Date of Hearing: July 8, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 41(Wiener and Wahab) – As Amended June 30, 2025

As Proposed to be Amended

SENATE VOTE: 37-0

SUBJECT: Pharmacy benefits.

SUMMARY: Prohibits a pharmacy benefit manager (PBM) from deriving income from pharmacy benefit management services provided to a payer, except for a flat, defined, dollar-amount fee that covers the cost of providing one or more pharmacy benefit management services (defined in the bill as a "pharmacy benefit management fee"). Prohibits the pharmacy benefit management fee from being directly or indirectly based on or contingent upon specified factors, including the amount of savings, rebates, or other fees charged, collected by or generated based on the activity of the PBM or its affiliated entities. Prohibits a PBM from conducting spread pricing in this state (spread pricing is when PBM charges a health plan a contracted price for prescription drugs, and that price differs from the amount the PBM pays the pharmacist or pharmacy). Requires a PBM to use a pass-through pricing model. Requires a PBM to reimburse a pharmacy the cost of a prescription drug in an amount that is no less than specified benchmarks. Requires a PBM to pay a pharmacy a dispensing fee that is no less than the dispensing fee that is paid by Medi-Cal. Requires a PBM, group purchasing organization (GPO), and affiliated entity to direct 100% of all prescription drug manufacturer rebates (as defined) for the sole purpose of offsetting defined cost-sharing, deductibles, and coinsurance contributions and reducing premiums of plan participants. Prohibits a PBM from contracting with drug manufacturers that implements exclusivity (on a PBM formulary) for those drug manufacturers' drugs, unless the PBM can demonstrate the extent to which exclusivity results in the lowest cost to the payer and the lowest cost-sharing for the plan participant. Prohibits numerous PBM activities affecting pharmacies. Requires services provided by a pharmacy benefit manager acting on behalf of a self-insured plan to be subject to this bill, unless preempted by federal law. Specifically, **this bill**:

Regulation of Pharmacy Benefit Manager Compensation from Payers

1) Prohibits a PBM from deriving income from pharmacy benefit management services provided to a payer in this state except for income derived from a "pharmacy benefit management fee" for pharmacy benefit management services provided.

2) Defines a "pharmacy benefit management fee" to mean a flat, defined, dollar-amount fee that covers the cost of providing one or more pharmacy benefit management services and that does not exceed the value of the service or services actually performed by the pharmacy benefit manager. Requires the value of the service or services to be based on the value to the health insurer or health plan.

3) Prohibits a pharmacy benefit management fee from directly or indirectly being based on or contingent upon any of the following:

a) Negotiating the price of prescription drugs, including negotiating and contracting for direct or indirect rebates, discounts, or other price concessions;

b) 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 is retained by the PBM or its affiliated entities; or,

c) 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.

4) Defines a "payer" to mean a health plan licensed by the Department of Managed Health Care (DMHC) or a health insurer licensed by the California Department of Insurance (CDI).

5) Requires a "health insurer" acting as a PBM that provides services in this state to be subject to this bill.

6) Requires services provided by a PBM acting on behalf of a self-insured plan to be subject to this bill, unless preempted by federal law.

7) Requires the amount of any pharmacy benefit management fee to be set forth in the agreement between the PBM and the payer, and requires the PBM to disclose the amount and types of PBM fees to the payer.

Pass-through Pricing Model Requirement for PBMs

8) Requires a PBM to use a "pass-through pricing model."

9) Defines a "pass-through pricing model" to mean a payment model used by a PBM in which the payments made by the health plan or health insurer client to the PBM for the covered outpatient drugs are both of the following:

a) Equivalent to the payments the PBM makes to a pharmacy or provider for those drugs, including any contracted professional dispensing fee between the PBM and its network of pharmacies, if the dispensing fee would be paid if the health plan or health insurer was making the payments directly; and,

b) Passed through in their entirety by the health plan or health insurer client or by the PBM to the pharmacy or provider that dispenses the drugs, and the payments are made in a manner that is not offset by any reconciliation.

10) Prohibits the above-described provisions from precluding a payer from paying performance bonuses to a PBM 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:

a) The wholesale acquisition cost of a drug;

b) 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 is retained by the PBM; or,

c) 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.

11) Requires compensation arrangements governed by the above-described requirements to be open for inspection by the DMHC.

Rebate Pass-Through Requirement

12) Requires a PBM, group purchasing organization (GPO), and affiliated entity to direct 100% of all prescription drug manufacturer rebates received to the payer or program, if the contractual arrangement delegates the negotiation of rebates to the PBM, GPO, or affiliated entity, for the sole purpose of offsetting defined cost-sharing, deductibles, and coinsurance contributions and reducing premiums of plan participants.

13) Defines a "rebate" to mean:

a) Compensation or remuneration of any kind received or recovered from a pharmaceutical manufacturer by a PBM, affiliated entity, or subcontractor, including a GPO, directly or indirectly, regardless of how the compensation or remuneration is categorized; and,

b) Fees that a PBM, affiliated entity, or subcontractor, including a GPO, receives from a pharmaceutical manufacturer.

14) Defines a "GPO" to mean a third party or affiliated person, including an out-of-state or international organization, employed by, contracted with, affiliated with, under common ownership or control by, or otherwise utilized by an entity that provides pharmacy benefit management services or by a PBM to negotiate, obtain, or otherwise procure rebates from drug manufacturers or wholesalers.

15) Defines an "affiliated entity" to mean any of the following:

a) An applicable group purchasing organization, drug manufacturer, distributor, wholesaler, rebate aggregator or other purchasing entity designed to aggregate rebates, or associated third party;

b) Any subsidiary, parent, affiliate, or subcontractor of a group health plan, any entity that provides pharmacy benefit management services on behalf of a group health plan, or any entity described in paragraph a); or,

c) Any other entity as designated by DMHC.

Prohibition on Spread Pricing

16) Prohibits, commencing January 1, 2026, a PBM from conducting spread pricing in this state.

