Date of Hearing: July 15, 2025

ASSEMBLY COMMITTEE ON JUDICIARY
Ash Kalra, Chair
SB 41 (Wiener) – As Amended July 9, 2025

As Proposed to be Amended

SENATE VOTE: 37-0

SUBJECT: PHARMACY BENEFITS

KEY ISSUE: SHOULD RECORDS AND INFORMATION ABOUT PRESCRIPTION DRUGS SUBMITTED BY HEALTH INSURERS TO THE CALIFORNIA DEPARTMENT OF INSURANCE AND BY HEALTH PLANS TO THE DEPARTMENT OF MANAGED HEALTH CARE BE EXEMPT FROM PUBLIC DISCLOSURE; AND SHOULD THE ATTORNEY GENERAL HAVE ENFORCEMENT AUTHORITY OVER RECENTLY ENACTED LAWS REGULATING PHARMACY BENEFIT MANAGERS?

SYNOPSIS

This bill, co-sponsored by the California Pharmacists Association (CPhA), California Chronic Care Coalition (CCCC), San Francisco AIDS Foundation (SFAF), and Los Angeles LGBT Center, seeks to address longstanding criticisms of Pharmacy Benefit Managers (PBMs) and their influence on drug pricing to ensure that PBMs' activities are driven by patient concerns and provider judgment, rather than profit motives. The Assembly Committee on Health, which recently approved the bill by a vote of 15-0, thoroughly analyzed issues relating to the regulation of PBMs. This analysis therefore focuses on the portions of the bill that are in this Committee's jurisdiction: (1) limits on public access to records in the possession of the Department of Insurance (CDI) and the Department of Managed Health Care (DMHC); and (2) the Attorney General (AG)'s authority to enforce this bill and existing laws relating to regulation of PBMs.

The prior version of this bill required PBMs to be regulated by CDI. The amendments of June 30 incorporated the DMHC-regulatory provisions of AB 116 into this bill and removed from the bill language relating to California Department of Insurance (CDI) oversight of PBMs. AB 116 was recently signed into law, so as a result of Assembly Health Committee amendments on July 9, 2025, provisions that duplicated AB 116 were either removed from this bill; or updated, as needed. The bill retains several provisions, however, that are related to PBM regulation, but not incorporated into AB 116, including sections regarding mandatory reports about prescription drugs submitted by health insurers to CDI and by health plans to DMHC and the confidentiality of such reports; and AG enforcement of laws regulating PBMs.

The bill authorizes the Attorney General (AG) to recover specified civil penalties and receive specific forms of relief for violations of the pharmacy benefit manager licensing provisions. Given that it no longer authorizes any private enforcement, the author has agreed to amend the bill to remove language requiring parties that sue in relation to laws regulating PBMs to notify the AG of their lawsuits. The author also has agreed to non-substantive clarifying amendments to bring two section of existing law that exempts certain information from public disclosure into alignment with the California Public Records Act (CPRA). The amendments are incorporated into the bill SUMMARY, below, and explained in the analysis. The analysis also points out that,

because language in a prior version of this bill authorizing the AG's access to otherwise confidential records, was not incorporated into AB 116—but confidentiality language out of alignment with the CPRA was codified – that the Legislature may wish to consider additional changes to the records confidentiality provisions enacted in AB 116.

This bill is supported by numerous healthcare advocacy organizations, rare disease foundations, academics, and political organizations, among others. It is opposed by California Alliance for Prescription Affordability (CAPA), California Association of Health Plans and numerous business groups.

SUMMARY: Limits public access to records submitted by Pharmacy Benefit Managers (PBM) to the California Department of Insurance and provides the Attorney General with enforcement authority over the recently enacted PBM Act. Specifically, **this bill**:

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) The price of prescription drugs, including 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.

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 acquisition or ingredient 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.

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 health care service plan or health insurer, any entity that provides pharmacy benefit management services on behalf of a health care service plan or health insurer, or any entity described in paragraph a); or,

    c) Any other entity as designated by DMHC.

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.

21) Requires a PBM to have a fiduciary duty to a self-insured employer plan that includes a duty to be fair and truthful toward the client, to act in the client's best interests, to avoid conflicts of interest, and to perform its duties with care, skill, prudence, and diligence.

