Date of Hearing: April 7, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1773 (Blanca Rubio) – As Amended March 16, 2026

SUBJECT: Pharmacy benefit managers.

SUMMARY: Requires the Department of Managed Health Care (DMHC) to maintain a public website to display a pharmacy benefit manager's (PBM) legal name, license number and status, initial licensure date, license expiration date.

EXISTING LAW:

1) Establishes DMHC to regulate health plans in the Health and Safety Code under the Knox-Keene Act. [Health and Safety Code (HSC) § 1340 *et seq*.]

2) Defines a "PBM" to mean a person, business, or other entity that, either directly or through an intermediary, affiliate, or both, acts as a price negotiator or group purchaser on behalf of a payer, or manages the prescription drug coverage provided by the payer, including, but not limited to, the:

   a) Processing and payment of claims for prescription drugs;

   b) Performance of drug utilization review;

   c) Processing of drug prior authorization requests;

   d) Adjudication of appeals or grievances related to prescription drug coverage;

   e) Contracting with network pharmacies; or,

   f) Controlling the cost of covered prescription drugs. [HSC § 1385.001]

3) Defines a "PBM" to include an entity performing the duties specified above that is under common ownership with, or control by, a payer, and excludes from the definition of a PBM specified entities, including a fully self-insured employee welfare benefit plan under ERISA, a state-regulated health plan or health insurer, and Department of Health Care Services (DHCS), including any contracts between DHCS and another entity related to the negotiation and collection of drug or medical supply rebates. [HSC § 1385.001]

4) Requires a PBM to secure a license from DMHC to engage in business in the state on or after January 1, 2027, or the date on which DMHC has established the licensure process, whichever is later. [HSC § 1385.008]

5) Establishes requirements for licensure as a PBM, including submitting specified information, (including financial statements) to DMHC, requires PBMs to reimburse the DMHC director for the actual cost of processing the application for licensure (capped at $25,000), lists specified acts or omissions that constitute grounds for disciplinary action by the DMHC director, and permits DMHC to conduct periodic routine and nonroutine surveys of a PBM. [HSC § 1385.001 *et seq.*]

6) Requires an application for a PBM license to be verified by an authorized representative of the applicant and in a form prescribed by DMHC. Permits DMHC to utilize forms and processes available to and required of health plan licensure applicants and licensees established in state law and through regulations. Requires an application to be submitted with the necessary fees and specified information and documentation. [HSC § 1385.009]

7) Establishes that a PBM license is effective until revoked or suspended by DMHC. [HSC § 1385.0015]

8) Permits the DMHC director, after appropriate notice and opportunity for a hearing, to suspend or revoke a PBM license or assess administrative penalties. [HSC § 1385.0018]

9) Permits a PBM whose license has been revoked or suspended for more than one year to petition DMHC to reinstate the license, as specified. [HSC § 1385.0019]

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, this bill is about making California's new PBM oversight framework transparent and usable for the people it is aiming to protect. The author states that in recent years, the Legislature has taken important steps to license and regulate PBMs, recognizing the powerful role they play in determining which drugs patients can access and at what cost. The author continues that even with these important policy reforms, there is still no simple, public way under existing law for a consumer, provider, or health plan to look up a PBM and confirm that it is licensed and in good standing with DMHC.

   The author argues that this bill closes that gap with a narrow, practical requirement: it directs DMHC to maintain a public website listing basic licensure information for each PBM—its legal name, license number and status, and key dates. The author continues that it does not change any of the underlying duties, enforcement tools, or financial requirements the Legislature has already enacted. Instead, the author argues that it makes the existing system transparent and easy to navigate, so that patients, pharmacies, health plans, and regulators are all working from the same, official information.

2) **BACKGROUND.**

   a) **Background on the drug supply chain and PBMs.** The drug supply chain refers to the process through which prescription drugs move from their development and manufacture to being made available for patient use. Pharmaceutical companies or contract manufacturers research, develop and produce drugs. Drugs are then packaged according to regulatory requirements. Wholesalers and distributors are entities that purchase drugs in bulk from manufacturers and then sell them to pharmacies, hospitals, clinics, and other health care providers. Pharmacies and hospitals are the final points of distribution where patients obtain their prescribed drugs, either through retail pharmacies (community pharmacies or "independents"), chain pharmacies, mail order pharmacies, or health care facilities such as hospitals and skilled nursing facilities. Pharmacists dispense medications prescribed by a health care provider (such as a physician, nurse practitioner, or podiatrist) who is authorized to prescribe medications.

PBMs manage the prescription drug benefit on behalf of third-party payers (health plans, insurers, self-insured employers, labor trusts, Medicare and Medicaid, and state and local governments). PBMs role varies by payer, but major PBM functions include processing claims, negotiating drug prices and discounts, managing formularies, establishing pharmacy networks, and more.

