State PBM Reform Inventory

Updated October 2026

Georgia

Issue	Summary	Citation
Licensing/Registration	PBMs must obtain a license to operate from the Insurance Commission, which must be renewed annually. Fees include $2,000 for an initial application and $1,000 for a renewal application. Applicants must file and maintain a bond worth $100,000 in favor of the Commissioner and maintain liability insurance coverage of at least $250,000. The Insurance Commission may suspend, revoke, or refuse to renew a license under certain circumstances set out in s. 33-64-2. The Commissioner may levy a civil monetary penalty of up to $2,000 per violation and up to $10,000 per willful violation. PBMs do not need a license as an administrator to perform pharmacy benefit management functions.	GA Code § 33-64-2 - 33-64-6 (2025)
Reporting Requirements	A PBM shall report annually to each health plan and the Department of Insurance the aggregate amount of all rebates and other payments that the PBM received from pharmaceutical manufacturers in connection with claims if administered on behalf of the health plan. A PBM shall report in the aggregate to a health plan the difference between the amount the PBM reimbursed a pharmacy and the amount the PBM charged the health plan. By March 1 of each year, a PBM shall provide a letter to the Insurance Commissioner attesting as to whether, in the previous calendar year, it engaged in the practices of steering or imposing point-of-sale fees or retroactive fees. The PBM shall also submit data detailing all prescription drug claims it administered for Georgia insureds on behalf of each health plan client and any other data the Commissioner deems necessary to evaluate whether a PBM may be engaged in the practice of	GA Code § 33-64-10 (2025); GA Code § 33-64-12 (2025)

	steering or imposing point-of-sale fees or retroactive fees. Such data shall be confidential and not subject to Article 4 of Chapter 18 of Title 50, relating to open records; provided, however, that the Commissioner shall prepare an aggregate report reflecting the total number of prescriptions administered by the reporting PBM on behalf of all health plans in the state, along with the total sum due to the state. The Department of Audits and Accounts shall have access to all confidential data collected by the Commissioner for audit purposes.	
PBM Income	**Rebate Pass-Through:** A PBM shall offer a health plan the ability to receive 100% of all rebates it receives from pharmaceutical manufacturers. **Spread Pricing:** A PBM shall offer a health plan the option of charging such health plan the same price for a prescription drug as it pays a pharmacy for the prescription drug. A PBM must charge a health benefit plan administered by or on behalf of the state or a political subdivision of the state, including any county or municipality, the same price for a prescription drug as it pays a pharmacy for the prescription drug.	GA Code § 33-64-10 (2025)
Pharmacy Contracting	**MAC Pricing:** Upon each contract execution or renewal between a PBM and a pharmacy or a pharmacy's contracting agent, a PBM shall: • Identify the sources utilized to determine multi-source generic drug • pricing and update such pricing information at least every five business days; and • Maintain a procedure to eliminate products from the multi-source generic list of drugs subject to such pricing or modify multi-source generic drug pricing within five business days when such drugs do not meet the standards and requirements, to remain consistent with pricing changes in the marketplace. A PBM shall reimburse pharmacies for drugs subject to multi-source generic drug pricing based upon pricing information that has been updated within five business days. A PBM may not place a drug on a multi-source generic list unless there are at	GA Code § 33-64-9 (2025); GA Code § 33-64-9.1 (2025); GA Code § 26-4-119 (2025); GA Code § 33-64-11 (2025); GA Code § 33-64-12 (2025)

	least two therapeutically equivalent, multi-source generic drugs, or at least one generic drug available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers. All network contracts shall include a process for internal appeals, investigations, and resolution of disputes regarding multi-source generic drug pricing. The process shall include the following: • The right to appeal shall be limited to 14 calendar days following reimbursement of the initial claim; and • A requirement that the health benefit plan issuer or PBM shall respond to an appeal described in subsection (a) of this Code section no later than 14 calendar days after the date the appeal was received by such health benefit plan issuer or PBM. For appeals that are denied, the PBM shall provide the reason for the denial and identify the NDC of a drug product that may be purchased by contracted pharmacies at a price at or below the MAC. If the appeal is successful, the health benefit plan issuer or PBM shall: • Adjust the MAC price that is the subject of the appeal effective on the day after the date the appeal is decided; • Apply the adjusted MAC price to all similarly situated pharmacists and pharmacies as determined by the health plan issuer or PBM; and • Allow the pharmacist or pharmacy that succeeded in the appeal to reverse and rebill the pharmacy benefits claim giving rise to the appeal. Appeals shall be upheld if: • The pharmacy being reimbursed for the drug subject to the multisource generic drug pricing in question was not reimbursed as required in subsection (b) of this Code section; or • The drug subject to the multi-source generic drug pricing in question does not meet the requirements set forth in subsection (c) of this Code section.	

	PBMs shall file the methodologies used in connection with determining MAC pricing lists with the Insurance Commission. **Minimum Reimbursement:** A PBM shall use the NADAC as a point of reference for the ingredient drug product component of a pharmacy's reimbursement for drugs appearing on the NADAC list. PBMs are not required to reimburse a pharmacy based on the NADAC price for a covered drug. A PBM shall produce a report every four months, which shall be provided to the Commissioner and published by the PBM on a website available to the public for no less than 24 months, of all drugs appearing on the NADAC list reimbursed at least 10 percent below the NADAC, as well as all drugs reimbursed at least 10 percent above the NADAC. For each drug in the report, a PBM shall include the month the drug was dispensed, the quantity of the drug dispensed, the amount the pharmacy was reimbursed per unit or dosage, whether the dispensing pharmacy was an affiliate, whether the drug was dispensed pursuant to a state or local government health plan, and the average NADAC for the month the drug was dispensed. Such report shall exclude drugs dispensed pursuant to the 340B Drug Discount Program. **Patient Steering:** A PBM shall be prohibited from engaging in patient steering. S. 26-4-119 defines activities that may be considered steering, including offering or implementing plan designs that require patients to utilize affiliated pharmacies or other pharmacies with affiliates, or that increase plan or patient costs, including requiring patients to pay the full cost for a prescription when patients choose not to use affiliated pharmacies or other pharmacies with affiliates. A PBM may not transfer records relative to prescription information containing patient-identifiable and prescriber-identifiable data to an affiliated pharmacy for any commercial purpose. This does not prohibit the exchange of prescription information between a PBM and an affiliated pharmacy for the	

	limited purposes of pharmacy reimbursement, formulary compliance, pharmacy care, or utilization review A PBM that engages in the practices of steering or imposing point-of-sale fees or retroactive fees shall be subject to a surcharge payable to the state of 10 percent on the aggregate dollar amount it reimbursed pharmacies in the previous calendar year for prescription drugs for Georgia insureds.	
Patient Cost-Sharing	**Copayment Adjustment Programs:** When calculating an insured's contribution to any out-of-pocket maximum, deductible, or copayment responsibility, a PBM shall include any amount paid by the insured or paid on their behalf through a third-party payment, financial assistance, discount, or product voucher for a prescription drug that does not have a generic equivalent or that has a generic equivalent but was obtained through prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process. **Maximum Cost-Sharing Levels**: A PBM may not charge or collect a copayment from an insured that exceeds the total submitted charges by the network pharmacy or other dispenser practice.	GA Code § 33-64-10 (2025)