22) Expands the existing fiduciary duty requirement PBMs have to payers enacted by AB 116, the health budget trailer bill, to also include a duty to avoid conflicts of interest.

23) 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.

24) 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.

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

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.

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.

e) Reimbursing a nonaffiliated pharmacy less for a pharmacist service than the PBM would reimburse an affiliated pharmacy for the same pharmacist service.

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.

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.

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.

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.

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.

41) Prohibits health plans and insurers that provide prescription drug coverage from calculating an enrollee's cost-sharing at an amount that exceeds the actual rate paid by the plan or insurer, 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.

42) Requires, to the extent a health plan or health insurer contract with a PBM issued, amended or renewed on or after January 1, 2026 includes disclosure on the net price paid by the PBM or GPO, then an enrollee's cost share is prohibited from being calculated at an amount that exceeds that net price paid.

43) 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.

44) 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.

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

46) 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.

47) 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.

48) 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.

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

50) 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.

51) 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.

52) Provides that except for the required report, all information and records submitted to the department pursuant to this section shall be deemed confidential, shall not be made public by the department, and shall be exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

53) Requires health insurers that report their rate information to the California Department of Insurance to report the following about the aggregate wholesale acquisition costs from a pharmaceutical manufacturer or labeler for each drug:

    a) The aggregate amount of rebates received by the pharmacy benefit manager for each drug.

    b) Any administrative fees received from the pharmaceutical manufacturer or labeler.

    c) The aggregate of payments, or the equivalent economic benefit, made by the pharmacy benefit manager to pharmacies owned or controlled by the pharmacy benefit manager for each drug.

    d) The aggregate of payments made by the pharmacy benefit manager to pharmacies not owned or controlled by the pharmacy benefit manager for each drug.

    e) The aggregate income from service fees that pharmacy benefit managers receive.

54) Clarifies that except for the public report that the Department of Insurance reports about the rate information provided by health insurers, all information and records submitted to the department pursuant to this section shall be deemed confidential, shall not be made public by the department, and shall be exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

55) 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.

56) 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.

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

EXISTING LAW:

1) Provides that the people have the right of access to information concerning the conduct of the people's business and, therefore, the writings of public officials and agencies shall be open to public scrutiny. Specifies that any law or rule that limits the public right of access shall be adopted with findings demonstrating the interest protected by the limitation. (California Constitution, art. I, Section 3.)

2) Provides that, in enacting the California Public Records Act (CPRA), the Legislature, mindful of the right of individuals to privacy, finds and declares that access to information concerning the conduct of the people's business is a fundamental and necessary right of every person in this state. (Government Code Section 7921.000. All further statutory references are to this code, unless otherwise indicated.)

3) Provides that public records are open to inspection at all times during the office hours of a state or local agency and every person has a right to inspect any public record, exempted as otherwise provided; and that any reasonably segregable portion of a record shall be available for inspection by any person requesting the record after deletion of the portions that are exempted by law. (Section 7922.525.)

4) Requires a public agency to justify withholding any record by demonstrating that the record in question is exempt under express provisions of this division, or that on the facts of the particular case the public interest served by not disclosing the record clearly outweighs the public interest served by disclosure of the record. (Section 7922.000.)

5) Provides that a public agency's disclosure of confidential information or records to another governmental agency that agrees to treat the disclosed material as confidential does not constitute a waiver of any exemptions or privileges when the receiving government agency agrees to maintain confidentiality of the information. (Section 7921.505 (c).)

6) 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) Section 1340 *et seq*. and Insurance Code Section 106 *et seq*.)

7) 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 Section 1385.008.)

8) 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 Section 1385.001.)

9) 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. (*Ibid*.)

10) 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 Section 1385.001 *et seq.*)

11) 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 Section 1385.0022.)

12) 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 Section 127673.05.)

13) 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 Section 1356.243 and Insurance Code Section 10123.205.)

14) 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*.)

15) Requires DMHC and CDI to compile the information from 13) and 14), 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*.)

16) Requires DMHC and CDI to keep confidential all of the covered prescription drug information reported by health plans and insurers that is described in 13) and 14), and makes the information protected from public disclosure, except for the report required pursuant to 15), above.

