EXPLAINER

What are Pharmacy Benefits?

SEPTEMBER 2026

California Health Benefits Review Program (CHBRP)
University of California, Berkeley

Background

Health insurance uses a lot of technical language, and it can quickly become confusing. One example is the distinction between the type a benefit that health care can fall under: the pharmacy vs. the medical benefit. This explainer helps clarify that distinction, review consumer protections related to prescription drug cost sharing, and outline specialty drug distribution practices commonly addressed in health policy legislation.

Pharmacy vs. Medical Benefits

Prescription drug coverage in the United States is generally split between two distinct insurance pathways: the medical benefit and the pharmacy benefit. Most insured patients in California have both types of coverage, but which one applies depends primarily on how a drug is given and where the patient receives it.[1] This distinction matters because it determines how the claim is processed, which billing codes are used, and how much the patient pays out of pocket. The policies that determine how the cost of a drug is divided between the patient and the insurer, known as cost-sharing rules, are often different under each benefit (National Association of Medication Access & Patient Advocacy, 2022).

- **Pharmacy Benefit*:*** Generally, drugs that are self-administered (e.g., oral pills, self-injections, patches, inhalers, suppositories) or administered by a pharmacist (e.g., vaccines). A retail, mail-order, or specialty pharmacy usually dispenses these drugs, and a pharmacy benefit manager (PBM) processes the claim using a unique number assigned to each drug, known as a National Drug Code (NDC).[2] The pharmacy bills the patient's health plan, insurer, or PBM for the cost of the drug, plus a dispensing fee that covers the pharmacy's overhead costs for filling the prescription (Berkeley Research Group, 2025).

- **Medical Benefit:** This generally covers drugs that a doctor or other clinician gives to a patient directly, such as infusions, chemotherapy, or injectables given in a doctor's office, hospital, or infusion center. Under the medical benefit, the health care professional typically buys the drug ahead of time and then bills the insurance company for both the drug and the cost of administering it through a process called "buy and bill." Instead of an NDC, the provider uses a Health Care Common Procedure Coding System (HCPCS) code to bill for a drug (National Association of Medication Access & Patient Advocacy, 2022).

Some drugs — such as specialty medications given by injection or infusion — can be covered under either benefit depending how the health plan is designed. Reimbursement amounts for the same specialty drug often differ depending

[1] For more information on the sources of medical and pharmacy benefit coverage, see CHBRP's resources *Sources of Health Insurance in California,* and *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.
[2] For more information on NDCs, see the Federal Drug Administration's NDC Directory.

on whether the drug is on the medical or pharmacy benefit and whether the patient's health insurance is under Medicare, Medi-Cal, or commercial payers.

What Pharmacy Benefit Costs Look Like to the Patient

Patients with state-regulated commercial insurance face some form of cost sharing regardless of which benefit covers the drug. But how much they owe — and whether that amount is capped — depends on the benefit type and the health plan design.[3] For drugs billed under the pharmacy benefit, California law caps how much a patient can be charged for a single prescription.[4] Each health plan categorizes its covered drugs into four "tiers," known as a formulary. Where a drug falls within a plan's four-tier formulary structure determines its cost-sharing cap (Table 1). For most Tier 4 drugs under high-deductible health plans (HDHPs), patients must also meet their annual deductible before the cap applies.

Drugs administered by a physician and billed through the medical benefit are not subject to these limits. Once an enrollee reaches their health plan's annual out-of-pocket maximum, the health plan or insurer is responsible for 100% of the patient's remaining health care costs for the remainder of the benefit plan year, including prescription drug costs (California Department of Managed Health Care, 2025).