17) Defines "spread pricing" to mean the model of prescription drug pricing in which a PBM charges a health plan or health insurer a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the PBM directly or indirectly pays the pharmacist or pharmacy.

18) Prohibits, if a preexisting contract between a PBM and a payer authorizes spread pricing, a subsequent amendment or renewal of that contract from containing that authorization. Requires spread pricing contract terms to be void on and after January 1, 2029.

19) Prohibits, commencing January 1, 2026, if a preexisting contract between a PBM a health plan or health insurer authorizes spread pricing, any subsequent amendment or renewal of that contract from authorizing spread pricing.

20) Prohibits a contract that is executed on or after January 1, 2026, between a PBM and a health plan or a health insurer from authorizing spread pricing.

Limitations on Exclusivity

21) Prohibits a PBM, notwithstanding any other law, from entering into, amending, enforcing, or renewing a contract on or after January 1, 2026, with manufacturers that do business in California that implement implicit or express exclusivity for those manufacturers' drugs, unless the PBM can demonstrate the extent to which exclusivity results in:

    a) The lowest cost to the payer; and,

    b) The lowest cost-sharing for the plan participant.

22) Prohibits a PBM, notwithstanding any other law, from entering into, amending, enforcing, or renewing a contract on or after January 1, 2026, with pharmacies or pharmacy services administration organizations that do business in California that expressly or implicitly restricts, or imposes implicit or express exclusivity on, nonaffiliated pharmacies' ability to contract with employers and payers.

23) Requires contracts entered into pursuant to the above-described provisions to be open for inspection and audit by the DMHC.

Rate Floor Reimbursement Requirements for PBM Reimbursement to Pharmacies

24) Requires a PBM to reimburse a pharmacy the cost of a prescription drug in an amount that is no less than the National Average Drug Acquisition Cost (NADAC) for that drug at the time of the pharmacy's dispensing of that drug, or the pharmacy's wholesale acquisition cost (WAC) of that drug if the drug does not appear on the NADAC index.

25) Requires a PBM to pay a pharmacy a dispensing fee that is no less than the dispensing fee that is paid by Medi-Cal (Medi-Cal dispensing fees are set in statute and are based upon a pharmacy's total [both Medicaid and non-Medicaid] annual claim volume of the previous year, with a higher dispensing fee for pharmacies with less than 90,000 claims per year; for those pharmacies, the dispensing fee is $13.20, and for pharmacies with more than 90,000 claims per year, the dispensing fee is $10.05).

Prohibitions on PBM Payment Reductions to Pharmacies

26) Prohibits a PBM from making or permitting any reduction of payment for pharmacist services by a PBM or a payer directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including without limitation, generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payment.

27) Prohibits a claim or aggregate of claims for pharmacist services from being directly or indirectly retroactively denied or reduced after adjudication of the claim or aggregate of claims unless any of the following have occurred:

    a) The original claim was submitted fraudulently;

    b) The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacist services; or,

    c) The pharmacist services were not properly rendered by the pharmacy or pharmacist.

28) Prohibits a PBM from reversing and resubmitting the claim of a contract pharmacy under any of the following circumstances:

    a) Without prior written notification to the contract pharmacy;

    b) Without just cause or attempt to first reconcile the claim with the pharmacy; or,

    c) More than 90 days after the claim was first affirmatively adjudicated.

29) Prohibits a PBM from charging a pharmacy or pharmacist a fee to process a claim electronically.

30) Prohibits the termination of a contract with a nonaffiliated pharmacy by a PBM from releasing the PBM from the obligation to make a payment due to the pharmacy for an affirmatively adjudicated claim unless payments are withheld because of an investigation relating to insurance fraud.

Prohibitions Against PBM Discrimination Against Non-Affiliated Pharmacies

31) Prohibits a PBM from imposing any requirements, conditions, or exclusions that discriminate against a “nonaffiliated pharmacy” in connection with dispensing drugs.

32) Defines a “nonaffiliated pharmacy” to mean a contract pharmacy that directly, or indirectly through one or more intermediaries, does not control, is not controlled by, and is not under common control with a PBM.

33) Defines prohibited discrimination to include all of the following:

    a) Terms or conditions applied to nonaffiliated pharmacies based on their status as a nonaffiliated pharmacy;

b) Refusing to contract with or terminating a contract with a nonaffiliated pharmacy on the basis that the pharmacy is a nonaffiliated pharmacy or for reasons other than those that apply equally to affiliated pharmacies;

c) Retaliation against a nonaffiliated pharmacy based on its exercise of any right or remedy under this bill; or,

d) Engaging in an unlawful action against a covered entity, including a violation of existing law that prohibits a PBM from discriminating against a covered entity or a specified pharmacy in connection with dispensing covered drugs, or that prevent a covered entity from retaining the benefits of discounted pricing for the purchase of covered drugs.

Prohibition on PBM Restrictions on Nonaffiliated Pharmacies

34) Prohibits a contract issued, amended, or renewed on or after January 1, 2026, between a nonaffiliated pharmacy and a PBM from prohibiting the pharmacy from offering either of the following as an ancillary service of the pharmacy:

a) The delivery of a prescription drug by mail or common carrier to a patient or personal representative on request of the patient or personal representative if the request is made before the drug is delivered; or,

b) The delivery of a prescription to a patient or personal representative by an employee or contractor of the pharmacy.

35) Prohibits, except as otherwise provided in a contract between the PBM and the pharmacy, the pharmacy from charging a PBM for the delivery service. Allows the use of remote pharmacies, secure locker systems, or other types of pickup stations if those services are otherwise permitted by law.

36) Requires contracts entered into pursuant to the provisions above to be open for inspection by DMHC.