FISCAL EFFECT: As currently in print this bill is keyed fiscal.

COMMENTS: This bill, co-sponsored by the California Pharmacists Association (CPhA), California Chronic Care Coalition (CCCC), San Francisco AIDS Foundation (SFAF), and Los Angeles LGBT Center, seeks to address longstanding criticisms of Pharmacy Benefit Managers (PBMs) and their influence on drug pricing to ensure that PBMs' activities are driven by patient concerns and provider judgment, rather than profit motives. The author explains the impetus for this measure:

> Senate Bill 41 reins in the worst abuses by pharmacy benefit managers (PBMs), insurance-industry middlemen who are driving up the price of prescription medication for Californians. This legislation will protect consumer choice, provide transparency on prescription drug prices, and improve our healthcare 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 healthcare 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. SB 41 fills that regulatory gap by requiring that all PBMs be licensed by the Department of Insurance and disclose basic information regarding their business practices to the state.

The Assembly Committee on Health, which recently approved the bill by a vote of 15-0, thoroughly analyzed issues relating to the regulation of PBMs. This analysis therefore focuses on the portions of the bill that are in this Committee's jurisdiction: (1) limits on public access to records in the possession of the Department of Insurance (CDI) and the Department of Managed Health Care (DMHC); and (2) the Attorney General (AG)'s authority to enforce this bill and existing laws relating to regulation of PBMs.

Background - PBMs and why are they important drivers of health costs. PBMs work as third parties that go between health insurance providers and drug manufacturers. PBMs help negotiate costs and payments between drug manufacturers, pharmacies, and healthcare insurance providers. PBMs also create prescription drug lists, called formularies. PBMs play a major role in negotiating the prices of prescription drugs, creating and managing formularies, and several other functions key to the management of pharmacy benefits for millions of Californians. According to the analysis by the Assembly Committee on Health:

> 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.

PBMs are important drivers of health costs for several reasons. PBMs negotiate discounts and rebates from drug manufacturers. While these discounts can lower costs, the complex rebate system has been criticized for lacking transparency and potentially inflating list prices. PBMs often set higher co-payments or co-insurance for non-preferred drugs, encouraging patients to choose cheaper alternatives. This cost-shifting can impact patients who need specific medications not on the formulary. PBMs charge administrative fees to health plans for their services. These fees contribute to overall healthcare costs, although they are intended to offset costs through negotiated savings. A recent New York Times investigation revealed that the largest PBMs often engage in business practices that advance their own financial interest at the expense of their clients and patients, including overcharging customers, driving independent drugstores out of business, and delaying or even preventing patients from getting their prescriptions. (N.Y. Times, *The Opaque Industry Secretly Inflating Prices for Prescription Drugs*, June 21, 2024, https://www.nytimes.com/2024/06/21/business/prescription-drug-costs-pbm.html.)

Prior iteration of this bill and recent overlapping budget trailer bill regarding health, AB 116. 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), Chap. 21, Statutes of 2025, the health budget trailer, contained the Governor's proposed TBL, which replaced previous laws requiring 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 also 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; and establishes 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 CDI. The amendments of June 30 incorporated the DMHC-regulatory provisions of AB 116 into this bill and removed from the bill language relating to California Department of Insurance (CDI) oversight of PBMs. AB 116 was recently signed into law, so as a result of Assembly Health Committee amendments on July 9, 2025, provisions that duplicated AB 116 were either removed from this bill; or updated, as needed. The bill retains several provisions, however, that are related to PBM regulation, but not incorporated into AB 116, including sections regarding mandatory reports about prescription drugs submitted by health insurers to CDI and by health plans to DMHC and the confidentiality of such reports; and AG enforcement of laws regulating PBMs.

Attorney General Enforcement. The bill authorizes the Attorney General (AG) to recover specified civil penalties and receive specific forms of relief for violations of the pharmacy benefit manager licensing provisions. It provides that any person who violates its provisions is subject to a civil penalty, which is to be assessed and recovered in a civil action brought in the name of the people of the State of California by the AG. The minimum penalty amount is $1,000 and the maximum is $7,500 for each violation. The AG is entitled to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for enforcement of this bill, and is also entitled to recover attorney's fees and costs incurred in remedying each violation.