PBMs role over time has changed significantly as third-party coverage of prescription drugs has expanded. PBMs were originally established to set reimbursement rates, process claims, and pay pharmacies on behalf of payers. PBMs are increasingly vertically integrated, with several large PBMs being owned by or affiliated with pharmacy chains, insurance companies, specialty pharmacies, mail order pharmacies, and health care providers. According to a Congressional Research Service 2023 publication, in 2022, the three largest PBMs (CVS Caremark, part of CVS Health, which owns Anthem; Express Scripts, which is owned by Cigna; and OptumRx, which is owned by UnitedHealthcare) processed a large majority of prescription drug claims in the United States. PBMs have also acquired mail order pharmacies and specialty pharmacies.

This gives PBMs considerable leverage with health payers, pharmacies, and drug manufacturers. Because of the significant behind-the-scenes impact PBMs have on the amount payers pay for drugs, how much pharmacies are reimbursed and which drugs are available to patients, PBMs have faced growing scrutiny at the state and federal level.

b) Prior Legislation and Health Budget Action. As part of the 2025-26 May Budget Revision, Governor Newsom proposed trailer bill language (TBL) to regulate PBMs directly through DMHC when they contract with state-licensed health plans and insurers. AB 116 (Committee on Budget), Chapter 21, Statutes of 2025, the health budget trailer, contained the Governor's proposed TBL, which replaced the previous requirement for PBM registration to instead require a PBM contracting with a health plan or health insurer to secure a license from the DMHC on or after January 1, 2027, or the date on which DMHC has established the licensure process, whichever is later.

AB 116 establishes application requirements, requires the payment of an application fee, requires a PBM to submit financial statements, authorizes the director to suspend or revoke a PBM license, requires a PBM have a fiduciary duty to its payer client, established a Pharmacy Benefit Manager Fund in the State Treasury, into which fees, fines, penalties, and reimbursements collected from PBMs would be deposited. Fines and administrative penalties for specified acts or omissions would be deposited into the newly created Pharmacy Benefit Manager Administrative Fines and Penalties Fund in the State Treasury.

SB 41 (Wiener), Chapter 605, Statutes of 2025, expanded on the provisions of AB 116 to regulate the actions of PBMs including prohibiting a PBM from deriving income from PBM services provided to a health plan or health insurer, except for a "pharmacy benefit management fee," requiring a PBM to use a pass-through pricing model, prohibiting a PBM from conducting spread pricing (when a PBM charges a health plan a price for prescription drugs, and that price differs from the amount the PBM pays the pharmacist or pharmacy), and requiring a PBM to direct 100% of all prescription drug manufacturer rebates for the sole purpose of offsetting cost-sharing, deductibles, and coinsurance contributions and reducing premiums.

3) **SUPPORT.** The Chronic Care Policy Alliance (CCPA) is sponsoring this bill, stating that consumers, health plans, pharmacies, and other stakeholders still lack a simple, public tool to verify which PBMs are licensed and in good standing with DMHC. CCPA argues that this information gap undermines the effectiveness of the state's new regulatory framework. CCPA continues that this bill states that it shall be implemented using existing resources, with a trigger ensuring no new costs unless future funding is appropriated. CCPA states that this transparency tool brings PBM licensure in line with standard practice for other regulated professionals—physicians, pharmacists, attorneys, insurance agents, and even health care service plans all have public license databases. CCPA concludes that this bill ensures that Californians can confirm that entities controlling access to their prescription medications are accountable under state law.

4) **PREVIOUS LEGISLATION.**

   a) AB 116 (Committee on Budget) replaced the previous requirement for PBM registration to instead require a PBM contracting with a health plan or health insurer to secure a license from the DMHC on or after January 1, 2027, or the date on which DMHC has established the licensure process, whichever is later.

   b) SB 41 (Wiener) prohibits a PBM from deriving income from PBM services provided to a health plan or health insurer, except for a "pharmacy benefit management fee." Requires a PBM to use a pass-through pricing model. Prohibits a PBM from conducting spread pricing. Requires a PBM to direct 100% of all prescription drug manufacturer rebates for the sole purpose of offsetting cost-sharing, deductibles, and coinsurance contributions and reducing premiums. Prohibits numerous PBM activities affecting pharmacies.

   c) SB 966 (Wiener) of 2024 was similar to SB 41, and additionally would have directed the California Department of Insurance to establish the licensing framework for PBMs. SB 966 was vetoed by Governor Newsom, who stated, in part:

