

California Senate Bill 41 Reshapes PBM Rules: What Pharmacies Must Do Now

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Executive Summary

Effective **January 1, 2026**, California's [Senate Bill 41 \(SB 41\)](#) fundamentally reforms pharmacy benefit manager (PBM) practices. It prohibits spread pricing, mandates a passthrough pricing model, and requires rebates to be passed to payers.

The law bans discriminatory network steering, protects pharmacy ancillary services, and establishes new claims payment integrity rules. PBMs must be licensed by 2027 and owe a fiduciary duty to payers. These changes increase transparency, level the playing field for nonaffiliated pharmacies, and introduce new enforcement mechanisms, with provisions phasing in through 2029.

Licensing and Oversight of PBMs

SB 41 requires PBMs that operate in California to obtain licensure from the Department of Managed Health Care (DMHC). The PBM licensure obligation takes effect on **January 1, 2027** (or upon the date the DMHC issues rules and opens the PBM licensing process—whichever is later).

Contracts issued, amended, or renewed on or after the operative licensure date should require the PBM to be licensed and in good standing. Failure to obtain or maintain required licensure may constitute a material breach and expose the PBM and potentially the plan/insurer to enforcement risk.

The DMHC is authorized to conduct surveys and examinations of licensed PBMs and require financial reporting, including audited annual financial statements and quarterly unaudited statements, subject to statutorily or regulatory-specified timelines. The Insurance Code also directs health insurers to utilize licensed PBMs once the DMHC licensure process is operative. See HSC §§ 1385.0011; 1385.0023; HSC § 1385.0033; HSC § 1385.0034; Ins. Code § 10125.2(d).

Prohibition of Spread Pricing and Mandatory Passthrough Model

SB 41 prohibits PBM spread pricing in PBM conduct and in contracts issued, amended, or renewed on or after **January 1, 2026**. Any contract clause authorizing spread pricing must be removed upon contract amendment or renewal, and all contract terms authorizing or permitting spread pricing are void by operation of law as of January 1, 2029, regardless of renewal or amendment status.

“**Spread pricing**” is defined as a PBM charging a plan or insurer more for a prescription drug than the PBM reimburses the dispensing pharmacy and retaining the difference.

SB 41 requires a passthrough pricing model under which PBM compensation is limited to disclosed pharmacy benefit management fees that are flat and not tied directly or indirectly to drug price metrics (for example, WAC, AWP), rebates, or premiums. Manufacturer rebates negotiated by PBMs or affiliates must be directed to the payer for use in offsetting cost-sharing and reducing premiums. HSC § 1367.2075(a)–(c), HSC § 1385.0031; Ins. Code § 10123.2045(a)–(c)).

Cost-Sharing Limits at the Point of Sale

For policies and contracts issued, amended, or renewed on or after **January 1, 2026**, or for PBM conduct beginning on that date as specified by statute, patient cost sharing for covered prescriptions may not exceed the actual rate paid by the plan or insurer.

Where the plan’s contract expressly discloses the PBM’s net price for the covered prescription, cost sharing may not exceed the disclosed PBM net price for that prescription. These are distinct rules, and cost sharing should not be described as a universal “lesser of” formula unless the plan contract includes a PBM net-price disclosure that creates the alternate cap. HSC § 1367.2075(a)–(c); Ins. Code § 10123.2045(a)–(c).

SB 41 refers to BPC § 4079 for consumer cost-sharing protections but does not define “actual rate” as the pharmacy’s retail cash price. Pharmacies should confirm with payers and PBMs how plan-paid amounts or disclosed PBM net prices are reported in point-of-sale adjudication systems.

Non-Discrimination and Network Conduct

SB 41 prohibits PBMs from imposing requirements, conditions, or exclusions that treat nonaffiliated pharmacies less favorably than affiliated pharmacies in connection with dispensing drugs.

