SENATE THIRD READING
SB 41 (Wiener and Wahab)
As Amended September 4, 2025
Majority vote

SUMMARY

Prohibits a pharmacy benefit manager (PBM) from deriving income from pharmacy benefit management services provided to a health plan or health insurer, except for a "pharmacy benefit management fee." Requires a PBM to use a pass-through pricing model. Prohibits a PBM from conducting spread pricing (when a PBM charges a health plan a price for prescription drugs, and that price differs from the amount the PBM pays the pharmacist or pharmacy). Requires a PBM to direct 100% of all prescription drug manufacturer rebates for the sole purpose of offsetting cost-sharing, deductibles, and coinsurance contributions and reducing premiums. Prohibits numerous PBM activities affecting pharmacies.

Major Provisions

1) *Defines a "pharmacy benefit management fee" to mean a flat, defined, dollar-amount fee that covers the cost of providing pharmacy benefit management services, and that does not exceed the bona fide value of the service or services actually performed by the PBM on behalf of a payer (a "payer" is defined as a health plan or health insurer).*

2) *Prohibits a pharmacy benefit management fee from directly or indirectly being based on or contingent upon specified factors, including prescription drug prices, the amount of savings, rebates, or other fees charged, realized, collected, or generated, the amount of premiums, deductibles, or other cost-sharing or fees charged, realized, or collected, coverage or formulary placement decisions, the volume or value of any referrals or business generated, or any other amounts or methodologies, as defined by the Department of Managed Health Care (DMHC) director.*

3) *Requires a PBM to use a pass-through pricing model, defined to mean a PBM payment model in which health plan/insurer payments to the PBM for outpatient drugs are equivalent to the payments the PBM makes to a pharmacy for those drugs, including any dispensing fee, and passed through in their entirety by the health plan or health insurer or by the PBM to the pharmacy, and the payments are made in a manner that is not offset by any reconciliation.*

4) *Defines "rebates" for purposes of the requirement that PBMs direct 100% of all prescription drug manufacturer rebates received to the payer or program, to mean compensation or remuneration of any kind, including fees, received or recovered from a pharmaceutical manufacturer by a PBM, affiliated entity, or subcontractor, including a group purchasing organization (GPO).*

5) *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 or that result in 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 specified factors.*

6) *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.

7) *Prohibits a PBM from making or permitting any reduction of payment for pharmacist services 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.*

8) *Prohibits a claim or claims for pharmacist services from being retroactively denied or reduced after adjudication of the claim unless the original claim was submitted fraudulently, the payment was incorrect because the pharmacy or pharmacist had already been paid, or the pharmacist services were not properly rendered.*

9) *Prohibits a PBM from reversing and resubmitting the claim of a contract pharmacy without prior written notification to the contract pharmacy, without just cause or attempting to first reconcile the claim with the pharmacy, or more than 90 days after the claim was first affirmatively adjudicated.*

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

11) *Prohibits a PBM contract termination with a nonaffiliated pharmacy from releasing the PBM from making a payment due to the pharmacy for an affirmatively adjudicated claim, unless payments are withheld because of an insurance fraud investigation.*

12) *Prohibits a PBM from imposing any requirements, conditions, or exclusions that discriminate against a "nonaffiliated pharmacy" in connection with dispensing drugs, including terms or conditions applied to nonaffiliated pharmacies based on their status as a nonaffiliated pharmacy, refusing to contract 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, retaliation against a nonaffiliated pharmacy based on its exercise of any right or remedy under this DMHC licensing provisions, engaging in an unlawful action against a covered entity, including a violation of existing law provisions barring discrimination by PBMs against covered entities or specified pharmacies, or reimbursing a nonaffiliated pharmacy less for a pharmacist service than the PBM would reimburse an affiliated pharmacy for the same pharmacist service.*

13) *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.*

14) *Prohibits a contract between a nonaffiliated pharmacy and a PBM from prohibiting the pharmacy from offering as an ancillary service the mail or common carrier delivery of a prescription drug on request, if the request is made before drug delivery, or the prescription delivery is by a pharmacy employee or contractor. 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.*

15) *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;

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.

16) Prohibits a PBM from retaliating (as defined) against a pharmacist or pharmacy based on the pharmacist's or pharmacy's exercise of a right or remedy under this bill.

17) 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.

18) 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, and expands the existing fiduciary duty requirement on PBM contracts with payers to include a duty to avoid conflicts of interest.

19) 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. 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.

20) Prohibits health plans and health 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 for the prescription drug, and requires that to include cost sharing 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.

21) Requires, to the extent that a health plan or health insurance contract with a PBM includes disclosure on the net price paid by the PBM or GPO, then an enrollee's cost share from being calculated at an amount that exceeds that net price paid.