   "Without a doubt, the public and the Legislature need a clearer understanding of how much PBM practices are driving up prescription drug costs. I commend the author for working to further tackle this issue through regulating PBM participation in the pharmacy delivery system. Currently, PBMs manage all aspects of prescription drug services for California's commercial health care market. I believe that PBMs must be held accountable to ensure that prescription drugs remain accessible throughout pharmacies across California and available at the lowest price possible. However, I am not convinced that SB 966's expansive licensing scheme will achieve such results."

   d) AB 2180 (Weber) of 2024 would have required a health plan, health insurance policy, or PBM that administers pharmacy benefits for a health plan or health insurer to apply any amounts paid by the enrollee, insured, or a third-party patient assistance program for prescription drugs toward the enrollee's or insured's cost-sharing requirement, and would have only applied those requirements with respect to enrollees or insureds who have a chronic disease or terminal illness. AB 2180 was held in the Assembly Appropriations Committee.

   e) AB 913 (Petrie-Norris) of 2023 would have required the Board of Pharmacy (BoP) to license and regulate PBMs that manage the prescription drug coverage provided by a health plan or health insurer, except as specified. Would have set forth various duties of

PBMs, including requirements to file a report with the BoP. AB 913 was not heard in the Assembly Business and Professions Committee.

f) SB 873 (Bradford) of 2023 would have required an enrollee's or insured's defined cost-sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. SB 873 was held in the Assembly Appropriations Committee.

g) AB 948 (Berman), Chapter 820, Statutes of 2023, prohibits the copayment, coinsurance, or any other form of cost-sharing for a covered outpatient prescription drug for an individual prescription from exceeding $250 for a supply of up to 30 days or $500 for bronze products, except as specified; and, requires a non-grandfathered individual or small group plan contract or insurance policy to use specified definitions for each tier of a drug formulary. Prohibits a copayment or percentage coinsurance from exceeding 50% of the cost to the plan and require a plan or insurer to ensure that the enrollee or insured is subject to the lowest cost-sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary, if there is a generic equivalent to a brand name drug. Deletes biologics from the tier four definition in existing law.

h) SB 524 (Skinner) of 2021 would have prohibited a health plan, a health insurer, or the agent thereof from engaging in patient steering, as specified. Would have defined "patient steering" to mean communicating to an enrollee or insured that they are required to have a prescription dispensed at, or pharmacy services provided by, a particular pharmacy, as specified, or offering group health care coverage contracts or policies that include provisions that limit access to only pharmacy providers that are owned or operated by the health care service plan, health insurer, or agent thereof. Governor Newsom vetoed AB 524 stating in part:

"While offering consumers a choice in pharmacies within their health plan or insurer networks is a worthwhile goal, the bill lacks clarity in key areas which may render it subject to misinterpretation or a lack of enforceability. It is unclear what business relationships between health plans, insurers, and their agents are intended to be affected because the bill does not define "agent" or "corporate affiliate." Furthermore, it is unclear what it means to "limit an enrollees' (or insureds') access" to certain pharmacy providers.

It is necessary to define these terms and concepts so appropriate oversight and enforcement may occur, particularly in light of the complexity of the contracting arrangements and benefit designs at issue. Finally, it is important to ensure that efforts to address these concerns do not have the unintended consequence of interfering with the ability of health plans and insurers to coordinate care and contain pharmaceutical costs for California's consumers."

i) AB 1803 (Committee on Health), Chapter 114, Statutes of 2019, requires a pharmacy to inform a customer at the point of sale for a covered prescription drug whether the retail price is lower than the applicable cost-sharing amount for the prescription drug, except as specified, and, if the customer pays the retail price, requires the pharmacy to submit the claim to the customer's health plan or health insurer beginning January 1, 2020.

j) AB 315 (Wood), Chapter 905, Statutes of 2018 requires PBMs to register with the DMHC, to exercise good faith and fair dealing, and to disclose, upon a purchaser's request, information with respect to prescription product benefits, as specified.

5) **POLICY COMMENT.** AB 116, which directs DMHC to create the PBM licensing framework, was passed into law just last year. The earliest that DMHC will begin licensing PBMs is January 1, 2027, but DMHC has the statutory flexibility to establish the licensure process later. Additionally, DMHC already licenses health plans and publicly posts a wealth of information on licensed plans, data reports, disciplinary actions, financials and more – much of which isn't statutorily required. DMHC also currently registers PBMs and maintains a webpage with information on registered PBMs and who they contract with. Given this, there is a high likelihood that as DMHC implements the PBM licensing process they will already post the information requested in this bill and more. The legislature may wish to question if this bill is premature or necessary.

REGISTERED SUPPORT / OPPOSITION:

Support

Chronic Care Policy Alliance (sponsor)
California Pharmacists Assocaition

Opposition

None on file

Analysis Prepared by: Riana King / HEALTH / (916) 319-2097