Attorney General Notice Provision. The bill in print also requires that, if the violation of specified provisions of the bill are alleged or at issue in any proceeding in any court of this state, then the person filing a brief or petition with the court in that proceeding is required to serve a copy of that brief or petition on the AG within three days of filing it with the court. A person who has filed any other document with the court in addition to a brief or petition must provide a copy of that document, without charge, to the AG, upon request, within five days of the request. The time for service may be extended by the court for good cause shown. The bill prohibits any judgment or relief, temporary or permanent, from being granted, or an opinion issued, until proof of service of the brief or petition on the AG is filed with the court.

The notice requirement in the bill originally was meant to ensure that if anyone pursues a cause of action against a PBM under any other law, such as the Unfair Competition Law, the AG would be notified of the lawsuit. In a prior iteration, the bill declared that a violation of its prohibition against a nonaffiliated pharmacy dispensing drugs, is an act of unfair competition under the Unfair Competition Law (UCL). But that provision was removed from the bill pursuant to the June 30, 2025 amendments. As a result, only the AG (and the Insurance Commissioner in relation to violations of the Insurance Code; and the director of DMHC in relation to violations of the Health and Safety Code) may enforce the bill and other provisions regulating PBMs. Therefore, it is no longer necessary for "the person filing a brief or petition with the court in that proceeding is required to serve a copy of that brief or petition on the AG within three days of filing it with the court." *The author has agreed to remove the AG notification provision from the bill, as explained below.*

Ongoing AG Authority to Enforce Laws Against Anti-Competitive Business Conduct. The bill clarifies that it does not affect the authority of the Attorney General to maintain or restore competitive, fair, and honest markets and prosecute violations of state and federal antitrust, consumer protection, unfair competition, unfair practices, or any other related law shall not be narrowed, abrogated, or otherwise altered. At the same time, the AG's authority "does not alter or abrogate [DMHC's] authority to enforce the provisions of the Health and Safety Code relating to PBMs.

Limitations on disclosure of information and records to the public. Access to information concerning the conduct of the people's business is a fundamental and necessary right of every person in this state. (Section 7921.000.) In 2004, the right of public access was enshrined in the California Constitution with the passage of Proposition 59 (Nov. 3, 2004, statewide general election), placed on the ballot by a unanimous vote of both houses of the Legislature. SCA 1 (Burton, Ch. 1, Stats. 2004) amended the California Constitution to specifically protect the right of the public to access and obtain government records: "The people have the right of access to information concerning the conduct of the people's business, and therefore . . . the writings of public officials and agencies shall be open to public scrutiny." (Cal. Const., art. I, sec. 3 (b)(1).)

In 2014, voters approved Proposition 42 (Jun. 3, 2014, statewide direct primary election), placed on the ballot by a unanimous vote of both houses of the Legislature, (SCA 3 (Leno, Ch. 123, Stats. 2013), to further increase public access to government records by requiring local agencies to comply with the CPRA and the Ralph M. Brown Act, and with any subsequent statutory enactment amending either act, as provided. (Cal. Const., art. I, sec. 3 (b)(7).)

Under the California Public Records Act (CPRA), public records are open at all times during the office hours of a public agency for inspection by the public, unless exempted. (Section 7922.525.) A public record is defined as any writing containing information relating to the conduct of the public's business prepared, owned, used, or retained by any public agency regardless of physical form or characteristics. (Section 7920.530.) Despite the CPRA's general rule that public records are open to inspection and subject to disclosure, the CPRA provides exceptions providing that a document, or a portion thereof, is not subject to public disclosure. An exemption can be explicit in the CPRA itself, pursuant to another law, or justified by the agency's determination that, based on the facts of the particular case, the public interest served by not disclosing the record clearly outweighs the public interest served by disclosure of the record. (See Sections 7922.000, 7922.525, 7922.530.)

Existing law requires health plans to report prescription drug information to DMHC and requires health insurers to report prescription drug information to CDI. Existing law makes both types of prescription drug information exempt from disclosure to the public. In identical provisions, current law (Health & Safety Code Section 1367.243 and Insurance Code Section 10123.205) provide as follows:

> (f) Except for the report required pursuant to subdivision (b), the department shall keep confidential all of the information provided to the department pursuant to this section, and the information shall be protected from public disclosure.

