State PBM Reform Inventory

Updated October 2026

Alabama

Issue	Summary	Citation
Licensing/Registration	PBMs must obtain a license to operate from the Department of Insurance (DOI). Licenses must be renewed annually. DOI may refuse to issue or renew a license if the applicant is found to have violated the insurance laws of this state or any other jurisdiction or has had an insurance certificate or license denied or revoked in any jurisdiction. The initial license application fee is set at $500. DOI calculates the proportionate share of the annual cost of PBM licensee renewal and oversight activities, with a minimum cost of $500 per year.	AL Code §27-45A-4 (2025)
Reporting Requirements	A PBM shall annually prepare a report by June 1 that discloses all the following to each client: 1. The aggregate amount of all rebates that the PBM received from pharmaceutical manufacturers on behalf of the client. 2. The aggregate amount of the rebates the PBM did not pass through to the client. 3. If the PBM or any consultant providing pharmacy benefit management services engages in spread pricing, the aggregated amount of the differences between the amount paid by the client for prescription drugs and the actual amount paid to the pharmacy or pharmacist for pharmacist services.	AL Code § 27-45A-9 (2025)
PBM Income	N/A	
Pharmacy Contracting Standards	**Patient steering** A PBM may not do any of the following: • Require a covered individual to purchase pharmacist services exclusively through a mail-order pharmacy or PBM affiliate.	AL Code § 27-45A-8 (2025); § 27-45A-6 (2025);

	• Prohibit or limit any covered individual from selecting an in-network pharmacy or pharmacist who agrees to contract terms and conditions. • Impose a monetary advantage or penalty under a health benefit plan that would affect a covered individual's choice of pharmacy among network pharmacies. • Use a covered individual's pharmacy services data collected pursuant to the provision of claims processing services for the purpose of soliciting, marketing, or referring the covered individual to a mail-order pharmacy or PBM affiliate. The PBM may notify covered individuals that a less costly option is available through mail-order or affiliate pharmacy, provided the notification states that switching to the less costly option is not mandatory. • Reimburse an in-network pharmacy or pharmacist in the state an amount less than the amount that the PBM reimburses a similarly situated PBM affiliate for providing the same pharmacist services to cover individuals in the same health benefit plan. These requirements do not apply to the administration of prescription drug benefits by a self-funded health benefit plan governed by ERISA.	AL Code § 27-45A-10 (2025)
Patient Cost-Sharing	**Maximum Cost-Sharing Levels:** Patient cost-sharing at the point of sale may not exceed the lesser of the contracted cost-share amount or the amount an individual would pay for a prescription if that individual were paying without insurance. This does not apply to self-funded health benefit plans governed by ERISA. **Copay Cap:** A health benefit plan that provides coverage for prescription insulin drugs shall cap the total amount of any cost-sharing or co-pay that an insured or beneficiary is required to pay under the plan for a covered prescription insulin drug at an amount not to exceed one hundred dollars ($100) per 30-day supply of the insulin drug, without regard to the policy deductible, regardless of the amount or type of insulin needed to fill the insured's or beneficiary's prescription. On January 1 of each year, the limit on the amount that an insured is required to pay for a 30-day supply of a covered prescription insulin drug shall	AL Code § 27-45A-8 (2025); AL Code § 27-63-1 (2025)

	increase by a percentage equal to the percentage change from the preceding year in the prescription drug component of the Consumer Price Index of the Bureau of Labor Statistics of the United States Department of Labor. This requirement does not apply to a health benefit plan if implementing the cost-sharing or co-pay cap would necessitate increasing the health benefit plan's cost-sharing for other services to comply with federally mandated actuarial values for non-grandfathered individual and small group plans.	