Prohibited conduct includes the following, without limitation:

- differential reimbursement or fee schedules;

- disparate audit, credentialing, or termination standards;
- contractual clauses that require or incentivize patient transfers to affiliated pharmacies; and
- financial inducements or plan designs that steer patients to affiliated pharmacies when nonaffiliated pharmacies are available in the network.

For contracts issued, amended, or renewed on or after **January 1, 2026**, PBMs may not require plan participants to use only affiliated pharmacies if nonaffiliated pharmacies are in network, financially induce prescription transfers only to affiliated pharmacies, or require nonaffiliated pharmacies to transfer prescriptions to affiliated pharmacies when they are in network.

Nonaffiliated pharmacies willing to accept the same terms as affiliated pharmacies are entitled to equal opportunity for preferred network status. HSC §§ 1385.0026–1385.0027.

Ancillary Services and Delivery Rights

Contracts issued, amended, or renewed on or after **January 1, 2026**, and PBM conduct beginning on that date, where statutorily specified, between a PBM and a nonaffiliated pharmacy may not prohibit ancillary services core to pharmacy practice, such as prescription delivery, patient counseling, adherence programs, or other permitted pharmacy services.

Pharmacies must be permitted to deliver prescriptions to patients or their personal representatives by mail or common carrier at the patient’s request, and by pharmacy employee or contractor when requested prior to delivery, subject to applicable law and controlled-substance rules.

PBM contracts issued, amended, or renewed on or after **January 1, 2026**, may not impose fees on nonaffiliated pharmacies for delivery services unless the contract expressly permits billing the PBM for delivery. In the absence of such contractual authorization, pharmacies may bill patients for delivery. Pharmacies should capture patient or personal representative delivery requests before shipment, maintain written proof of patient authorization when required, and prepare consent language for staff and signage. HSC § 1385.0028.

Claims Integrity and Payment Protections

Effective **January 1, 2026**, SB 41 establishes comprehensive payment integrity standards governing PBM conduct and all PBM contracts issued, amended, or renewed on or after that date (Health & Safety Code § 1385.0029).

Prohibited Retroactive Reconciliations

- A PBM may not retroactively reduce payment for pharmacist services through reconciliations or adjustments intended to achieve a particular “effective rate,” “blend,” or “target” reimbursement level, or other after-the-fact rate alignment (§ 1385.0029(e)).

Ban on Electronic Transmission Fees

- A PBM may not charge or assess any fee to a pharmacy related to the electronic transmission or adjudication of prescription drug claims.

Reverse and Resubmit Restrictions

- A PBM may reverse and resubmit a claim only if:
 - (1) the PBM provides prior written notification to the pharmacy;
 - (2) the PBM has just cause or has first attempted to reconcile the claim with the pharmacy; and
 - (3) the reversal and resubmission occur within 90 days of the original adjudication (§ 1385.0029(f)–(h)).

Post-Termination Payment Obligations

- PBMs remain obligated to pay claims that were properly adjudicated prior to contract termination, except where nonpayment is supported by documented evidence of fraud (§ 1385.0029(i)).

The DMHC may enforce these provisions under its PBM licensure authority. Pharmacies should maintain records of claims communications, payment adjustments, and any reverse or resubmit notices for potential regulatory review.

Contracting and Exclusivity Constraints

SB 41 restricts PBM contracting with manufacturers, pharmacies, and Pharmacy Services Administrative Organizations (PSAOs) effective **January 1, 2026**, for PBM conduct and for contracts issued, amended, or renewed on or after that date. This applies to contracts that implement explicit or implicit exclusivity, unless the PBM can demonstrate that exclusivity results in the lowest cost to the payer and lowest cost sharing for participants.

PBMs may not enter into or enforce contracts that restrict nonaffiliated pharmacies' ability to contract with employers and payers. HSC § 1385.0032,

Transparency, Disclosure, and Duties

SB 41 codifies a duty of good faith and fair dealing for PBMs and adds an express fiduciary duty from PBMs to their payer clients under HSC § 1385.0022. SB 41 grants purchasers the right to request certain quarterly disclosures under BPC § 4441, rights which are distinct from DMHC's financial reporting and examination duties for licensed PBMs.

