State PBM Reform Inventory

Updated October 2026

California

Issue	Summary	Citation
Licensing/Registration	Currently, PBMs must register with the Department of Managed Health Care. Starting earlier of the date the Department of Managed Health Care issues licensure rules or January 1, 2027, PBMs must obtain a license from the department to operate. The department shall develop an application form that contains at least the information required in s. 1385.009 and establish application fees in accordance with s. 1385.0016. A PBM shall reimburse the director for the actual cost of processing their application up to $25,000. A health care service plan that contracts with a PBM for management of any or all its prescription drug coverage shall require the PBM to register with the Department of Managed Health Care.	CA HSC § 1385.004; CA HSC § 1385.005; CA HSC § 1385.009; CA HSC § 1385.0016
Reporting Requirements	The PBM shall, on a quarterly basis, disclose, upon the request of an insurer, the following information with respect to prescription benefits specific to the insurer: • The aggregate WACs and rebates (including utilization discounts) from a pharmaceutical manufacturer or labeler for each therapeutic category of drugs containing three or more drugs. • Any administrative fees received from the pharmaceutical manufacturer or labeler. • Whether the PBM has a contract, agreement, or other arrangement with a pharmaceutical manufacturer to exclusively dispense or provide a drug to a purchaser's employees, insureds, or enrollees, and the application of all consideration or economic benefits collected or received pursuant to that arrangement. • Prescription drug utilization information for the purchaser's enrollees or insureds that is not specific to any individual enrollee or insured. • The aggregate of payments, or the equivalent economic benefit, made by the PBM to pharmacies owned or	CA BPC § 4441; CA HSC § 1385.005; CA HSC § 1385.0011

	controlled by the PBM and to pharmacies not owned or controlled by the PBM. • The aggregate amount of the fees imposed on, or collected from, network pharmacies or other assessments against network pharmacies, and the application of those amounts collected pursuant to the contract with the purchaser. A PBM shall submit to the department annual financial statements within 120 days after the close of the fiscal year. An audit shall be conducted in accordance with generally accepted auditing standards and the rules and regulations of the director. Within 45 days after the close of each quarter of its fiscal year, a PBM shall submit its quarterly unaudited financial statement, prepared in accordance with generally accepted accounting principles and consisting of at least a balance sheet, statement of income, statement of cash flows, statement of changes in equity, and notes to financial statements as of the date and for the period specified by the director. The director may require the submission of these reports on a monthly or other periodic basis.	
PBM Income	**Spread Pricing:** Starting January 1, 2026, no contract that is established or renewed between a health care service plan and a licensed PBM may authorize spread pricing. If a preexisting contract between a PBM and a payer authorizes spread pricing, a subsequent amendment or renewal of that contract shall not contain that authorization. Spread pricing contract terms shall be void on and after January 1, 2029. **Bona Fide Service Fee:** For contracts issued or renewed after January 1, 2026, a PBM shall not derive income from pharmacy benefit management services provided to a payer except for income derived from a pharmacy benefit management fee for pharmacy benefit management services provided. • The amount of any pharmacy benefit management fee shall be set forth in the agreement between the PBM and the payer.	CA HSC § 1385.0031; CA INS § 10123.2045; CA HSC § 1385.0034; CA HSC § 1385.0029

	• The PBM shall disclose the amount and types of pharmacy benefit management fees to the payer. • A pharmacy benefit management fee may not be based on the acquisition or ingredient cost of a drug, the amount of rebates or other price concessions negotiated by the PBM, the amount of cost-sharing collected by the PBM, coverage or formulary placement decisions made by the PBM, or any other methodology determined by the department. **Rebate Pass-Through:** For contracts issued or renewed after January 1, 2026, a PBM shall use a passthrough pricing model. A PBM, group purchasing organization, and affiliated entity shall direct 100 percent of all prescription drug manufacturer rebates received to the payer or program, if the contractual arrangement delegates the negotiation of rebates to the PBM, group purchasing organization, or affiliated entity, for the sole purpose of offsetting defined cost sharing, deductibles, and coinsurance contributions and reducing premiums of plan participants. PBMs may receive performance bonused based on savings to the payer that decrease premiums paid by the plan participant or that result in plan participants paying the lowest level of cost sharing, deductibles, and coinsurance for a drug, as long as the performance bonus is not based or contingent on any of the following: • The acquisition or ingredient cost of a drug. • The amount of savings, rebates, or other fees charged, realized, or collected by, or generated based on the activity of, the PBM or its affiliated entities that are retained by the PBM. • The amount of premiums, deductibles, or other cost-sharing or fees charged, realized, or collected by the PBM or its affiliated entities from patients or other persons on behalf of a patient, except for performance bonuses that are based or contingent on a decrease in premiums, deductibles, or other cost-sharing.	

