Office of Senate Floor Analyses
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UNFINISHED BUSINESS

Bill No: SB 41
Author: Wiener (D) and Wahab (D), et al.
Amended: 9/4/25 in Assembly
Vote: 21

SENATE HEALTH COMMITTEE: 11-0, 4/23/25
AYES: Menjivar, Valladares, Durazo, Gonzalez, Grove, Limón, Padilla, Richardson, Rubio, Weber Pierson, Wiener

SENATE JUDICIARY COMMITTEE: 13-0, 4/29/25
AYES: Umberg, Niello, Allen, Arreguín, Ashby, Caballero, Durazo, Laird, Stern, Valladares, Wahab, Weber Pierson, Wiener

SENATE APPROPRIATIONS COMMITTEE: 6-0, 5/23/25
AYES: Caballero, Seyarto, Cabaldon, Grayson, Richardson, Wahab
NO VOTE RECORDED: Dahle

SENATE FLOOR: 37-0, 5/28/25
AYES: 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
NO VOTE RECORDED: Cervantes, Limón, Reyes

SUBJECT: Pharmacy benefits

SOURCE: California Chronic Care Coalition
California Pharmacists Association
Los Angeles LGBT Center
San Francisco AIDS Foundation

DIGEST: This bill prohibits pharmacy benefit managers (PBMs) from retaining the difference in payment to a pharmacy compared to the amount paid by the

health plan or insurer (spread pricing); requires 100% pass through of rebates to health plans and insurers that PBMs negotiate with drug manufacturers; bans PBM and drug manufacturer contracts that require exclusivity for a manufacturer's drugs, medical devices, or other products unless low premiums and cost-sharing can be demonstrated; bans PBM and pharmacy or pharmacy services administration organization contracts that restrict or impose exclusivity on a nonaffiliated pharmacies' ability to contract with employers, health insurers, and health plans; prohibits numerous additional PBM activities impacting pharmacies.

Assembly Amendments eliminate specified payment requirements and dispensing fees for pharmacies. Clarify provisions of this bill and adjust the bill in recognition of the passage of AB 116, Chapter 21, Statutes of 2025 which establishes PBM licensure at the Department of Managed Health Care (DMHC) on or after January 1, 2027. Require 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. Require disclosure on the net price paid by the PBM or group purchasing organization, and prohibit an enrollee's or insured's cost-share from being calculated at an amount that exceeds that net price. Revise definitions. Revise DMHC disclosure requirements regarding PBMs. Eliminate prohibition on PBM from interfering with patient's right to timely access.Require a PBM that contracts with an insurer to comply with specified sections of law, and states that consumer complaints against PBM are considered complaints against the insurer. Specify requirements on PBMs licensed by DMHC that contract with insurers.

ANALYSIS:

Existing state law:

1) Establishes DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act); CDI to regulate health and other insurance; and, the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [Health and Safety Code (HSC) §1340, et seq., INS §106, et seq., and WIC §14000, et seq.]

2) Prohibits on or after January 1, 2027, or the date DMHC has established a PBM licensure process, a person from engaging in business as a PBM for a health plan or insurer in California unless that person has first secured a licensed from the director of DMHC. Require PBMs to report data to DMHC and the Department of Health Care Access and Information. Subjects PBMs to

enforcement authority by DMHC, including civil penalties, fines, and administrative penalties.[HSC §1385.008, et seq.,]

This bill:

1) Prohibits, beginning January 1, 2026, a health plan contract or health insurance policy that provides prescription drug coverage from calculating an enrollee's or insured's cost-sharing, at an amount that exceeds the actual rate paid for the prescription drug by the plan, and, requires cost-sharing provisions consistent with specified existing law. Requires cost-sharing to include deductibles and copayments.

2) Prohibits a PBM from imposing requirements, conditions, or exclusions that discriminate against a nonaffiliated pharmacy in connection with dispensing drugs, as specified.
3) 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.

4) Prohibits the pharmacy from charging a PBM for the delivery service. This does not prohibit the use of remote pharmacies, secure locker systems, or other types of pickup stations if those services are otherwise permitted by law.

5) Requires the PBM to use a pass through pricing model. Requires PBMs to direct 100% of all prescription drug manufacturer rebates received to the health plan, health insurer, or program, if the contractual arrangement delegates the negotiation of rebates to the PBM, for the sole purpose of offsetting defined cost-sharing, deductibles, and coinsurance contributions and reducing premiums of plan participants.

6) Prohibits a PBM from deriving income from PBM services provided to a health plan or insurer except from a PBM fee for PBM services provided. Requires the amount to be set forth in the agreement between the PBM and health plan or insurer, and requires the PBM to disclose the amount and types of PBM fees to

the health insurer and health plan.

7) Permits the payment of performance bonuses based on savings to the health plan or insurer that decreases payments paid by the enrollee and insured or subscriber and policy holder, or that results in enrollees or insureds paying the lowest level cost-sharing, deductibles, and coinsurance for a drug, as long as the bonuses are not based or contingent on 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, 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 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.

8) Makes compensation arrangements, as specified, open for inspection by DMHC.

9) Prohibits, beginning January 1, 2026, a contract executed, or a contract amendment or renewal between a PBM and health plan or insurer from authorizing spread pricing. Defines "spread pricing" as 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 differs from the amount the PBM directly or indirectly pays the pharmacist or pharmacy.