Prohibitions Against Specified PBM Actions

37) Prohibits a PBM from doing any of the following:

a) Requiring a plan participant to use only an affiliated pharmacy if there are nonaffiliated pharmacies in the network (an “affiliated pharmacy” is defined as a contract pharmacy that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with a PBM);

b) Financially inducing a plan participant to transfer a prescription only to an affiliated pharmacy if there are nonaffiliated pharmacies in the network;

c) Requiring a nonaffiliated pharmacy to transfer a prescription to an affiliated pharmacy if there are nonaffiliated pharmacies in the network. Allows a purchaser or PBM to offer to 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;

d) Unreasonably restricting 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;

e) Communicating to or misleading 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 nonaffiliated pharmacies that have the ability to dispense the medication or provide the services and are also in network; or,

f) Denying a nonaffiliated contract pharmacy the opportunity to participate in a PBM network with 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.

Prohibitions Against PBM Retaliation Against Pharmacists and Pharmacies

38) Prohibits a PBM from retaliating against a pharmacist or pharmacy based on the pharmacist's or pharmacy's exercise of a right or remedy under this bill. Defines "retaliation" to include any of the following:

a) Terminating or refusing to renew a contract with the pharmacist or pharmacy;

b) Subjecting the pharmacist or pharmacy to increased audits without cause; or,

c) Failing to promptly pay the pharmacist or pharmacy money owed by the PBM to the pharmacist or pharmacy.

Continued Allowance for PBMS to Use Pharmacy Networks

39) Prohibits the provisions of this bill from precluding a PBM or a purchaser of pharmacy benefit manager services from establishing a network of contracting pharmacies.

Self-Insured Plans Use of a PBM

40) Requires services provided by a PBM manager acting on behalf of a self-insured plan to be subject to this bill, unless preempted by federal law.

Patient Cost-Sharing for Prescription Drugs

41) Prohibits health plans and insurers that provide prescription drug coverage from calculating an enrollee's cost-sharing at an amount that exceeds the price paid by the PBM or GPO for the prescription drug, and requires that to include cost-sharing (defined to include deductibles and copayments) provisions consistent with the existing law requirement that a pharmacy inform a customer at the point of sale whether the retail price is lower than the applicable cost-sharing amount for the prescription drug, unless the pharmacy automatically charges the customer the lower price.

Prohibitions on PBM Restrictions on Patient Choice and Advertisements

42) Prohibits a PBM, except as permitted under existing law, from unreasonably obstructing or interfering with a patient's right to timely access a prescription drug or device that has been legally prescribed for that patient at a contract pharmacy of their choice.

43) Prohibits a PBM from making, disseminating, or causing or permitting the use of an advertisement, promotion, solicitation, representation, proposal, or offer that is known to be, or reasonably should be known to be, untrue, deceptive, or misleading.

44) Permits the DMHC to investigate referrals provided by the California State Board of Pharmacy.

Exemption for Collectively Bargained Taft-Hartley Self-Insurance Prescription Drug Plan

45) Prohibits this bill from applying to a collectively bargained Taft-Hartley self-insured prescription drug plan offered pursuant to the federal Employee Retirement Income Security Act of 1974 (ERISA) or to a PBM's provision of pharmacy benefit management services pursuant to that Taft-Hartley plan.

46) Requires, to the extent a PBM is providing services for other payers in addition to a collectively bargained self-insured plan that provides prescription drug plans governed by federal law, this bill to apply to the PBM in its performance of pharmacy benefit management services pursuant to those other payers.

Patient Complaints by an Insured

47) Requires a complaint made by an insured that includes potential violations by a PBM of the terms of the licensure provisions and this bill to be considered by the Department of Insurance to be a complaint against the insurer.

PBM Contracts with Health Insurers and the Business of Insurance

48) Requires any activity conducted by a PBM contracting with a health insurer to be construed as the business of insurance.

Expanded Prescription Drug Reporting Requirements to DMHC

49) Expands the existing scope of reporting to DMHC on covered prescription drugs, (which currently includes reporting on the 25 most frequently prescribed drugs, the 25 most costly drugs by total annual plan spending, the 25 drugs with the highest year-over-year increase in total annual plan spending), to also include:

    a) The aggregate WAC from a pharmaceutical manufacturer or labeler for each drug;

    b) The aggregate amount of rebates received by the PBM for each drug;

    c) Any administrative fees received from the pharmaceutical manufacturer or labeler;

    d) The aggregate of payments, or the equivalent economic benefit, made by the PBM to pharmacies owned or controlled by the PBM for each drug;

e) The aggregate of payments made by the PBM to pharmacies not owned or controlled by the PBM for each drug; and,

f) The aggregate fees that pharmacy benefit managers receive.

50) Requires DMHC, in preparing the required report, to ensure that the information regarding rebates is aggregated and does not reveal information specific to individual health plans or manufacturers, or reveal any manufacturer's individual or aggregated discounted prices for a drug.

Notification to Attorney General and Penalties for Violations

51) Requires, if a violation of this bill is alleged and is at issue in a proceeding in the Supreme Court, a state court of appeal, or the appellate division of a superior court, a person filing a brief or petition with the court in that proceeding to serve, within three days of filing with the court, a copy of the brief or petition on the Attorney General (AG) at a service address designated on the AG's internet website for service of papers under this section, or, if a service address is not designated, at the AG's office in the City and County of San Francisco.

52) Requires, upon the AG's request, a person who has filed any other document, including all or a portion of the appellate record, with the court in addition to a brief or petition, to provide a copy of that document, without charge, to the AG within five days of the request. Permits the time for service to be extended by the Chief Justice of California or presiding justice or judge for good cause shown. Prohibits a judgment or relief, temporary or permanent, from being granted, and prohibits an opinion from being issued, until proof of service of the brief or petition on the AG is filed with the court.

53) Makes a person that violates this bill subject to an injunction and liable for a civil penalty of not less than $1,000 or more than $7,500 for each violation, which is required to be assessed and recovered in a civil action brought in the name of the people of the State of California by the AG.