PBMs must provide at least 30 days' advance notice of material contract changes affecting reimbursement or other key terms to pharmacy network providers unless a shorter period is expressly permitted by statute or regulation. HSC § 1385.0022; BPC § 4441(c)–(e).

Enforcement, Remedies, and Attorney General Authority

SB 41 authorizes DMHC to examine compliance with PBM duties (including good faith and fiduciary obligations) under its licensure authority (§ 1385.0034). This authority includes surveys, examinations, and financial reporting reviews, similar to DMHC's traditional oversight of health plans under the Knox-Keene Act. Willful violations are crimes under the Knox-Keene Act, amplifying deterrence.

The Attorney General may pursue violations of the PBM provisions. Available remedies include specific performance, injunctive relief, and civil penalties ranging from \$1,000 to \$7,500 per violation, plus equitable relief and recovery of attorney's fees and costs.

The statute expressly preserves the Attorney General's existing authority and amends the Insurance Code so that a complaint made by an enrollee against a PBM may be considered a complaint against the health plan or insurer itself. HSC § 1385.0033; HSC § 1385.0023(c); [Ins. Code § 10125.2\(b\)–\(d\)](#).

Implementation Timeline

Changes under SB 41 take effect across the following dates (Cal. Health & Safety Code § 1395.6 et seq.; Ins. Code § 10133 et seq.):

January 1, 2026

- PBM conduct and contracts issued, amended, or renewed on or after this date are subject to key prohibitions and duties, including the ban on spread pricing in PBM conduct and in affected contracts, point-of-sale cost-sharing limitations (subject to plan contract disclosures), claims integrity and payment protections, anti-steering and nondiscrimination rules, and ancillary service/delivery rights for nonaffiliated pharmacies (see HSC §§ 1385.0026–1385.0031; HSC § 1367.2075; Ins. Code § 10123.2045).

January 1, 2027

- PBM licensure obligations and insurer–PBM contract requirements become enforceable on this date or upon DMHC establishing and operationalizing the PBM licensure process, whichever occurs later (see HSC §§ 1385.0011; 1385.0023; Ins. Code § 10125.2(d)).

January 1, 2029

- Any spread-pricing contract term is void by operation of law as of January 1, 2029, regardless of renewal or amendment status (see HSC § 1385.0031).

Practical Implications and Next Steps for Pharmacies

The shift to a passthrough reimbursement model and elimination of spread pricing should increase pricing transparency and reduce misalignment between payer payments and pharmacy reimbursement.

Pharmacies may experience changes in fee structures and the categorization of PBM compensation. Nonaffiliated pharmacies will have new statutory tools to resist network steering and differential reimbursement practices, and greater freedom to provide delivery services.

Operationally, pharmacies should take the following actions:

- Review and renegotiate PBM network agreements to remove spread pricing and implement passthrough reimbursement methodologies;
- Adjust point-of-sale processes aligned to plan-paid or net-price caps on cost sharing; document and escalate suspected discriminatory terms or steering;
- Implement safeguards against retroactive claim adjustments or “effective-rate” reconciliations except for clerical-error corrections; and
- Align delivery workflows with the ancillary-services protections.

In addition, pharmacies should standardize contract definitions for key terms such as “passthrough pricing model,” “pharmacy benefit-management fee,” “affiliated pharmacy,” “rebate,” and “spread pricing.” This will help ensure they mirror SB 41 definitions to minimize dispute risk and prevent PBM-fee language from being tied directly or indirectly to drug-price metrics or retained rebates.