10) Prohibits a PBM from making or permitting any reduction of payment for pharmacist services by a PBM, health plan, or a health insurer 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.

Comments

According to the author of this bill:

> 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. 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. This bill fills that regulatory gap by requiring that all PBMs be licensed by CDI and disclose basic information regarding their business practices to the state.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Assembly Appropriations Committee:

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.

SUPPORT: (Verified 9/9/25)

California Chronic Care Coalition (co-source)
California Pharmacists Association (co-source)
Los Angeles LGBT Center (co-source)
San Francisco AIDS Foundation (co-source)
AiArthritis
AIDS Healthcare Foundation
Alliance for Patient Access
ALS Association
American Diabetes Association
Biocom California
California Access Coalition
California Health Collaborative
California Life Sciences Association
California Medical Association
California Physicians Alliance
California Rheumatology Alliance
California Society of Health System Pharmacists
California State Board of Pharmacy
Coalition of State Rheumatology Organizations
Crohns and Colitis Foundation
Cystic Fibrosis Research, Inc.
End the Epidemics
Glide
Hemophilia Council of California
Indivisible CA: StateStrong
Infusion Access Foundation
International Bipolar Foundation
Keck Medicine of USC
Liver Coalition of San Diego

Lupus and Allied Diseases Association, Inc.
Lupus LA
National Association of Chain Drug Stores
National Community Pharmacists Association
National Infusion Center Association
National Multiple Sclerosis Society
National Psoriasis Foundation
North East Medical Services
Pharmaceutical Research and Manufacturers of America
San Francisco Marin Medical Society
Santa Monica Democratic Club
Spondylitis Association of America
United Nurses Association of California/Union of Health Care Professionals
Several individuals

OPPOSITION: (Verified 9/9/25)

AFSCME Local 685
America's Health Insurance Plans
American Muslims for Sustainability
Association of California Life & Health Insurance Companies
California African American Chamber of Commerce
California Asian Chamber of Commerce
California Association of Health Plans
California Chamber of Commerce
California Hispanic Chambers of Commerce
California Poultry Association
Clergy and Laity United for Economic Justice
Community Church
Hardesty LLC
Los Angeles Civil Rights Association
Pharmaceutical Care Management Association
Service Employees International Union 721, Bargaining Unit 702
Shalom International
Sherman Oaks United Methodist Church
Sperantia Foundation
Several individuals

ARGUMENTS IN SUPPORT: The California Pharmacist Association, the California Chronic Care Coalition, San Francisco AIDS Foundation, and Los Angeles LGBT Center cosponsor this bill. The cosponsors write, "The self-dealing

nature of PBMs is on full display when they steer patients to their company-owned mail-order, community and specialty pharmacies, all of which calls into question the ability of PBMs to fairly represent the employers, providers, and patients they purport to serve. With soaring healthcare costs, there is increasing scrutiny on providers, hospitals, manufacturers and insurance companies. The only healthcare entities that have seemingly avoided transparency and oversight are PBMs. The FTC has issued a scathing report on the business practices of PBMs. By providing transparency and oversight of PBMs, harmful practices can be subject to scrutiny and in some cases, prohibited." The ALS Association writes, "Some PBMs own their own pharmacy chains and mail order pharmacies, creating potential conflicts of interest in which they may prioritize their own pharmacies in network contracts or steer patients towards them, regardless of whether another pharmacy might offer better service or prices or to the detriment of ALS and other patients who rely on medications. In addition to owning pharmacies, in many cases, health plans and PBMs are now one in the same. While there may be some efficiencies, vertical integration can create conflicts of interest that prioritize the financial interests of the integrated company over patient care. The closure of community pharmacies is another concern and can have broader public health implications, as it may lead to poorer health outcomes for affected populations." The California State Board of Pharmacy writes complaints from consumers and health care providers have ranged from delays accessing essential medication to concerns about the impact of PBM business practices on patient care, and believes that legislative action is imperative to address these challenges effectively.

ARGUMENTS IN OPPOSITION: The Pharmaceutical Care Management Association (PCMA) writes that PBMs administer prescription drug benefits and operate mail-order and specialty pharmacies for nearly 29 million Californians and are projected to save Californians more than $108 billion over the next ten years, including more than $11 billion in Medi-Cal, and, this bill will not only diminish these savings but result in higher costs for all Californians. PCMA believes greater transparency across the supply chain will help the state make truly informed decisions about public policy relating to prescription drugs. PCMA also believes DMHC may be the more logical entity to license and oversee PBMs. PCMA believes this bill will benefit drug manufactures and some pharmacies but it does nothing to help consumers and believes it would result in premium increases of at least $150 per member per month. PCMA believes the current pay-for-PBM performance model is effective and should be an option for PBM clients. Banning performance-based contracts would cause health insurance premiums to increase by $3.1 billion. The California Chamber of Commerce (Chamber) writes that this bill would weaken preferred networks, eliminate cost-efficient benefit design

approaches and likely result in increased drug cost for patients. The Chamber believes that spread pricing reduces the risk of higher pharmaceutical spending for employers since it holds the employer harmless for enrollee's pharmacy shopping choices and aligns the interests of the PBM, pharmacy, and plan sponsor to achieve the lowest possible cost. The Los Angeles Civil Rights Association and other opponents write that this bill would levy a new health care tax on California employers, employees, and patients by mandating a new pharmacy fee that is about five times higher than the current fee.

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
9/9/25 14:46:23

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