54) Requires, notwithstanding any other law, the Attorney General to be entitled to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for enforcement of this bill, and requires the AG to be entitled to recover attorney's fees and costs incurred in remedying each violation.

55) Prohibits the above-described provisions from altering or abrogating the DMHC's authority to enforce this bill.

Severability

56) Requires the provisions of this bill to be severable, and if any provision of this bill or its application is held invalid, that invalidity is prohibited from affecting other provisions or applications that can be given effect without the invalid provision or application.

EXISTING LAW:

1) Establishes DMHC to regulate health plans in the Health and Safety Code under the Knox-Keene Act, and requires CDI to regulate health insurers under the Insurance Code. [Health and Safety Code (HSC) § 1340 *et seq*. and Insurance Code (INS) § 106 *et seq*.]

2) Prohibits, pursuant to the recently enacted health budget trailer bill AB 116 (Committee on Budget), Chapter 21, Statutes of 2025, on or after January 1, 2027, or the date on which the DMHC has established the licensure process, a person from engaging in business as a PBM for a payer (a payer is defined as a state-regulated health plan or health insurer) in this state unless that person has first secured a license from the director of the DMHC. [HSC § 1385.008]

3) 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.

4) 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]

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 a PBM to have a fiduciary duty to its payer client that includes a duty to be fair and truthful toward the payer, to act in the payer's best interests, and to perform its duties with care, skill, prudence, and diligence. [HSC § 1385.0022]

7) Establishes the Pharmacy Benefit Manager Administrative Fines and Penalties Fund in the State Treasury, and requires fines and administrative penalties to be deposited into the Pharmacy Benefit Manager Administrative Fines and Penalties Fund. [HSC § 1385.0024]

8) Requires the Department of Health Care Access and Information (HCAI) to implement and administer the Health Care Payments Data System to learn about and seek to improve public health, population health, social determinants of health, and the health care system. [HSC § 12761 *et seq.*]

9) Requires PBMs, pursuant to AB 116, for the purpose of providing information for inclusion in the Health Care Payments Data System, to provide to HCAI data regarding drug pricing, the fees paid for pharmacy benefit management services, payments or rebates to or from PBMs regarding drugs or services, and other information as needed to provide transparency on pricing and payments related to prescription drugs. [HSC § 127673.05]

10) 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, unless the pharmacy automatically charges the customer the lower price. [Business and Professions Code § 4079]

11) Requires a health plan or health insurer that reports rate information, as specified, to report information no later than October 1 of each year that demonstrates the overall impact of drug costs on health care premiums. [HSC § 1356.243 and INS § 10123.205]

12) Requires health plans and insurers, for all covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, to report:

    a) The 25 most frequently prescribed drugs;

    b) The 25 most costly drugs by total annual plan spending; and,

    c) The 25 drugs with the highest year-over-year increase in total annual plan spending. [*Ibid*.]

13) Requires DMHC and CDI to compile the information from 10) and 11) above into a report for the public and Legislators where the data is aggregated and does not reveal information specific to individual plans. Requires the report to be published on DMHC's and CDI's website. [*Ibid*.]

FISCAL EFFECT: This bill, as recently amended, has not been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill reins in the worst abuses by PBMs, insurance-industry middlemen who are driving up the price of prescription medication for Californians. This bill will protect consumer choice, provide transparency on prescription drug prices, and improve our health care system by ensuring that PBMs are appropriately regulated. Vertical integration and a lack of oversight have allowed some PBMs to engage in unfair business practices that undermine health care access and drive up the cost of prescription drugs. PBMs have developed a compensation scheme that creates perverse incentives to raise drug prices in some circumstances, and the complete lack of oversight has also allowed some PBMs to steer patients toward pharmacies they own, pocket large portions of the rebates they negotiate with drug manufacturers, and make misleading

statements to customers. By raising fees and lowering reimbursement rates, PBMs are also making it hard for many independent pharmacies to stock vital medications, and forcing many of them to close. These business practices drive up the cost of prescription drugs, and force consumers and pharmacies to pay the price. The author concludes this bill fills that regulatory gap by requiring that all PBMs disclose basic information regarding their business practices to the state.

2) **PRIOR LEGISLATION AND RECENT HEALTH BUDGET TRAILER BILL**. As part of the 2025-26 May Budget Revision, Governor Newsom proposed trailer bill language (TBL) to regulate PBMs directly through the 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.

   The prior version of this bill required PBMs to be regulated by the CDI. The amendments of June 30 incorporate the DMHC-regulatory provisions of AB 116 and the prior contents of this bill within the DMHC regulatory scheme. This bill is analyzed "as proposed to be amended" because AB 116 was recently signed into law. The provisions of this bill that duplicate those provisions will be amended out of this bill, or updated to have provisions of this bill apply to what is now existing law as enacted by AB 116.

3) **PRESCRIPTION DRUG SPENDING AND SB 17 REPORT**. SB 17 (Hernandez), Chapter 603, Statutes of 2017 requires health plans in the commercial market to annually report their prescription drug costs to the DMHC. This report looks at the impact of the cost of prescription drugs on health plan premiums and compares this data across the reporting years. The cost of prescription drugs continues to impact the affordability of health care overall, with health plans paying about $13.6 billion for prescription drugs in 2023 (minus $2.6 billion in rebates). Prescription drug costs have increased at a higher rate compared to medical expenses and health plan premiums. Total prescription drug costs increased by 10.8% in 2023, whereas total medical expenses increased by 4% and health plan premiums increased by 6.2% from 2022 to 2023. Prescription drugs accounted for 15.1% of total health plan premiums in 2023, compared to 14.3% in 2022. Specialty drugs (a drug with a plan negotiated monthly cost prior to rebate that exceed the dollar threshold for a specialty drug under Medicare Part D) and brand name drugs were the primary drivers of the increase in total prescription drug-cost spending for 2023. Specialty drugs account for only 2% of all prescriptions dispensed but accounted for 65.8% of total annual spending on prescription drugs. In contrast, generic drugs accounted for 89.2% of all prescriptions but only 12.7% of the total annual spending on prescription drugs. According to the DMHC, health plans paid

almost $1.3 billion more on prescription drugs in 2023 than in 2022. Since 2017, total prescription drug costs paid by health plans increased by $4.9 billion or 56%.

