State PBM Reform Inventory

Updated October 2026

Colorado

Issue	Summary	Citation
Licensing/Registration	Starting in 2024, a person shall not establish or operate as a PBM in this state unless the person has registered with the insurance commission. Each carrier must submit to the commissioner a list of all PBMs the carrier contracts with or uses for claims processing services or other prescription drug or device services.	C.R.S. § 10-16-122.1 (2026)
Reporting Requirements	Starting January 1, 2027, a contract between a PBM and a covered person's health benefit plan must include a provision that requires the PBM to disclose prescription drug cost information to the health benefit plan, including claims-level pharmacy data and PBM income derived from prohibited sources that the PBM must pass through to the health benefit plan. The information must be provided within thirty days after the date of the notification to the PBM by the health benefit plan or at regular negotiated reporting intervals necessary for the health benefit plan to determine the PBM's compliance with the contract terms and this section. The PBM shall assess no additional fees with regard to the provision of this information. The contract between the PBM and a covered person's health benefit plan must include a provision authorizing the health benefit plan to annually execute an audit for the purpose of validating compliance with contract terms and this section.	C.R.S. 10-16-122.8
PBM Income	**Bona Fide Service Fee:** Starting January 1, 2027, PBM may earn income derived from the assessment of a single, flat-dollar service fee for the provision of a prescription drug, which service fee is transparently expressed in a written agreement between the PBM and health benefit plan. The single, flat-dollar service fee may vary from client to client of the PBM based on the number of health benefit plan participants, clinical and administrative services provided, value-based payment arrangement, and other considerations.	C.R.S. 10-16-122.8

	Starting January 1, 2027, a PBM shall not: • Earn any income that is directly or indirectly based on the price or cost of a prescription drug, including income from prescription drug mark-ups, copayments that exceed the cost of prescription drugs, up-charging or spread-pricing, or manufacturer-derived revenues; or • Design a prescription drug formulary to favor a certain branded pharmaceutical or biologic over a therapeutically equivalent generic or biosimilar, unless the branded pharmaceutical or biologic has a lower net acquisition cost and that lower cost is reflected in a lower out-of-pocket expense for consumers.	
Pharmacy Contracting	**MAC Pricing:** • In each contract between a PBM and a pharmacy, the pharmacy shall be given the right to obtain from the PBM, within ten days after any request, a current list of the sources used to determine MAC pricing. The PBM shall update the pricing information at least every 7 days and provide a means by which contracted pharmacies may promptly review pricing updates in a format that is readily available and accessible. • Each contract between a PBM and a pharmacy must include a process to appeal, investigate, and resolve disputes regarding MAC pricing. **Minimum Reimbursement:** Starting January 1, 2027, a PBM shall reimburse an unaffiliated pharmacy or a PBM-affiliated retail, mail order, or specialty pharmacy for the fulfillment of a prescription drug in an amount equal to the NADAC for the dispensed prescription drug ingredients and a reasonable and adequate dispensing fee. If the NADAC is not available at the time a prescription drug is administered or dispensed, a PBM shall not reimburse in an amount that is less than the WAC of the prescription drug.	C.R.S. § 25-37-103.5; C.R.S. 10-16-122.8
Patient Cost-Sharing	**Maximum Cost-Sharing Levels:** A PBM shall not require a pharmacy to charge or collect a copayment from a covered person that exceeds the total charges submitted by the network pharmacy.	C.R.S. § 10-16-122.7; C.R.S. § 10-16-161;

	Copay Adjustment Programs: Effective January 1, 2025, when calculating a covered person's overall contribution to an out-of-pocket maximum or cost-sharing requirement under the covered person's health benefit plan, a carrier or PBM shall include any amount paid by the covered person or on behalf of the covered person if: • The drug does not have a generic equivalent, biosimilar, or interchangeable biosimilar; or • The drug has a generic equivalent, biosimilar, or interchangeable biosimilar, and the covered person is using the brand-name drug after obtaining prior authorization, complying with a step therapy protocol, or receiving approval through the carrier's or PBM's exceptions, appeals, or review process. This requirement does not apply to HSA-eligible high-deductible plans until after a covered person has met their minimum deductible under IRS rules. **Copay Cap:** A carrier that provides coverage for prescription insulin drugs pursuant to the terms of a health coverage plan the carrier offers shall cap the total amount that a covered person is required to pay for all covered prescription insulin drugs at an amount not to exceed $100 for the covered person's entire 30-day supply of insulin, regardless of the amount or type of insulin needed to fill the covered person's prescription or the number of prescriptions. **Contribution Credits/Coupons:** When calculating a covered person's contribution to an out-of-pocket-maximum or cost-sharing requirement under the plan, the plan must account for and credit to the covered person an out-of-pocket expense they incur by purchasing a prescription drug directly from a pharmacy or DTC platform. The carrier shall apply the contribution credit to the out-of-pocket maximum or cost-sharing requirement that is applicable in the plan year in which the out-of-pocket expense was incurred. The covered person must provide proof of payment within 90 days of purchase. The carrier shall not apply the contribution credit if:	C.R.S. 10-16-151; C.R.S. 10-16-161

	• For an amount of a covered person's out-of-pocket expense incurred by the direct purchase of a prescription drug that is greater than the amount the covered person would have incurred if they had obtained the same prescription drug in the same plan year from an in-network pharmacy and pursuant to the terms of their plan; • If the covered person does not provide proof of payment; • If the covered person incurred the out-of-pocket expense by purchasing a prescription drug that is not covered under the formulary of the covered person's plan, unless the carrier grants an exception; or • If the covered person does not comply with the carrier's utilization management processes, including prior authorization and step therapy protocols required under the covered person's plan	