Community Pharmacy Association
of New York State

August 3, 2026

Honorable Kathy M. Hochul
Governor
Executive Chamber, State Capitol
Albany, NY 12224

Re: Request for Approval of S5939C, Skoufis/A5882C, McDonald, Patient Access to Pharmacy Act

Dear Governor Hochul:

The Community Pharmacy Association of New York State (CPANYS) represents pharmacies of all types and sizes, and in every county across the State. Together, we are focused on protecting patient access to pharmacy care and strengthening the role that pharmacists play as part of the health care team to improve patient health outcomes while reducing costs.

CPANYS would first like to recognize the leadership of your Administration on pharmacy benefit manager (PBM) reform, healthcare affordability, and protecting patient access to care. We respectfully seek your approval of S5939C/A5882C which aligns with these important goals. The legislation, the Patient Access to Pharmacy Act (PAPA), would require health plans and their PBMs in the state-regulated commercial market to at a minimum, pay in-network pharmacies at the Medicaid reimbursement rates. Since 2023, New York Medicaid (NYRx) has used a transparent, cost-based reimbursement methodology based on national and regional cost surveys which determine the cost to procure and dispense medications. The Medicaid rates would serve as the minimum reimbursement for pharmacies caring for patients with commercial insurance.

Throughout the legislative process, the bill was amended multiple times in response to feedback received. The bill excludes collective bargaining and self-insured plans at the request of unions. Also, the bill includes a requirement for PBMs to have an appeals process that pharmacies can use should their drug product or dispensing costs exceed NADAC rates.

Protecting Patient Access to Community Pharmacy Care in NYS

New Yorkers throughout the state rely on their local, community pharmacies every day to help manage illness and keep them well. This includes access to essential medications and other clinical services like disease preventing immunizations, point of care testing, drug therapy management and others provided by highly trained pharmacists and their pharmacy teams. However, pharmacy deserts continue to grow especially in rural and urban communities that are already underserved and face significant healthcare disparities. In the last five years, nearly 1000 pharmacies closed in our State. This has included both independents and chain pharmacies in regions across New York including several hundred Rite Aid pharmacies that closed as the result of its bankruptcy. A primary driver for these closures are the tactics used by large national PBMs to limit networks, enact policies which advantage their own pharmacies and reimbursement practices which pay pharmacies at rates that are below their costs to procure and dispense medications. The situation has become untenable and requires state intervention and regulation in the commercial insurance market as this legislation would provide.

This legislation also supports and protects the local, New York State pharmacy businesses and the hundreds of thousands of New Yorkers they employ.

Precedence for this Legislation in NYS

This legislation builds on the actions taken by the State Medicaid program which reimburses pharmacies using a cost-based methodology both for medication and other pharmacy-related costs to dispense drugs to patients. CMS has a national cost survey, National Average Drug Acquisition Cost (NADAC), which states including New York use to set pharmacy drug costs in Medicaid. Also, state and regional cost of dispensing surveys have been completed and serve as the basis for the professional fee paid to pharmacies in New York Medicaid. Using these surveys, Medicaid has been paying pharmacies at NADAC plus the identified dispense fee of $10.18 for covered outpatient drug reimbursement since 2023. This legislation builds on this successful model requiring that at a minimum, PBMs must pay pharmacies at the NADAC plus dispensing fee rate used in Medicaid in the state-regulated commercial insurance market.

The New York State Department of Health recently stated that the transition of the NY Medicaid Pharmacy Benefit from Managed Care (MMC) to Fee-For-Service (FFS) to NYRx, achieved an estimated $655 million in Non-Federal savings year-to-date in 2205, *driven by $608 million in additional rebates and $47 million in lower costs due to pricing differences between MMC and FFS.* These savings exceed the FY 2024 Enacted Target of $535 million by $120 million in Non-Federal savings. This clearly demonstrates the success of the cost-based reimbursement model in generating state savings.

Further in 2024, your Administration championed a similar policy for mental health and substance use disorder services. As proposed in your SFY 2024-25 Executive Budget and enacted in the final state budget (Part AA of Chapter 57 of the laws of 2024), New York now requires state-regulated commercial insures to pay at minimum at Medicaid rates (APGs) for most behavioral health services. Prior to enacting this policy, commercial insurers were paying one-third to a half of the reimbursement rates paid by Medicaid, so in essence Medicaid was subsidizing outpatient behavioral healthcare while commercial plans underpaid providers. The same situation exists today for community pharmacies with outpatient drug reimbursement, and we ask that your Administration support a similar approach to make Medicaid the floor so PBMs are prohibited from paying pharmacies below their costs, by signing this bill into law.