Confidentiality for this type of information reported by insurers and other business entities to regulators is not unusual in the Insurance and Health & Safety Code. For example, Insurance Code 10181.7 provides that "contracted rates between a health insurer and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act." What is unusual about the two confidentiality provisions in this bill is the fact that they do not acknowledge the existence of the CPRA. *As detailed below, the author has agreed to update these provisions to do so.*

Author's amendments. In order to update the language of Health & Safety Code Section 1385.0033 to account for the fact that no private parties can bring a cause of action to enforce the PBM Act, the author proposes the following clarifying amendment to Section 14 for the bill:

> **1385.0033.** (a) ~~If a violation of this article 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 shall serve, within three days of filing with the court, a copy of the brief or petition on the Attorney General at a service address designated on the Attorney General's internet website for service of papers under this section, or, if a service address is not designated, at the Attorney General's office in the City and County of San Francisco. Upon the Attorney General'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 shall provide a copy of that document, without charge, to the Attorney General within five days of the request. The time for service may be extended by~~

~~the Chief Justice of California or presiding justice or judge for good cause shown. A judgment or relief, temporary or permanent, shall not be granted, nor shall an opinion be issued, until proof of service of the brief or petition on the Attorney General is filed with the court.~~

~~(b)~~ A person that violates this article shall be subject to an injunction and liable for a civil penalty of not less than one thousand dollars ($1,000) or more than seven thousand five hundred dollars ($7,500) for each violation, which shall be assessed and recovered in a civil action brought in the name of the people of the State of California by the Attorney General.

~~(c)~~ ***(b)*** Notwithstanding any other law, the Attorney General shall be entitled to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for enforcement of this article and shall be entitled to recover attorney's fees and costs incurred in remedying each violation.

~~(d) This section does not alter or abrogate the department's authority to enforce this article.~~

Confidentiality of DMHC and CDI records. In order to align these two provisions with the CPRA without affecting the confidentiality protection provided to prescription drug information that is required to be reported by health plans and insurers to DMHC and CDI, the author has agreed to the following minor clarifying amendments to both Health & Safety Code Section 1367.243 and Insurance Code Section 10123.205 so they will read as follows (modeled on the wording of Insurance Code Section 10181.7). This is merely a clarification of existing law. The amendments read as follows:

(f) Except for the report required pursuant to subdivision (b), ***all information and records submitted to*** the department ***pursuant to this section*** shall ~~keep~~ ***be deemed*** confidential ~~all of the information provided to the department pursuant to this section, and the information shall be protected from public disclosure~~ ***information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code)***.

Are additional amendments – to existing law enacted by AB 116 – necessary and appropriate? A prior version of this bill (when it envisioned CDI being in charge of PBM regulation) proposed to enact Insurance Code Sections 17015 and 17025 that would have expressly authorized AG access to otherwise confidential records for law enforcement purposes. Those sections had identical language that read as follows:

(f) Except for the reports required pursuant to subdivisions (b) and (d), the information submitted to the department pursuant to subdivisions (a) and (c) shall be deemed confidential and shall not be disclosed to the public pursuant to the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code). **This section does not prevent disclosure to the Attorney General to investigate, prosecute, or defend any legal claim or cause or action, or to use the reports in any court or proceeding of law.**

The bill also proposed Insurance Code Section 17075 (d) to read as follows:

(d) Section 735.5 [of the Insurance Code, which makes confidential all records and information in the course of an examination by the Commissioner] **does not prevent disclosure of information and data acquired during an examination to the Attorney General to investigate, prosecute, or defend any legal claim or cause of action, or to use the information and data in any court or proceeding of law**. In any matter arising under

> this chapter, the department may provide to the Attorney General information related to competition and obtain an opinion from a consultant or consultants with the expertise to assess the competitive impact of the matter.