Table 1: Out-of-Pocket Caps per Formulary Tier Under the Pharmacy Benefit

Tier	Drug Types Included	Per-Rx Cap (30-day)	Which Plans This Applies To
Tier 1	Most generic drugs; low-cost preferred brand-name drugs	$250 max	Most DMHC-regulated plans and CDI-regulated policies*
Tier 2	Nonpreferred generics; preferred brand-name drugs	$250 max	Most DMHC-regulated plans and CDI-regulated policies*
Tier 3	Nonpreferred brand-name drugs; drugs with a lower-cost therapeutic alternative	$250 max ($500 for bronze plans**)	Most plans; bronze plans have a higher cap
Tier 4 (specialty/highest cost)	Biologics; specialty pharmacy-only drugs; drugs needing special training; drugs costing plans over $600/month	$250 max ($500 for bronze plans and HDHPs)	Most plans' HDHP enrollees must meet their annual deductible first

Source: California Health Benefits Review Program, 2026.
*Caps under HSC §1342.73 and INS §10123.1932 apply to non-grandfathered plans and policies regulated by DMHC or CDI. Self-insured employer plans (governed by federal ERISA law), grandfathered health plans, and Medicare Part D plans are not subject to these limits.
**Bronze plans in Covered California, California's state health insurance marketplace.
Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care; HDHP = high-deductible health plan; Rx = prescription.

"Bagging" Models

Because billing for a specialty drug depends on which benefit covers it, health plans and PBMs have developed distribution practices — commonly known as "bagging" models — that route certain drugs through the pharmacy benefit instead of the medical benefit. These models are different from the traditional "buy-and-bill" process, where a provider purchases and stores a drug on-site, and bills the medical benefit for both the drug and the cost of administering it. Under bagging arrangements, an outside specialty pharmacy dispenses the drug instead, and the claim is billed to the pharmacy benefit rather than the medical benefit (Pearson et al., 2023).

[3] In general, Medi-Cal beneficiaries do not have cost-sharing responsibilities. Beginning October 1, 2028, Medi-Cal enrollees who are age 19–64, not pregnant, not enrolled in Medicare, and have income above $15,560 per year may be subject to copayments for certain services, capped at 5% of household income annually; exemptions apply for community health center and rural health clinic services, emergency care, preventive checkups, and prenatal/pediatric care (California Department of Health Care Services, n.d.).
[4] Health and Safety Code § 1342.73; Insurance Code § 10123.1932. The copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for a supply of up to 30 days generally cannot exceed $250, with a higher $500 cap applying to bronze-level plans.

The stated goal is to reduce drug costs by streamlining how drugs are distributed and negotiating better prices with drug manufacturers (Pearson et al., 2023). However, switching which benefit a drug falls under can also change what the patient owes, since the medical and pharmacy benefits often have separate deductibles, cost-sharing rules, and (for pharmacy-benefit drugs) the tier-based caps described above.

- **White-Bagging:** An outside specialty pharmacy delivers a patient's specialty drug directly to the hospital, infusion center, or other medical facility, where the facility stores the drug until the patient's appointment and then administers it. The provider bills separately for administering the drug, while the specialty pharmacy bills the pharmacy benefit separately for the drug itself. One industry estimate found that nearly 30% of oncology drugs under commercial plans require white-bagging, meaning patients were required to receive their drugs from a specialty pharmacy rather than directly from their provider (CompleteRx, 2023).

- **Brown-Bagging:** A patient obtains their medication from a specialty pharmacy and brings it to the provider's office to be administered. Like white-bagging, this shifts billing from the medical benefit to the pharmacy benefit. The difference is that the patient — not the provider — is responsible for picking up the drug and transporting the drug (Gallagher et al, 2022).

- **Clear-Bagging:** A hospital or health system's own internal specialty pharmacy dispenses the patient's specialty drug and delivers it directly to the provider, instead of using an outside pharmacy. Because the drug is dispensed in-house, this approach is meant to reduce drug waste and minimize treatment delays (AMCP, 2024).

- **Gold-Bagging:** The health system controls the entire process—prescribing, dispensing, and administering the drug—using its own in-house specialty pharmacy for high-cost medications. Because this approach relies less on an outside or plan-preferred pharmacy, it is often described as a more controlled model with fewer points of potential failure, though it allows health systems to keep the drug's profit margin instead of sharing savings with health plans and insurers (AMCP, 2024).