4) **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 are as follows:

   a) **Claims processing**. PBMs process claims for prescription medications submitted by pharmacies to third-party payers for reimbursement.

   b) **Negotiate Drug Prices and Discounts**. PBMs negotiate with pharmaceutical manufacturers for discounts, rebates, and pricing structures to reduce the cost of prescription drugs. PBMs do this by leveraging their purchasing power, representing large groups of patients (from plans/insurers, self-insured employers, health plans, labor trusts, etc.), to secure lower prices for drugs.

   c) **Formularies**. Formularies are lists of preferred medications that PBMs establish and manage on behalf of third-party payers that determine which drugs are covered and at what level of cost-sharing for a patient. PBMs evaluate drugs based on factors such as cost, clinical effectiveness, and safety when deciding which drugs to include on the formulary.

   d) **Pharmacy Networks**. PBMs contract with pharmacies to establish pharmacy networks. The pharmacy network determines where patients can fill prescriptions. PBMs negotiate payment rates with pharmacies, determining how much pharmacies are paid for dispensing medications. Pharmacies are typically paid a contracted amount for the drug (the "ingredient cost") and a fee for filling the drug (a "dispensing fee").

   e) **Utilization Management**. PBMs steer patients toward lower-cost drugs (generic or preferred brand medications) and use step therapy or prior authorization to ensure that less expensive or clinically appropriate treatments are used first. PBMs also monitor drug utilization (how and when patients use their medications). These programs are aimed at ensuring drugs are prescribed appropriately, avoid overuse, underuse, or misuse, and optimize treatment. Medication therapy management programs help identify potential issues, such as drug interactions or incorrect dosing.

f) Specialty Medications. Specialty medications are often high-cost drugs for complex or chronic conditions. PBMs manage the distribution and cost of these medications by negotiating prices, managing distribution through specialty pharmacies, and implementing programs that ensure proper use.

g) Drug Delivery and Mail Order Pharmacies. Many PBMs operate their own mail-order pharmacies, so patients can obtain their medications via mail or delivery.

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 (CRS) 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.

5) NADAC AND PHARMACY DRUG COST PAYMENT FLOOR. This bill requires PBMs to reimburse pharmacies for prescription drugs at a rate no less than the NADAC amount at the time the drug is dispensed, or, if the drug is not listed on the NADAC index, at no less than the pharmacy's WAC. WAC is a commonly used drug pricing benchmark in the U.S. pharmaceutical market, and is the published list price of the manufacturer sold to wholesalers or direct purchasers, not including discounts, rebates, or other price concessions.

Under federal Medicaid law, the Secretary of Health and Human Services is authorized to contract for the monthly determination of retail survey prices for covered outpatient drugs. These surveys are designed to reflect a nationwide average of pharmacy acquisition costs. NADAC was developed by the Centers for Medicare & Medicaid Services (CMS) to enhance the transparency, accuracy, and fairness of Medicaid pharmacy reimbursement for ingredient costs. To establish NADAC, CMS contracts with Myers and Stauffer LC, a national certified public accountant (CPA) firm, to conduct monthly surveys of retail community pharmacies.

State regulation of health plans and insurers primarily focuses on ensuring enrollee access to care and generally does not dictate the payment rates that commercial plans must pay health care providers, including pharmacies. In this bill, the use of NADAC is proposed as a rate floor, meaning pharmacies (or their group purchasing organizations) could still negotiate higher ingredient cost reimbursements with PBMs. In addition, the requirements of this bill would also apply to mail-order pharmacies, which operate under a different cost structure than traditional retail pharmacies.

Finally, participation in the NADAC survey is voluntary, and several large retail chains, including CVS, Walgreens (which together account for approximately 30% of the national

market), and Costco, do not participate. Because the survey does not require all pharmacies to report data, and because some entities that do not participate in the NADAC survey may have lower acquisition costs than other pharmacies, NADAC may not reflect the average drug ingredient cost across all types of pharmacies.

6) **MEDI-CAL DISPENSING FEE PAYMENT FLOOR**. This bill requires a PBM to pay a pharmacy a dispensing fee that is no less than the dispensing fee that is paid by Medi-Cal. The dispensing fee is defined by this bill as the fee paid to a pharmacy for the preparation, packaging, and dispensing of a prescription drug. Dispensing fees paid by PBMs to pharmacies are typically contractually determined and not publicly disclosed but vary depending on the payer type, state regulations, and whether the PBM is providing services in commercial coverage, Medicare, or to a Medicaid plan.

   The Medi-Cal dispensing fee is set in statute and is based upon a pharmacy's total (both Medicaid and non-Medicaid) annual claim volume for the previous year, with a higher dispensing fee for pharmacies with less than 90,000 claims per year. For those pharmacies, the dispensing fee is $13.20. For pharmacies with more than 90,000 claims per year, the dispensing fee is $10.05.

   As is typical in commercial contractual payment arrangements, the dispensing fee amounts paid by PBMs to pharmacies are not currently publicly reported. An August 2022 report by the Commonwealth Fund titled "*Competition, Consolidation, and Evolution in the Pharmacy Market"* reported dispensing fees average $2.05 per prescription for commercial insurers, but fees can vary by payer. A 2022 Milligram Health report on dispensing fees paid by Medicare Part D found the mean overall dispensing fee across plan, pharmacy and drug to be $0.65 for all in-network pharmacies, $0.68 for preferred network pharmacies, and $0.62 for non-preferred network pharmacies.

