pharmacy or pharmacist services;

(ii) Creating, modifying, implementing, or indirectly establishing any fee on a pharmacy, pharmacist, or a medicaid beneficiary without first seeking and obtaining written approval from the department to do so;

(iii) Requiring a medicaid beneficiary to obtain a specialty drug from a specialty pharmacy owned by or otherwise associated with the state pharmacy benefit manager;

(iv) Requiring or incentivizing a medicaid beneficiary to use a pharmacy owned by or otherwise associated with the state pharmacy benefit manager; and

(v) Requiring a medicaid beneficiary to use a mail-order pharmaceutical distributor or mail-order pharmacy.

(e) The solicitation of proposals to serve as the state pharmacy benefit manager shall include, in addition to the requirements pursuant to chapter 103F, a requirement that all applicants disclose the following information as part of their proposal:

(1) Any activity, policy, practice, contract including any national pharmacy contract, or agreement of the applicant that may directly or indirectly present a conflict of interest in the applicant's relationship with the department or a medicaid managed care organization;

(2) If the applicant is conducting business as a pharmacy benefit manager:

(A) Any direct or indirect fees, charges, or any kind of assessments imposed by the applicant on pharmacies licensed in the State:

(i) With which the applicant shares common ownership, management, or control;

(ii) Which are owned, managed, or controlled by any of the applicant's management companies, parent companies, subsidiary companies, jointly held companies, or companies otherwise affiliated by a common owner, manager, or holding company;

(iii) Which share any common members on the board of directors; or

(iv) Which share managers in common;

(B) Any direct or indirect fees, charges, or any kind of assessments imposed by the applicant on pharmacies licensed in the State that operate:

(i) More than ten locations in the State; or

(ii) Ten or fewer locations in the State; and

(C) All common ownership, management, common members of a board of directors, shared managers, or control of a pharmacy benefit manager, or any of the applicant's management companies, parent companies, subsidiary companies, jointly held companies, or companies otherwise affiliated by a common owner, manager, or holding company with:

(i) A managed care organization and its affiliated companies;

(ii) An entity that contracts on behalf of a pharmacy or any pharmacy services administration organization and its affiliated companies;

(iii) A drug wholesaler or distributor and its affiliated companies;

(iv) A third-party payor and its affiliated companies; and

(v) A pharmacy and its affiliated companies.

(f) Before entering into a state pharmacy benefit manager contract with a third-party administrator, the department shall submit a copy of the contract to the chief procurement officer, attorney general, director of health, and insurance commissioner for review and comment.

§ **-3 Single preferred drug list; rules.** (a) The state pharmacy benefit manager shall use a single preferred drug list established by the department for each medicaid managed care organization.

(b) The department shall adopt rules pursuant to chapter 91 for the purposes of this chapter. The rules shall establish at minimum:

(1) Reimbursement methodologies; provided that the methodologies shall not discriminate against pharmacies owned or contracted by a health care facility that is registered as a covered entity pursuant to title 42 United States Code section 256b, to the extent allowable by the Centers for Medicare and Medicaid Services; and

(2) Dispensing fees that may take into account applicable guidance by the Centers for Medicare and Medicaid Services and that may, to the extent permitted under federal law, vary by pharmacy type, including rural and independently owned pharmacies, chain pharmacies, and pharmacies owned or contracted by a health care facility that is registered as a covered entity pursuant to title 42 United States Code section 256b.

(c) The state pharmacy benefit manager shall use the reimbursement methodologies and dispensing fees established by

the department pursuant to subsection (b) for each medicaid managed care organization.

(d) The state pharmacy benefit manager shall administer, adjudicate, and reimburse pharmacy benefit claims submitted by pharmacies to the state pharmacy benefit manager in accordance with:

(1) The terms of any contract between a health care facility that is registered as a covered entity pursuant to title 42 United States Code section 256b and a medicaid managed care organization;

(2) The terms and conditions of the contract between the state pharmacy benefit manager and the State; and

(3) The reimbursement methodologies and dispensing fees established by the department pursuant to subsection (b).

(e) The following shall apply to the state pharmacy benefit manager, the contract between the state pharmacy benefit manager and the department, and, where applicable, any contract between the state pharmacy benefit manager and a pharmacy:

(1) The department shall review and shall approve or deny any contract, any change in the terms of a contract,

or suspension or termination of a contract between the state pharmacy benefit manager and:

(A) A pharmacy licensed under chapter 461; or

(B) An entity that contacts on behalf of a pharmacy licensed under chapter 461;

(2) The state pharmacy benefit manager shall comply with sections 431S-3 and 431S-4;

(3) Upon the establishment of or awarding of the contract to a third-party administrator to serve as, the state pharmacy benefit manager, the state pharmacy benefit manager shall not enter into, renew, extend, or amend a national contract with any pharmacy that is inconsistent with:

(A) The terms and conditions of the contract between the state pharmacy benefit manager and the State; or

(B) The reimbursement methodologies and dispensing fees established by the department pursuant to subsection (b);

(4) When creating or establishing a pharmacy network for a managed care organization with whom the department

contracts for the delivery of medicaid services, the state pharmacy benefit manager shall not discriminate against any pharmacy or pharmacist that is:

(A) Located within the geographic coverage area of the managed care organization; and

(B) Willing to agree to or accept reasonable terms and conditions established by the state pharmacy benefit manager, or other administrator for network participation, including obtaining preferred participation status;

Provided that discrimination prohibited by this paragraph shall include denying a pharmacy the opportunity to participate in a pharmacy network at preferred participation status; and

(5) A contract between the state pharmacy benefit manager and a pharmacy shall not release the state pharmacy benefit manager from the obligation to make any payments owed to the pharmacy for services rendered before the termination of the contract between the state pharmacy benefit manager and the pharmacy or removal of the pharmacy from the pharmacy network.