Experience in Other States & Nationally

Commercial cost-based reimbursement floors are already law in ten states. The model continues to be adopted because it works, not because it breaks the market or increases costs. West Virginia is a state where the impact of this cost-based commercial insurance requirement has been measured and the policy has brought rates down. Since 2023, the state's Insurance Commissioner has required commercial health insurers to isolate the effect of West Virginia's PBM laws to address "spread" pricing and set a rate reimbursement floor in their annual rate filings. Across three years of filings, insurers reported that the reform reduced their rate requests in virtually every case — by as much as 14%, and most commonly by 5 to 9% (WV Insurance Bulletin 26-01, February 2026). When a state required PBMs to pay adequate rates and put money back into the system, insurers asked for less, not more in rate filings.

Even some PBMs are using cost-plus pricing including transparent PBMs like Capital Rx which has built their reimbursement model around it. Given this, PBMs cannot credibly claim it would be harmful for New York to require the use of this model. But this legislation is critical to guarantee that every pharmacy receives sustainable, cost-based reimbursement in the commercial market to remain viable.

PBM Transparency for Drug Affordability

New York State has been a leader in enacting a number of requirements and reforms to regulate PBM practices in order to protect patient access to essential medication and other pharmacy care provided by community pharmacies. This includes PBM licensure requirements, state oversight with the creation of a new PBM Bureau in the Department of Financial Services and a series of regulations related to PBM practices including most recently the adoption of Market Conduct regulations. We applaud these efforts; however this legislation is the next essential step that New York must take to bring transparency and fairness to PBM reimbursement of community pharmacies in the commercial market.

A cost-based payment model provides full transparency to the state, to health insurance plans that employ PBMs to manage drug benefits and to community pharmacies. Enacting this legislation will put an end to the currently opaque practices by PBMs to charge health insurance plans one amount, underpay network pharmacies and keep the difference, which is called "spread," all while securing and keeping the rebates that PBMs negotiate with drug manufacturers. As experienced in other states, this transparent, cost-based reimbursement model reduces drug costs and premium rates.

This legislation will stop the predatory and self-serving practices of large national PBMs like Caremark, Optum Rx and Express Scripts, which control over 80% of the market, and have been found to pay local pharmacies below their costs to line their pockets while paying their own pharmacies at better rates.

Countering PBM Claims

We have heard PBM/health plan interests claim that this bill would create a "prescription tax" imposing a new net cost of $10 per prescription. However, as New York Medicaid has found, using a cost-based national reimbursement benchmark (NADAC) often reduces the price paid for the drug itself. This savings is used to pay pharmacies for their cost to dispense medications (staffing, rent, other expenses). And as other state experience has demonstrated, transparent cost-based reimbursement has resulted in more affordable pharmacy benefits.

Opponents also claim that this bill will result in an increase in premiums and/or an increase in drug costs for consumers. As previously stated, this has not been the case in the other states that have enacted similar laws. If health plans attempt to apply for a premium increase in response to this measure, the Department of Financial Services (DFS) is now collecting information from PBMs related to the drug rebates they collect and their "spread" (the difference between what PBMs charge health plans and actually pay network pharmacies). DFS will be able factor PBM profits from keeping rebates, spread pricing and imposing other fees on pharmacies into any premium increase requests. These large national PBMs continue to report record profits in the billions of dollars at the expense of states, health plans, pharmacies and ultimately consumers and only through this legislation and a cost-based reimbursement model can we determine the true cost of pharmacy care – what PBMs are being paid compared with how much they are spending on pharmacy benefits and how much they are pocketing as profit.

In sum, this legislation is critical to bring fairness and transparency to drug pricing and pharmacy care in the commercial market. We respectfully request your approval to ensure that community pharmacies are able to continue to meet the growing needs of their communities and to stop large, national PBMs practices of paying below-cost reimbursement to network pharmacies in order to grow their record, billion-dollar profits, at the expense of pharmacies and consumers.

Thank you for your consideration of this important request and information. We welcome continued discussions with your office.

Sincerely,

Michael Scozzaro, RPh
Officer

Cc: Brian Mahanna, Counsel to the Governor
Craig Alfred, Assistant Counsel to the Governor
Megan Baldwin, Deputy Secretary for Health to the Governor