7) **PAYER PAYMENTS TO PBMs**. This bill requires payments made by payers to PBMs to be through a flat, defined, dollar-amount fee (a "pharmacy benefit management fee") that covers the cost of providing one or more pharmacy benefit management services and that does not exceed the value of the service or services actually performed by the PBM. This bill prohibits the pharmacy benefit management fee from being directly or indirectly based on or contingent upon specified factors, including 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 is retained by the PBM or its affiliated entities.

   Instead, this bill would require a PBM to use a pass-through pricing model. A hypothetical example of payments under a pass-through pricing model is a patient would present a prescription for a covered prescription drug that costs $20, with the patient's co-payment being $10. The patient would pay the required co-payment, the pharmacy would bill the PBM for the $10, the pharmacy would receive $10, the PBM would bill the health plan for $10 (because spread pricing is prohibited by this bill), and the PBM would receive a fee from the health plan for processing the payment.

   According to the Congressional Research Services (CRS) report, PBMs contracts with payers can specify different methods of compensation, including administrative fees for claims processing and other services. Where allowed, PBMs may engage in spread pricing. Some contracts allow PBMs to keep a portion of savings generated from negotiations with drug

manufacturers, rather than passing on such savings to the health payer. PBMs also generate revenue by dispensing drugs from their own mail-order and specialty drug pharmacies, rather than through contracted health plan network pharmacies.

A 2023 JAMA Health Forum Special Communication (JAMA article) titled "*Pharmacy Benefit Managers History, Business Practices, Economics, and Policy"* states that rebate retention incentivizes the PBM to maximize rebates, even if doing so results in offering a preferred formulary position to drugs with higher list prices, and spread pricing contracts incentivize PBMs to squeeze lower costs out of their pharmacy networks. The JAMA article states these strategies create an environment that favors larger PBMs with more negotiating leverage, incentivizing horizontal integration through mergers and acquisitions. The same dynamics also create an incentive toward vertical integration with PBM-owned or PBM-affiliated pharmacies, particularly for high-cost specialty pharmaceuticals, which have a massively disproportionate impact on total drug spending.

The JAMA article states that drug manufacturers in competitive therapeutic areas may have an incentive to offer, and some PBMs may have an incentive to accept, a high-list-price and high-rebate strategy. The JAMA article states a PBM may prefer products with high list prices for which it can negotiate high rebates, rather than comparable drugs with lower list prices and smaller rebates, if the PBM retains some percentage of the rebates and its contract with the plan sponsor does not require 100% pass-through. The JAMA article states these pricing incentives have led multiple manufacturers, such as Amgen and Viatris, to launch the same drug products at different list prices (a low-price product with no rebate and a higher-price version with rebates) to appeal to different purchasers. Although it seems counterintuitive that any purchaser would prefer a higher price, the JAMA articles states both companies expect the high-list-price/high-rebate option to be more attractive to PBMs that retain some of the rebate.

8) SUPPORT. This bill is jointly sponsored by the California Pharmacists Association (CPhA), California Chronic Care Coalition (CCCC), San Francisco AIDS Foundation (SFAF), and Los Angeles LGBT Center to address a number of unfair business practices by some PBMs The sponsors state pharmacies are closing at record numbers. The recent announcement that Rite Aid is going out of business is further proof. Over 300 Rite Aid Pharmacies in California alone are closing, representing 5% of community pharmacies and over 4,000 jobs. Walgreens has also closed a number of stores, most recently a dozen in San Francisco, and every day, the sponsors state they see independent pharmacies closing throughout the state.

The sponsors note that PBMs were originally created to negotiate on behalf of health plans, but now operate with serious conflicts of interest and minimal transparency. They control nearly every aspect of the prescription drug supply chain, including pricing, rebates, and formularies, and often steer patients to their own affiliated mail-order or specialty pharmacies. Recent mergers between major PBMs and insurers (e.g., CVS/Aetna, Cigna/Express Scripts, UnitedHealth/OptumRx) have amplified these conflicts and inflated profit margins. Additionally, these three PBMs also own pharmacies. This vertical integration creates perverse incentives that harm patients, restrict choice, and drive independent pharmacies out of business by reimbursing them below cost while favoring their own pharmacies. The sponsors contend that, as other sectors of health care face increasing oversight, PBMs have largely escaped scrutiny, despite their central role in rising drug costs

and shrinking pharmacy access. The sponsors argue this bill is a necessary step to bring fairness, transparency, and accountability to this powerful and opaque industry to address multiple issues identified in a scathing Federal Trade Commission report on the business practices of PBMs, including massive price mark-ups, self-serving reimbursement practices, steering profitable prescriptions to affiliated pharmacies, excessive revenue from prescriptions filled at affiliated pharmacies, and charging plan sponsors more than they reimbursed pharmacies.

Blue Shield of California, various health care provider associations, and disease specific groups write in support that this would prohibit harmful practices such as spread pricing, ensures rebates directly lower patient costs, and prevent PBMs from steering to affiliated pharmacies. The Pharmaceutical Research and Manufacturers of America and Biocom California write the PBM industry has become increasingly dominated by a small number of companies, operates without accountability, and the current PBM compensation model has created misaligned incentives that can perpetuate PBMs favoring medicines with high list prices and large rebates.

9) **OPPOSITION**. The Pharmaceutical Care Management Association (PCMA) writes in opposition that, while this legislation will benefit drug manufacturers and potentially help some pharmacies, it does nothing to directly help consumers, and it estimates premiums would increase by at least $200 per fully insured member per month for Californians. PCMA objects to multiple provisions of this bill including the establishment of mandatory reimbursement and dispensing fees for pharmacies, which PCMA argues removes any market factors in private sector negotiations. PCMA states no other entity in the drug supply chain is mandated to pay another entity in the drug supply chain a set amount, and NADAC is based on responses from pharmacies, and does not reflect the true acquisition cost of drugs because it does not include discounts and rebates pharmacies receive from wholesalers. PCMA states it estimates these provisions could cost the state of California over $1 billion in excess drug spending in the first year, and over $10.8 billion over the next ten years, and estimate the dispensing fee mandate alone would increase premiums by $60.61 per fully insured member per month.