	Note: The spread pricing, bona fide service fee, and rebate pass-through requirements do not apply to PBMs serving Taft-Hartley self-insured prescription drug plans that are governed by ERISA.	
Pharmacy Contracting	**MAC Pricing:** • PBMs shall make available to a network pharmacy, upon request, the most up-to-date MAC list or lists used by the PBM in a readily accessible, secure, and usable Web-based format or another comparable format. • PBMs should review and adjust to the MAC of each drug on an MAC list using the most recent data sources available at least once every 7 days. • PBMs should also establish a clearly defined process for a network pharmacy to appeal to the MAC for a drug on a MAC list. • A contracting pharmacy shall be provided for no less than 14 business days following receipt of payment for the claim upon which the appeal is based to file an appeal with a PBM. The PBM shall make a final determination regarding a contracting pharmacy's appeal within 7 business days of the PBM's receipt of the appeal. • If an appeal is denied by a PBM, the PBM shall provide to the contracting pharmacy the reason for the denial and the NDC of an equivalent drug that may be purchased by a similarly situated pharmacy at the price that is equal to or less than the MAC of the appealed drug. • If an appeal is upheld by a PBM, the PBM shall adjust the MAC of the appealed drug for the appealing contracting pharmacy, and all similarly situated contracting pharmacies in the state within 1 calendar day of the date of determination. The PBM shall permit the appealing pharmacy to reverse and resubmit the claim upon which the appeal was based to receive the corrected reimbursement. A drug shall not be included on a MAC list or reimbursed on a MAC basis unless all the following apply: • The drug is listed as "A" or "B" rated in the most recent version of the FDA's approved drug products with therapeutic equivalent evaluations, also known as the Orange Book, or has an "NA," "NR," or "Z" rating or a similar	CA BPC § 4440; CA HSC § 1385.0026; CA HSC § 1385.0027

	rating by a nationally recognized pricing reference, such as Medi-Span or First Databank. • The drug is generally available for purchase in the state from a national or regional wholesaler. • The drug is not obsolete. **Patient Steering:** A PBM may not reimburse a nonaffiliated pharmacy for a pharmacist service at a rate lower than the rate it would reimburse an affiliated pharmacy for the same service. **A PBM shall not:** • Require a plan participant to use only an affiliated pharmacy if there are nonaffiliated pharmacies in the network. • Financially induce a plan participant to transfer a prescription only to an affiliated pharmacy if there are nonaffiliated pharmacies in the network. • Require a nonaffiliated pharmacy to transfer a prescription to an affiliated pharmacy if there are nonaffiliated pharmacies in the network. This section does not prevent a purchaser or PBM from offering plan participants financial incentives to use a particular pharmacy, such as lower copays, coinsurance, or any other cost-sharing for a prescription when the prescription is dispensed. • Unreasonably restrict a plan participant from using a particular contracted pharmacy for the purpose of receiving pharmacist services covered by the plan participant's contract or policy. • Communicate to or mislead a plan participant, in any manner, that the plan participant is required to have a prescription dispensed at, or pharmacy services provided by, a particular affiliated pharmacy or pharmacies if there are other non-affiliated pharmacies that have the ability to dispense the medication or provide the services and are also in network. • Deny a nonaffiliated contract pharmacy the opportunity to participate in a PBM network as preferred participation status if the pharmacy is willing to accept the same terms and conditions that the PBM has established for affiliated pharmacies as a condition of preferred network participation status.	

Patient Cost-Sharing	**Maximum Cost-Sharing Levels:** A health insurance policy issued, amended, or renewed on or after January 1, 2026, that provides prescription drug coverage shall not calculate an insured's cost-sharing at an amount that exceeds: • The actual rate paid by the insurer for the prescription drug; • The net price paid by the PBM or GPO, if available. **Copay Cap:** A large group health care service plan contract or insurance policy that is issued, amended, or renewed on or after January 1, 2026, shall not impose a copayment, coinsurance, deductible, or any other cost-sharing on an insulin prescription drug that exceeds $35 for a 30-day supply. At least one insulin for a given drug type in all forms and concentrations shall be on the prescription drug formulary. An individual or small group health care service plan contract or insurance policy that is issued, amended, or renewed on or after January 1, 2027, shall not impose a copayment, coinsurance, deductible, or any other cost-sharing on an insulin prescription drug that exceeds $35 for a 30-day supply. If an individual or small group health care service plan contract maintains a drug formulary grouped into tiers, the cost-sharing cap shall apply only to insulin prescription drugs that are in the two lowest tiers. At least one insulin for a given drug type in all forms and concentrations shall be on each of the two lowest tiers. If there is no Tier 1 or Tier 2 insulin prescription drug that is clinically appropriate for an enrollee, the health care service plan shall limit the cost-sharing for a higher-tier drug to no more than $35 for a 30-day supply for an individual enrollee.	CA HSC § 1367.2075; CA HSC § 1367.51; CA INS § 10176.61