§ **-4 Payment arrangements.** (a) All payment arrangements between the department, a medicaid managed care organization, and the state pharmacy benefit manager shall comply with state and federal laws, regulations adopted by the Centers for Medicare and Medicaid Services, and any other agreement between the department and the Centers for Medicare and Medicaid Services.

(b) The department may change a payment arrangement to comply with state and federal laws, regulations adopted by the Centers for Medicare and Medicaid Services, or any other agreement between the department and the Centers for Medicare and Medicaid Services.

§ **-5 Consultation.** The department shall consult with the med-QUEST healthcare advisory committee, established pursuant to title 42 Code of Federal Regulations section 431.12, in the development, implementation, and oversight of the state pharmacy benefit manager program established pursuant to this chapter.

§ **-6 Annual Report.** The department shall submit a report on the pharmacy benefit manager program established pursuant to this chapter and its findings and recommendations,

including any proposed legislation, to the legislature no later than twenty days prior to the convening of each regular session, beginning with the regular session of ."

SECTION 3. Chapter 431S, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§431S- Medicaid managed care organization; medicaid benefits; administration; penalty.** (a) Notwithstanding any law to the contrary, a pharmacy benefit manager contracted with a medicaid managed care organization to administer medicaid benefits shall not:

(1) Adjust, modify, change, or amend reimbursement methodologies, dispensing fees, and any other fees paid by the pharmacy benefit manager to pharmacies licensed in the State;

(2) Create, modify, implement, or indirectly establish any fee on a pharmacy, pharmacist, or a medicaid beneficiary in the State; or

(3) Make any adjustments, modifications, or changes to a pharmacy network for the managed care organization

with whom the pharmacy benefit manager has contracted to administer medicaid benefits.

(b) Notwithstanding any other law to the contrary, a pharmacy benefit manager contracted with a medicaid managed care organization to administer medicaid benefits shall:

(1) Administer, adjudicate, and, when appropriate, reimburse any pharmacy benefit claim submitted to the managed care organization before the termination of the contract between the pharmacy benefit manager and the managed care organization in accordance with the terms of the contract between the pharmacy benefit manager and the managed care organization; and

(2) Not be released from its obligation to make any payments owed to a pharmacy licensed in the State for pharmacy services rendered before the termination of the contract between the pharmacy benefit manager and the managed care organization.

(c) Any pharmacy benefit manager who violates this section shall be fined not more than $25,000 for each separate offense. Each date of violation shall constitute a separate offense. Any

action taken to impose or collect the penalty provided for in this subsection shall be considered a civil action.

(d) For the purposes of this section, "medicaid managed care organization" means an entity with which the department of human services has contracted to serve as a managed care organization as defined in title 42 Code of Federal Regulations section 438.2."

SECTION 4. The department of human services shall submit a report relating to the status of the establishment of or selection of and contracting with a third-party administrator to serve as the state pharmacy benefit manager pursuant to this Act and its findings and recommendations, including any proposed legislation, to the legislature no later than twenty days prior to the convening of the regular session of 2027.

SECTION 5. There is appropriated out of the general revenues of the State of Hawaii the sum of $ or so much thereof as may be necessary for fiscal year 2026-2027 for the department of human services to establish or select and contract with a third-party administrator to serve as the state pharmacy benefit manager pursuant to this Act.

The sum appropriated shall be expended by the department of human services for the purposes of this Act.

SECTION 6. The department of human services shall notify the legislature and the revisor of statutes immediately upon:

(1) The establishment of the state pharmacy benefit manager pursuant to this Act; or

(2) The awarding of a contract to a third-party administrator to serve as the state pharmacy benefit manager and the execution of a contract with a third-party administrator to serve as the state pharmacy benefit manager pursuant to this Act.

SECTION 7. New statutory material is underscored.

SECTION 8. This Act shall take effect on July 1, 2050; provided that:

(1) Sections 2 and 3 shall take effect upon approval of the Hawaii Medicaid state plan by the Centers of Medicare and Medicaid Services; and

(2) Section 3 shall be repealed upon the expiration of days after the establishment of, or execution of a contract with a third-party administrator to

serve as, the state pharmacy benefit manager pursuant to this Act.

INTRODUCED BY: _____

S.B. NO. 2208

Report Title:
DHS; Med-QUEST Division; State Pharmacy Benefit Manager Program; Medicaid Managed Care Organization; Standard Contract Form; Spread-Pricing; Rules; Reports; Appropriation

Description:
Requires the Department of Human Services to establish or select and contract with a third-party administrator to serve as the State Pharmacy Benefit Manager (PBM) who shall be responsible for administering all pharmacy benefits for medicaid beneficiaries enrolled with medicaid managed care organization. Requires medicaid managed care organizations to contract with and utilize the State PBM. Establishes requirements to procure the State PBM in addition to the requirements under state law governing purchases of health and human services. Establishes requirements and prohibitions for the contract to be used by the DHS when contracting with the state PBM. Requires the DHS to establish a single-preferred drug list to be used by the State PBM. Requires the DHS to consult with the Med-QUEST Healthcare Advisory Committee on the development, implementation, and oversight of the State PBM program. Requires reports to the Legislature. Appropriates funds.

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