Because bagging arrangements shift billing between benefits with different cost-sharing rules, patient advocates and some state lawmakers have raised concerns about them. While white-bagging may lower costs without limiting access to care, it has also drawn concern from health care providers around patient safety, access, added burden on clinical staff, and drug waste. Some providers note that separating the dispensing pharmacy from the clinician who administers the drug can create logistical challenges for patients and increase the risk of dosing or delivery errors. As a result, several states have moved to restrict the practice, though publicly available evidence on the effects of bagging and site-of-service policies remains limited (Pearson et al., 2023).

Impact on California Enrollees

California's pharmacy benefit cost-sharing protections apply to a large share of the state's insured population but affect enrollees unevenly. About 13.2 million Californians have a state-regulated pharmacy benefit and qualify for the state's per-prescription cost-sharing caps, but relatively few enrollees ever reach the $250 cap (CHBRP, 2024). CHBRP estimated that only about 3% of the affected population — roughly 342,300 people — hit the cap as of 2018.[5] For that group, though, the savings can be significant: CHBRP found that enrollees taking high-cost prescription drugs had average annual medical and prescription costs of about $42,700, compared to roughly $3,700 for enrollees who were not taking high-cost drugs (CHBRP, 2018).

These high costs are even more concentrated among specialty drugs. Specialty drugs make up just 1.8% of all prescriptions dispensed in California, but they account for 63% of the state's total annual prescription drug spending. Among enrollees who use specialty drugs and have access to copay assistance, the average cost per specialty prescription is $8,001 (California Department of Managed Health Care, 2025). These trends have increased drug spending for health plans and insurers, and in turn, for the enrollees and plan sponsors who pay premiums: statewide health plan spending on prescription drugs reached $14.9 billion in 2024, a 72% increase since 2017. Together, these

[5] This estimate reflects 2018 data and may not capture more recent shifts in high-cost prescription drug utilization, including the expanded use of GLP-1 agonists for diabetes and weight management since 2018. Current figures for the share of enrollees reaching the cap and associated cost differentials may differ from those reported here.

figures suggest that while California's cost-sharing caps offer meaningful protection to the relatively small number of enrollees who rely on high-cost specialty drugs, the broader cost pressures these drugs place on the insurance system — and on health insurance premiums — continue to grow and may be an area of continued area of interest for California legislators.

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About the California Health Benefits Review Program (CHBRP)

Drawing on the experience and assistance of multi-disciplinary faculty, researchers, and analysts based at the University of California, CHBRP provides the California Legislature with timely, independent, and rigorous evidence-based analyses of introduced health insurance benefits-related legislation. Most frequently, CHBRP analyzes proposed health insurance benefit mandates (e.g., mandates to cover a test, treatment, or service, such as continuous glucose monitors). For more about CHBRP's 60-day analysis process, see the resource Academic Rigor on a Legislature's Timeline.

To read any of the bill analyses CHBRP has completed, see the Completed Analysis page on CHBRP's website. In addition to analysis of introduced legislation, CHBRP produces other publications including several annually updated resources, as well as issue briefs and explainers.

CHBRP Staff

Garen Corbett, MS, Director
Adara Citron, MPH, Associate Director
An-Chi Tsou, PhD, Principal Policy Analyst
Anna Pickrell, MPH, Principal Policy Analyst
Karen Shore, PhD, Contractor*
Nisha Kurani, MPP, Contractor*
*Independent Contractor working with CHBRP to support analyses and other projects.

California Health Benefits Review Program
MC 3116
Berkeley, CA 94720-3116
info@chbrp.org
(510) 664-5306

CHBRP is an independent program administered and housed by the University of California, Berkeley, under the Office of the Vice Chancellor for Research.

Acknowledgements

This explainer was prepared by Maddie Christmann, MPH candidate. Drafts were reviewed by An-Chi Tsou, PhD, and Garen Corbett, MS, of CHBRP.

CHBRP assumes full responsibility for the issue brief and the accuracy of its contents.

Suggested Citation

California Health Benefits Review Program (CHBRP). (2026). Explainer: What are Pharmacy Benefits?. Berkeley, CA.