California Enacts PBM Reform Law

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A recently enacted California law establishes extensive new requirements for pharmacy benefit managers ("PBMs") doing business in the state. The law is intended to increase regulatory oversight, enhance transparency, and address the revenue-generating abilities of PBMs. Effective dates vary by provision, with many going into effect on January 1, 2026.

Senate Bill 41

On October 11, 2025, California Governor Gavin Newsom signed Senate Bill 41 ("SB 41") into law. SB 41 covers a wide range of topics relating to PBMs. This update summarizes key provisions that could affect employer-sponsored health plans, and is not intended to cover all details of the law.

Price and Compensation

- No spread pricing. PBMs are prohibited from including spread pricing in contracts starting January 1, 2026. Spread pricing is a model of prescription drug pricing in which the contracted price charged for a drug by a PBM differs from the amount paid to the pharmacy. Spread pricing terms in existing contracts will be void on or after January 1, 2029.

- Passthrough pricing required. PBMs must use a passthrough model of pricing for prescription drugs. Under this model, payments made by a health care service plan or health insurer to a PBM for a prescription drug must equal the payments the PBM makes to a pharmacy for the drugs, including dispensing fees.

- 100% rebate passthrough. The law requires PBMs to direct 100% of manufacturer rebates received to be passed through to the payer or program for the sole purpose of offsetting cost sharing and reducing premiums for plan participants.

- Cost sharing cannot exceed the "actual rate" paid or "net price" paid. Health care service plan contracts or health insurance policies issued, amended, or renewed on or after January 1, 2026, are generally prohibited from calculating an insured's cost sharing for a prescription drug (including deductibles and copayments) at an amount that is greater than the "actual rate" paid by the plan for the drug or, if the contract includes disclosure of the "net price," the "net price" paid by the PBM for the drug.

- Note that these cost-sharing requirements appear to only apply to fully insured plans issued in California. They are not applicable to ERISA self-funded plans.

- Limitations on PBM compensation. PBMs cannot derive income from PBM services provided to a payer other than a defined service fee for those services. The amount must be defined in the agreement between the PBM and payer and cannot be tied to drug prices or patient cost sharing. The law permits performance bonuses to PBMs based on savings, depending on what the bonus is based.

- Other pharmacy pricing protections.

  - PBMs cannot reduce payments for pharmacist services under a reconciliation process to achieve certain reimbursement rates.

  - PBMs cannot retroactively deny or reduce pharmacy claims after adjudication except in limited circumstances (e.g., the claim was submitted fraudulently).

  - PBMs can reverse and resubmit claims from a contract pharmacy only: (1) with prior written notification; (2) with just cause or after attempting to first reconcile the claim; and (3) within 90 days of the claim being adjudicated.

  - PBMs cannot charge a pharmacy a fee to process claims electronically.

Limitations on Manufacturer Exclusivity and Treatment of Nonaffiliated Pharmacies

- Limitations on exclusivity with manufacturers. PBMs cannot enter exclusive arrangements with manufacturers on or after January 1, 2026, unless it can be demonstrated that the arrangements result in the lowest cost to the payer and the lowest cost sharing for the plan participant.

- Limitations on favorable treatment of affiliated pharmacies over nonaffiliated pharmacies. PBMs are prohibited from denying a nonaffiliated pharmacy the opportunity to participate in their network if the pharmacy is willing to accept the same terms and conditions established for affiliated pharmacies. The law also limits certain "steering" actions by PBMs that favor affiliated pharmacies over nonaffiliated pharmacies (e.g., requiring a plan participant to use only an affiliated pharmacy if there are nonaffiliated pharmacies in the network). PBMs are prohibited from discriminating against a nonaffiliated pharmacy in connection with dispensing drugs. PBMs also cannot enter into contracts that restrict or impose exclusivity on nonaffiliated pharmacies' ability to contract with employers and payers, beginning January 1, 2026.

Regulatory Oversight, Transparency, and Ethical Obligations

- Licensure requirement. For PBM contracts issued, amended, or renewed on or after January 1, 2027, the PBM must be licensed and in good standing with the California Department of Managed Health Care ("DMHC").

- Ethical and fiduciary obligations. PBMs must exercise good faith and fair dealing and must inform a purchaser in writing of any activity, policy, or practice presenting a conflict of interest. PBMs owe a fiduciary duty to a self-insured employer plan, as well as a payer client, which 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.

- Disclosure and reporting requirements. PBMs must provide detailed disclosures to a purchaser, including drug pricing, rebate, administrative fee, drug utilization, and pharmacy financial arrangement information, quarterly upon request. PBMs must also submit financial statements to the DMHC. The DMHC may conduct periodic routine and nonroutine surveys of a PBM.

Scope and Applicability

SB 41 aims to regulate PBMs conducting business in California, which will affect fully insured group health plans that contract with PBMs in the state.

While SB 41 specifically excludes a "self-insured employee welfare benefit plan" subject to ERISA from the definition of a PBM, it is unclear how much of the law intends to apply to PBMs working with self-insured plans. Certain provisions regulating PBM practices are drafted in a way that may affect PBM contracts more broadly, including those with self-funded ERISA plans. The law also specifically addresses a PBM's fiduciary obligation to self-insured employer plans, as well as to payer clients.

State PBM laws that are merely regulating PBM reimbursement practices to pharmacies are not preempted by ERISA. Indeed, SB 41 appears to have been drafted with an intent to avoid ERISA preemption. However, given the evolving ERISA preemption landscape with respect to state PBM laws, it is not yet clear which provisions of SB 41 will be preempted by ERISA and therefore not apply to self-funded ERISA plans.

Additional guidance from the California Department of Insurance (DOI) and DMHC is expected and we will continue to monitor this issue as more information and regulations become available.

The law specifically does not apply to a collectively bargained Taft-Hartley self-insured plan under ERISA or to a PBM's provision of PBM services pursuant to that Taft-Hartley plan.

Employer Action

Employers that sponsor fully insured plans contracting with PBMs in California can expect their insurance carrier to work with the PBMs to comply with the new requirements and do not need to take any action at this time.

Employers that sponsor self-funded plans contracting with PBMs in California should reach out to their TPA and/or PBM to determine if the new law requires any benefit design changes.