   Second, PCMA states this bill exempts self-funded Taft-Hartley plans but not self-funded union and trust health plans, self-funded employer plans, and health plans. PCMA states it fails to see the policy rationale in exempting some unions and trusts but not all self-funded union and trusts. PCMA also objects to the reporting requirements in this bill for several reasons, including being concerned with drug manufacturers being able to reverse engineer pricing information from their competitors, resulting in higher drug prices. PCMA also objects to the provision allowing pharmacies to participate in a PBMs network without having to agree to the PBMs terms and conditions, which PCMA states typically include quality standards as well as reimbursement rates, stating that pharmacies would be free to charge whatever amount they wanted for the drugs they dispense.

   PCMA also objects to the provisions of this bill mandating how PBMs are reimbursed by payers, arguing that prohibiting employers and health plan sponsors from choosing how to compensate PBMs based on the savings they provide will encourage drug manufacturers to raise their prices. PCMA states PBM clients should have the option to pay a PBM based on the discount achieved by PBM negotiations with drug manufacturers. PCMA argues enacting this provision could increase annual insurance premiums by $150 per month per

commercially insured patients in California. PCMA objects to the prohibition against the use of spread pricing contracts, stating that spread pricing enables health plans and employers to better manage their total drug spend with greater certainty, and these contracts are not imposed on health plans and employers, and that health plans and employers often ask for them when issuing their requests for proposals so they can compare different PBM payment models and determine which one best suit their specific needs.

Finally, PCMA objects to the exclusivity provisions, stating this provision would impact patient costs as brand drug manufacturers will often seek greater market share impact by providing a significantly deeper discount than another drug in the same therapeutic class. PCMA states PBMs advantage of this competition between competing brand drugs by giving the deepest discounted drug exclusive formulary placement, and PCMA states this provision would upend drug discounts, leading to higher profits for drug manufacturers and higher costs for patients.

The Chamber of Commerce, various local businesses, health plans, community and religious groups, write in opposition that this bill, by banning spread pricing and abolishing performance-based payments to PBM, will increase premium and drug costs for the millions of California patients who receive their health insurance coverage through the commercial market.

10) **DOUBLE REFERRAL**. This bill is double referred. Should it pass out of this Committee, it will be referred to the Assembly Judiciary Committee.

11) **RELATED LEGISLATION**. AB 910 (Bonta) would require a PBM to hold a fiduciary duty in the performance of its contracted duties to a health plan. Requires a PBM and any affiliated entities to pass 100% of all prescription drug manufacturer rebates received to the health plan for the sole purpose of offsetting cost-sharing, including copayments, deductibles, and coinsurance contributions, and reducing premiums of enrollees. Would prohibit a PBM and any affiliated entity from deriving income from spread pricing, as defined. Would prohibit a PBM and any affiliated entity from deriving income from PBM services provided to a health plan except for income derived from a bona fide service fee. Would require a PBM to report to the DMHC specified information, including a list of the 100 most costly drugs, the 100 most frequently prescribed drugs, the 100 highest revenue-producing drugs, and PBM revenue and expenses. Would require DMHC to compile the information reported into a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums, to determine PBM's impact on the market, the impact of rebates on pharmacy costs, the impact of PBM relationships with affiliated entities, and the value PBMs provide to consumers. AB 910 was made a two-year bill on the Assembly Appropriations Committee suspense file.

12) **PREVIOUS LEGISLATION**.

a) SB 966 (Wiener) of 2024 was similar to SB 41. In his veto message, Governor Newsom indicated he believes that PBMs must be held accountable to ensure that prescription drugs remain accessible throughout pharmacies across California and available at the lowest price possible, but he was not convinced that SB 966's expansive licensing scheme would achieve such results. He directed the California Health and Human Services Agency to propose a legislative approach to gather much needed data on PBMs next year, which can be considered in conjunction with data from our entire health care delivery

system. The Governor stated California needs more granular information to fully understand the cost drivers in the prescription drug market and the role that PMBs play in pricing, and that California should collect comprehensive information from the pharmacy delivery system about the total cost of care for providing individual prescription drug products, including but not limited to wholesale acquisition costs, fees, payments, discounts, and rebates paid to and received by PBMs. The Governor stated that these next steps, together with the CalRx program and the Office of Health Care Affordability's work, will offer a multi-pronged approach to improving affordability of prescription drugs in California.

b) 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.

c) AB 913 (Petrie-Norris) of 2023 would have required the Board of Pharmacy 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.

d) 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.

e) 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.

f) AB 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."

g) 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.

h) 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.

13) PROPOSED AMENDMENTS. Because AB 116 was recently signed into law, the provisions of this bill that duplicate those provisions will be amended out of this bill, or updated to have the provisions of this bill apply to what is now existing law as enacted by AB 116. In addition, the committee is proposing the following amendments for consideration:

a) Scope of PBM regulation. AB 116, the health budget trailer bill, applies the DMHC regulatory requirements on PBMs that contract with payers (defined as state-regulated health plans and health insurers). Employers who provide coverage through self-insured arrangements (where the employer pays the health coverage claims directly) typically use PBMs to administer their prescription drug benefit, and are not subject to the provisions of AB 116. By contrast, this bill applies more broadly by including within the definition of a "health insurer" the services provided by a PBM acting on behalf of a self-insured plan, unless pre-empted by federal law. In addition, several provisions of this bill apply to PBMs generally. To which PBM contractual arrangements should the provisions of this bill be applied?