These provisions were removed from the bill on June 30th to account for AB 116 being signed into law and placing DMHC in charge of PBM regulation. AB 116 did not include any of the language authorizing AG access to records reported to DMHC relating to regulation of PBMs. Furthermore, AB 116 enacted an extremely strict confidentiality provision. As enacted in Section 19 of AB 116, Health & Safety Code Section 1385.0011 now reads as follows:

> 1385.0011. (a) A pharmacy benefit manager shall submit to the department financial statements prepared as of the close of its fiscal year within 120 days after the close of the fiscal year. These financial statements shall be accompanied by a report, certificate, or opinion of an independent certified public accountant or independent public accountant. An audit shall be conducted in accordance with generally accepted auditing standards and the rules and regulations of the director.
> . . .
>
> (i) Financial and other records produced, disclosed, or otherwise made available by an organization pursuant to this section shall be received and maintained on a confidential basis and protected from public disclosure.

As enacted in Section 29 of AB 116, Health & Safety Code Section 1385.0021 now reads as follows:

> 1385.0021. (a) The director shall withhold from public inspection, pursuant to the applicable state or federal law, information received in connection with an application, including applications for interpretive opinions, submissions, or reports filed by a pharmacy benefit manager, if, in the opinion of the director, the public inspection of the information is not necessary for the purposes of the law under which the information was filed, and the information is reasonably shown to meet either of the following:
> (1) The information is proprietary or of a confidential business nature, including trade secrets, the information has been confidentially maintained by the business entity, and the release of the information would be damaging or prejudicial to the business concern.
> (2) The information is such that the private or public interest is served by withholding the information.
> (b) Requests for confidentiality of information shall be submitted to and processed by the department consistent with regulations adopted and amended pursuant to this chapter relating to the request for confidentiality of information.

There is nothing unusual about a confidential records law exempting from public disclosure proprietary information, including trade secrets, submitted to a state agency in compliance with the law (See Government Code Sections 7929.011 (a)(3) [due diligence materials, or information related to customers, and competitors, including summaries, reports, analyses, recommendations, projections, or estimates related thereto provided to IBank]; and 7927.605 (a) [corporate financial records, corporate proprietary information including trade secrets, and information relating to siting within the state furnished to a government agency by a private company for the purpose of permitting the agency to work with the company in retaining, locating, or expanding a facility within California].) But these records provisions are unusual and arguably problematic in a couple of ways.

First, none of these provisions acknowledges the existence of, or their conflict with, the CPRA, which by its terms makes all records in the possession of a public agency presumptively open to public inspection and disclosure. (Government Code Section 7922.525.)

Second, the language of Section 29 is completely at odds with the CPRA in that it allows the pharmaceutical industry to dictate whether records in the possession of DMHC, a public agency, should not be subject to public disclosure; and requires the DMHC director to consider – in determining whether to release information and records, whether release would be damaging or prejudicial to the business concern as a factor in deciding whether to release the records. This is unprecedented in the CPRA and other provisions of existing law governing the disclosure of public records.

Third, these sections, in contrast to the proposed Insurance Sections 17015, 17025, and 17075 in a prior version of this bill do not include an exception, authorizing the AG to have access to the information and records reported to DMHC. Absent such an exception, the AG may be forced to serve investigative subpoenas on DMHC and file a petition to compel compliance with the subpoena if DMHC were to views the confidentiality protections in AB 116 as absolute. Furthermore, it is possible that the AG might lose, notwithstanding the AG's normally expansive power, if a court found that the Legislature must not have intended to authorize disclosure to the AG (especially given the legislative record of that language not being transferred over to AB 116). Without the information sharing authority that had been provided by the pre-June 30th version of this bill, it is unclear whether the AG's office has the authority it needs to obtain information and records related to PBMs in order to investigate, prosecute, or defend any legal claim or cause or action related to PBMs, as provided in this bill.

The AG routinely obtains and handles confidential information in a confidential manner, so disclosure by DMHC should not be an issue. The AG normally can secure confidential information from state agencies (CDI/DMHC included) either informally or by means of an investigative subpoena under Government Code Section 11180 *et seq*., which binds the AG to maintain the confidentiality of the records.

As this bill moves forward, and as the Legislature considers further refinements to AB 116, the Legislature may wish to consider amending the provisions of existing law enacted by AB 116 dealing with the confidentiality of DMHC records to ensure that (1) the records are exempted from public disclosure in a manner that is consistent with the California Public Records Act (which does not provide private businesses with the ability to dictate whether records are public); and (2) confidential information and records reported to DMHC can be shared with the AG so that the AG is able to carry out the duties and powers specified by this bill.

