Date of Hearing: August 20, 2025

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
SB 41 (Wiener) – As Amended July 17, 2025

Policy Committee:	Health	Vote:	14 - 0
	Judiciary		11 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill places various restrictions on the practices of a pharmacy benefit manager (PBM), including how the PBM pays pharmacies and how the PBM is compensated. The bill also requires a health plan or insurer include additional information in its annual prescription drug data report and authorizes the Attorney General to enforce PBM licensing.

For a complete enumeration of the provisions of this bill, please refer to the Assembly Health Committee or Assembly Judiciary Committee analysis. Since the policy committee analyses were published, the bill has been amended as follows:

1) Requires all information and records a health plan or insurer submits to the Department of Managed Health Care (DMHC) or the Department of Insurance (CDI) pursuant to the reporting requirements in this bill be deemed confidential information that DMHC or CDI must not make public and exempts the information from disclosure under the California Public Records Act.

2) Deletes a provision requiring a party that sues for an alleged violation of the provisions of this bill notify the AG of the lawsuit.

FISCAL EFFECT:

DMHC estimates costs of approximately $2.8 million for nine additional staff positions in fiscal year (FY) 2026-27 and $3.3 million in FY 2027-28 and annually thereafter for 12 positions to address provider complaints, conduct legal research and provide guidance to plans, review compensation arrangements of PBM contracts, develop survey methodology and tools to access health plan compliance, address enforcement referrals, and provide technological and administrative support (Managed Care Fund).

CDI estimates costs of $541,000 in FY 2025-26, $1.0 million in FY 2026-27, and $935,000 in FY 2027-28 and ongoing, to compile and report additional information, inform insurers of new requirements, address complaints and enforcement referrals, and review PBM contracts (Insurance Fund).

The Department of Justice (DOJ) anticipates costs of approximately $250,000 to $5 million in FY 2025-26 and $1 million to $10 million in FY 2026-27 and ongoing to defend the bill against litigation by PBMs or their trade association; DOJ could bill DHMC for these costs (Legal Services Revolving Fund). DOJ also notes costs of an unknown but potentially significant

amount to investigate potential violations; such costs could potentially be recovered out of an award of attorney's fees and costs.

COMMENTS:

1) **Purpose.** This bill is sponsored by the California Pharmacists Association (CPhA), California Chronic Care Coalition, San Francisco AIDS Foundation, and Los Angeles LGBT Center. 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 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.
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> 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.

2) **Background.** PBMs manage prescription drug benefits on behalf of third-party payers (health plans, insurers, self-insured employers, labor trusts, Medicare and Medicaid, and state and local governments). According to the Assembly Health Committee analysis, PBMs were originally established to set reimbursement rates, process claims, and pay pharmacies on behalf of payers. PBMs' roles vary by payer, but major PBM functions now include processing claims for prescription medications; negotiating with pharmaceutical manufacturers for discounts, rebates, and pricing structures to reduce the cost of prescription drugs; developing formularies, which are lists of preferred medications that PBMs establish and manage on behalf of third-party payers; establishing pharmacy networks by contracting with pharmacies; and utilization management.

   PBMs are increasingly vertically integrated, with several large PBMs being owned by or affiliated with pharmacy chains, insurance companies, specialty pharmacies, mail order pharmacies, or health care providers. According to a Congressional Research Service publication, in 2022, the three largest PBMs processed a large majority of prescription drug claims in the U.S. PBMs have also acquired mail order pharmacies and specialty pharmacies.

   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.

3) **Health Budget Trailer Bill**. AB 116 (Committee on Budget), Chapter 21, Statutes of 2025, the health budget trailer bill, establishes PBM license and application requirements, requires the payment of an application fee, requires a PBM to submit financial statements, authorizes the director of DMHC 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.

4) **Support**. The sponsors of this bill point to pharmacies closing at record numbers and that every day, independent pharmacies are 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. The sponsors state PBMs 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 (CVS/Aetna, Cigna/Express Scripts, UnitedHealth/OptumRx) have amplified these conflicts and inflated profit margins. Additionally, these three PBMs own pharmacies. The sponsors contend 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 argue 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 the PBM reimbursed pharmacies.

   Blue Shield of California, various health care provider associations, and disease-specific groups also write in support of this bill. The Pharmaceutical Research and Manufacturers of America and Biocom California write the PBM industry 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.

5) **Opposition.** The Pharmaceutical Care Management Association (PCMA) writes in opposition that this legislation will benefit drug manufacturers, but does nothing to directly help consumers, and argues premiums would increase by at least $150 per fully insured member per month as a result. PCMA contends that until data is collected from all entities in the drug supply chain, the state will have very limited insight into the real cost of prescription drugs, rendering this bill premature. PCMA objects to multiple provisions, including the mandatory reimbursement and dispensing fees for pharmacies, which PCMA argues removes any market factors in private sector negotiations. PCMA contends specific provisions of this bill could cost the state over $11 billion over the next ten years.

PCMA also objects to the reporting requirements in this bill for several reasons, including the idea that drug manufacturers might be able to reverse engineer pricing information from their competitors. PCMA also objects to the provision allowing pharmacies to participate in a PBM's network without having to agree to the PBM's terms and conditions, which PCMA states typically include quality standards as well as reimbursement rates, and that pharmacies would be free to charge whatever amount they wanted. PCMA also objects to provisions mandating how PBMs are reimbursed by payers and the prohibition on spread pricing contracts, among others. PCMA contends prohibiting a PBM from linking fees to the cost of a drug would result in drug manufacturers increasing the cost of a drug.

6) **Related Legislation**. AB 910 (Bonta) requires a PBM to hold a fiduciary duty in the performance of its contracted duties to a health plan, and specifies the obligations of the PBM to carry out that duty. AB 910 requires a PBM report to DMHC specified information, and requires DMHC compile the information into a report that demonstrates the overall effects of drug costs, rebates, PBMs, and PBMs' relationships with affiliated entities on health care costs. AB 910 was made a two-year bill in this committee.

7) **Prior Legislation**. SB 966 (Wiener), of the 2023-24 Legislative Session, was similar to this bill, but also included PBM licensing. In his veto message, Governor Newsom stated:

> I believe that PBMs must be held accountable to ensure that prescription drugs remain accessible throughout pharmacies across California and available at the lowest price possible. However, I am not convinced that SB 966's expansive licensing scheme will achieve such results…
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> I am directing 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…[W]e need more granular information to fully understand the cost drivers in the prescription drug market and the role that [PBMs] play in pricing. Specifically, 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.
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> 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.

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