b) Fiduciary Duty. As indicated above, SB 41 applies its provisions to PBM contracts with health plans, health insurers, self-insured employers, and to PBMs generally, but exempts from this bill a PBM contract with a collectively bargained Taft-Hartley self-insured prescription drug plan and a PBM's provision of pharmacy benefit management services to that Taft-Hartley plan. AB 116 contained a requirement that PBMs have a fiduciary duty to its payer client (defined to be limited to health plans and insurers) that includes a duty to be fair and truthful toward the payer, to act in the payer's best interests, and to perform its duties with care, skill, prudence, and diligence. The committee may wish to extend the fiduciary duty requirement to PBM contracts with self-insured employer plans,

joint labor management trusts, and multi-employer Taft-Hartley trust fund plans, and broadening the existing law requirement in AB 116 to also include the avoidance of conflicts of interest.

c) **Payment Floor to Pharmacies**. This bill requires a PBM to reimburse a pharmacy the cost of a prescription drug in an amount that is no less than NADAC for that drug at the time of the pharmacy's dispensing of that drug, or the pharmacy's WAC of that drug if the drug does not appear on the NADAC index. In addition, this bill requires a PBM to pay a pharmacy a dispensing fee that is no less than the dispensing fee that is paid by Medi-Cal. As previously noted, the state does not generally set rates in the commercial market, the NADAC survey is voluntary, several major pharmacy chains do not participate, and the NADAC requirement would apply to prescriptions delivered by mail order. Additionally, the dispensing fee paid by Medi-Cal is significantly higher than what the publicly available dispensing fee amounts paid by commercial payors and in Medicare Part D. CPhA (one of the co-sponsors) has supplied data on below acquisition cost drug ingredient cost reimbursement, and cites payment issues as being a cause of pharmacy closures. However, any increased costs resulting from any increase in drug ingredient cost reimbursement and dispensing fees would likely be passed on to payers (health plans and insurers) and, by extension, to consumers purchasing health coverage. The committee may wish to delete these provisions from this bill.

d) **Performance bonus payment provision**. This bill allows a plan to pay a PBM performance bonuses based on savings to the payer as long as the performance bonus is not based or contingent on the WAC of a drug. The committee may wish to consider whether this provision should be expanded to prohibit performance bonus that are not solely limited to WAC.

e) **Enrollee cost-sharing**. The most recent amendments to this bill prohibit a health plan or health insurer that provides prescription drug coverage from calculating an enrollee's cost sharing at an amount that exceeds the "price paid by the PBM or GPO" for the prescription drug. Previously, this cost-sharing amount was based on the "actual rate paid by the plan." Under the newly amended language, it is unclear whether the "price paid by the PBM or GPO" would be known to the plan or insurer as the amount of the PBM or GPO-negotiated drug rebate is confidential on a drug by drug basis, rebates are typically done in arrears, and the price paid net of rebates is unlikely to be known at the point of sale. The committee may wish to limit this requirement to when information on the price paid by the PBM or GPO is available to the plan.

f) Drafting Clarifications and Proposed Author's Amendments:

To replace (in Section 7) references to "group plan" in the definition of "affiliated entity" with "health care service plan or health insurer."

g) To clarify (in Section 7) the prohibition on the pharmacy benefit management fees being based on the price of prescription drugs, rebates or other price concessions.

h) The author is requesting language to include (in Section 29) a prohibition against PBMs reimbursing non-affiliated pharmacies less for a pharmacist service than the PBM would reimburse an affiliated pharmacy for the same pharmacist service. This provision was inadvertently deleted by prior amendments.

REGISTERED SUPPORT / OPPOSITION:

Support

California Pharmacists Association (co-sponsor)
California Chronic Care Coalition (co-sponsor)
Los Angeles LGBT Center (co-sponsor)
San Francisco AIDS Foundation (co-sponsor)
AIDS Healthcare Foundation
Blue Shield of California
California Academy of Child and Adolescent Psychiatry
California Life Sciences Association
California Society of Health System Pharmacists
Community Clinic Association of Los Angeles County
Cystic Fibrosis Research, Inc.
Indivisible CA: StateStrong
Infusion Access Foundation
Keck Medicine of the University of Southern California
National Infusion Center Association
National Multiple Sclerosis Society
Pharmaceutical Research and Manufacturers of America
San Francisco Marin Medical Society
Santa Monica Democratic Club
Spondylitis Association of America
The ALS Association
Several individuals

Opposition

100 Black Men of the Bay Area
Abate-A-Weed
Abel Glass & Screen Company
Alfonso & Berriz, APC
America's Health Insurance Plans
American Benefits Council
American Muslims for Sustainability
Asian Industry B2B
Association of California Life & Health Insurance Companies
At Industrial Products
Bell Chamber of Commerce
California African American Chamber of Commerce
California Alliance for Prescription Affordability
California Association of Health Plans
California Chamber of Commerce
California Clothing Recylcers
California Hispanic Chambers of Commerce
California Retail Hardware Association
Cerna Home Care
CJB & Associates LLC

Clergy and Laity United for Economic Justice
Coalition of Small & Disabled Veteran Business Owners
Community Church Oakland
Crisp Catering
Cypress Chamber of Commerce
Ethnos Community Church
EW Packaging
Flasher Barricade Association
Granite Bay Benefits
Hardesty LLC
Hollywood Church of God
Iglesia Cristiana De Camarillo
Iglesia Latinamerican Reformada
Iglesia Misionera Renacer
Kiwanis Club of Huntington Beach
LA Verne Chamber of Commerce
Law Offices of James E. Mahoney, Jr.
Lucky Boy Burgers
Menifee Bicycles
Motel 6 (South Gate)
North Hollywood Hardware
Oakland Youth First Scotlan Youth & Family Center
Orange County Hispanic Chamber of Commerce
Pharmaceutical Care Management Association
Relles Florist
Sal's Mexican Restaurant
San Juan Capistrano Chamber of Commerce
Saputo Construction Company
Seabreeze Books & Charts
Shalom International
Slavic-American Chamber of Commerce
South Gate Chamber of Commerce
Spaces Renewed
Supremas
The Black and Brown Coalition
The Row LA - the Church Without Walls - Skid Row
The Sperantia Foundation
Tournament Advisors LLC
West Oakland Job Resource Center
Western Steel Council
Several individuals

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