ARGUMENTS IN SUPPORT: The co-sponsors write the following in their joint letter of sponsorship/support:

> 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.

As other sectors of healthcare face increasing oversight, PBMs have largely escaped scrutiny—despite their central role in raising drug costs and shrinking pharmacy access. Their business practices are now under investigation by federal and state regulators. SB 41 is a necessary step to bring fairness, transparency, and accountability to this powerful and opaque industry.
. . .

It is time that California joins the vast majority of states in ensuring that pharmacy benefit managers are held accountable for their business activities that harm patients and lead to mass closures on community pharmacies. We have no doubt that this important measure will improve health outcomes, reduce overall healthcare spending, and create a more equitable healthcare system.

***ARGUMENTS IN OPPOSITION**:* A coalition of business groups in opposition to the bill (accounting for a significant percentage of the total number of groups in opposition) writes:

Senate Bill 41 . . .would significantly impede employers' ability to provide affordable, accessible prescription drug benefits to millions of hardworking California employees. Provisions contained in SB 41 would hamper California employers' ability to provide their employees and their family members with affordable, high-quality health care benefits. SB 41 would also interfere with an employer's ability to make sound business decisions, including their ability to invest in other health benefits like employee wellness programs or educational courses on best drug utilization practices, as well as ways to help lower patients' cost-sharing methods in health plans.

All these offerings are made possible due to the flexibility and choices available in the commercial market, and stripping away employers' ability to make these business decisions will lead to higher monthly premiums for their employees while making it more difficult and costly to provide competitive, high-quality health care benefits. SB 41 will not result in lower costs for employers or employees and, in fact, is supported by drug manufacturers because it will increase their profits.

SB 41 would effectively ban how many employers engage and manage their prescription drug benefits, which would cause an enormous spike in premium costs for the millions of California patients who receive their health insurance coverage through the commercial market.

REGISTERED SUPPORT / OPPOSITION:

Support

Aids Healthcare Foundation
ALS Association; the
Biocom California
Blue Shield of California
California Academy of Child and Adolescent Psychiatry
California Access Coalition

California Chronic Care Coalition
California Life Sciences Association
California Pharmacists Association
California Society of Health System Pharmacists
California State Board of Pharmacy
Community Clinic Association of Los Angeles County (CCALAC)
Crohns and Colitis Foundation
Cystic Fibrosis Research, INC. (CFRI)
Health Access California
Indivisible Ca: Statestrong
Infusion Access Foundation
Los Angeles LGBT Center
National Association of Chain Drug Stores
National Infusion Center Association (NICA)
National Multiple Sclerosis Society
North East Medical Services (NEMS)
Pharmaceutical Research and Manufacturers of America
San Francisco Aids Foundation
San Francisco Marin Medical Society
Santa Monica Democratic Club
Spondylitis Association of America
University of Southern California (USC)
One individual

Opposition

Abate-a-weed
Abel Glass & Screen Company
Alfonso & Berriz, APC
American Benefits Council
American Muslims for Sustainability
Asian Industry B2b
At Industrial Products
Bell Chamber of Commerce
Cal Asian Chamber of Commerce
California African American Chamber of Commerce
California Alliance for Prescription Affordability (CAPA)
California Association of Health Plans
California Clothing Recylcers
California Hispanic Chambers of Commerce
California Retail Hardware Association
Cerna Home Care
Cjb & Associates LLC
Coalition of Small & Disabled Veteran Business Owners
Crisp Catering
Cypress Chamber of Commerce
Ethnos Community Church
Ew Packaging
Flasher Barricade Association

Granite Bay Benefits
Hardesty LLC
Kiwanis Club of Huntington Beach
LA Verne Chamber of Commerce
Lucky Boy Burgers
Menifee Bicycles
Motel 6 (south Gate)
North Hollywood Hardware
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
Sherman Oaks United Methodist Church
Slavic-American Chamber of Commerce
South Gate Chamber of Commerce
Spaces Renewed
Supremas
Tournament Advisors LLC
Western Steel Council
One individual

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