22) Authorizes a complaint made by an insured that includes a potential violations by a PBM of the terms of the PBM licensure provisions of existing law and those provisions amended by this bill to be considered by the California Department of Insurance (CDI) to be a complaint against the health insurer, instead of requiring such a complaint to be considered a complaint against the health insurer in existing law.

23) Requires, if a health insurer delegates functions to a PBM, the PBM to comply with the Insurance Code (IC), as applicable. Requires a health insurer to specify by contract the PBM's responsibilities, and to monitor the PBM to ensure compliance with the IC. Requires the health insurer, notwithstanding the delegation, to remain responsible for compliance with the IC.

24) Requires a contract between a health insurer and a PBM issued, amended, or renewed on or after January 1, 2027, or the date on which the DMHC has established the PBM licensure process, whichever is later, to require the PBM to be licensed and in good standing with the DMHC, and requires a contract term that violates the PBM licensure provisions to be void on and after January 1, 2029.

25) Permits CDI to issue guidance regarding implementation of, and compliance with, the requirements in 20) through 24) above and related provisions, and exempts this guidance from the rule-making provisions of the Administrative Procedure Act until January 1, 2030. Requires CDI to consult with stakeholders in developing guidance.

26) Makes a person that violates the PBM regulation provisions under the jurisdiction of DMHC subject to an injunction and liable for a civil penalty of $1,000 to $7,500 for each violation, assessed and recovered in a civil action brought by the Attorney General (AG). Entitles the AG to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for enforcement of the PBM regulation provisions, and entitles the AG to recover attorney's fees and costs incurred in remedying each violation.

27) Prohibits the DMHC director from being required to disclose specified records, including corporate financial records and any record which is exempt from disclosure under express provisions of the California Public Records Act, that are filed by the PBM in compliance with the DMHC licensure requirements that have not previously been made public, and requires the DMHC director to disclose information or records to the AG in order to investigate, prosecute or defend any legal claim or cause of action related to PBM regulation, or to use the reports in any court or proceeding related to PBM regulation.

COMMENTS

Health plans and insurers often contract with PBMs to manage their prescription drug benefit. Major PBM functions including processing pharmacy claims for reimbursement, negotiating with pharmaceutical manufacturers, establishing formularies (lists of which drugs are covered

and at what level of cost-sharing for a patient), and contracting with pharmacies to establish pharmacy networks where patients can fill prescriptions. AB 116 (Committee on Budget), Chapter 21, Statutes of 2025 contained the Governor's 2025-26 May Revise proposal to directly license and regulate PBMs contracting with payers through DMHC. In addition, AB 116 requires a PBM to provide specified data to the Department of Health Care Access and Information regarding drug pricing, 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.

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.

Arguments in 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, would ensure rebates directly lower patient costs, and prevent PBMs from steering patients 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.

Arguments in 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 $150 per fully insured member per month for Californians. PCMA objects to multiple provisions of this bill including 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 states this bill exempts self-funded Taft-Hartley plans but not self-funded union and trust health plans, and 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 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. PCMA argues the definition of "rebates" would not allow PBMs to link fees to the cost of a drug, which it argues would remove a tool used to disincentive pharmaceutical manufacturers from raising the list price of a drug.

PCMA also objects to the provision allowing pharmacies to participate in a PBM 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.

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.

FISCAL COMMENTS

According to the Assembly Appropriations Committee:

1) 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).
2) 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.

VOTES

SENATE FLOOR: 37-0-3
YES: Allen, Alvarado-Gil, Archuleta, Arreguín, Ashby, Becker, Blakespear, Cabaldon, Caballero, Choi, Cortese, Dahle, Durazo, Gonzalez, Grayson, Grove, Hurtado, Jones, Laird, McGuire, McNerney, Menjivar, Niello, Ochoa Bogh, Padilla, Pérez, Richardson, Rubio, Seyarto, Smallwood-Cuevas, Stern, Strickland, Umberg, Valladares, Wahab, Weber Pierson, Wiener
ABS, ABST OR NV: Cervantes, Limón, Reyes

ASM HEALTH: 14-0-2
YES: Bonta, Addis, Aguiar-Curry, Caloza, Rogers, Flora, Mark González, Elhawary, Patel, Celeste Rodriguez, Sanchez, Schiavo, Sharp-Collins, Stefani
ABS, ABST OR NV: Chen, Ellis

ASM JUDICIARY: 11-0-1
YES: Kalra, Dixon, Bauer-Kahan, Bryan, Connolly, Harabedian, Pacheco, Papan, Sanchez, Stefani, Zbur
ABS, ABST OR NV: Macedo

ASM APPROPRIATIONS: 11-0-4
YES: Wicks, Arambula, Calderon, Caloza, Elhawary, Fong, Mark González, Ahrens, Pacheco, Pellerin, Solache
ABS, ABST OR NV: Sanchez, Dixon, Ta, Tangipa

UPDATED

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