Pharmacy management should develop a readiness and monitoring plan aligning contract-lifecycle management, reimbursement analytics, and operational controls with SB 41’s phased requirements. Priority actions include:

- Identify 2026–2027 contract events;
- Negotiate removal of spread-pricing terms and insertion of passthrough reimbursement provisions;
- Ensure point-of-sale systems reflect cost-sharing caps;
- Revising delivery policies to reflect ancillary-service rights;
- Train staff on nondiscrimination protections; and
- Establish a recordkeeping and audit framework to support potential enforcement or DMHC referral.

60-Day Action Checklist

1. Contract Inventory and Triage

- Identify PBM, GPO, specialty-mail, and PSAO contracts; list renewal/amendment dates; flag spread-pricing language, rebate retention clauses, exclusivity terms, reconciliation or “effective rate” provisions, reverse-and-resubmit rights, and delivery restrictions. Assign contract owner and priority level for each flagged clause

2. System Validation

- Verify that claims adjudication software computes member cost-sharing from the actual plan-paid or net-price amount. Confirm whether a PBM net-price disclosure exists in the plan contract and condition adjudication logic on that disclosure where applicable.

3. Amendment Templates

- Draft and/or negotiate PBM-contract amendments implementing passthrough pricing, explicit PBM-fee disclosure (flat FMV fee), rebate passthrough and quarterly reporting clauses, deletion of spread-pricing authorizations, reverse/resubmit safeguards, and licensure/good-standing material-breach language.

4. Rebate Accounting Map

- Build a rebate inflow/outflow ledger and controls to verify 100 percent passthrough to payers; require quarterly PBM rebate reconciliation reports and supporting detail to reconcile manufacturer payments, remittances to payers, and any administrative allocations.

5. Network Policy Cleanup

- Remove or object to affiliate-only restrictions; insert parity language that nonaffiliated pharmacies are eligible for preferred status on the same terms and conditions offered to affiliated pharmacies; add delivery rights and nondiscrimination enforcement clauses.

6. Licensure Monitoring

- Track DMHC PBM-licensure rulemaking [on their website](#). Insert insurer-contract language requiring PBM DMHC licensure and good standing by the operative date (**January 1, 2027**, or when DMHC implements licensure) and specify material-breach remedies for failure to obtain/maintain licensure.

7. Claims and Reconciliation Review

- Audit historical and current PBM reconciliation practices for retroactive “effective-rate” adjustments, claw-backs, and electronic transmission fees.

- Document instances of reverse-and-resubmit conducted without prior written notice or reconciliation attempts; preserve all communications, ERA/835 files, remittance advices, and reconciliation spreadsheets for dispute or enforcement.

8. Exemption Audit

- Identify ERISA/self-insured carve-outs and Taft-Hartley exempt plans; quantify volumes and contractual scope; evaluate whether the PBM's mixed servicing of exempt and nonexempt business creates commingling or cross-subsidization risks and requires segregation or accounting controls where appropriate (see HSC § 1385.0034).

9. Consult Legal Counsel

- Engage outside/in-house counsel to draft, review, and prioritize amendment templates, to support negotiations, and to advise on enforcement strategy and regulatory referral thresholds.

Ongoing Compliance and Monitoring

- **Pharmacies should implement a continuous compliance framework** that includes quarterly reviews of PBM contracts, rebate flows, and adjudication logic to maintain SB 41 alignment.
- **Internal dashboards or compliance logs should document contract amendments**, dispute escalations, audit results, and all advance notices of material network changes.
- **Pharmacies and PSAOs should monitor DMHC rulemaking and interpretive guidance**, track exclusivity clauses and reimbursement differentials, and collect data on audit frequency or network restrictions that may indicate discriminatory or noncompliant PBM conduct.
- **All contemporaneous records of PBM performance and communications should be preserved** to support audits, contractual challenges, or enforcement referrals through the DMHC or the DOI.

Conclusion

Senate Bill 41 represents a foundational shift in California's pharmacy landscape, fundamentally restructuring the PBM-pharmacy relationship. The bill replaces opaque price capture and discretionary PBM practices with a framework centered on transparency, payer-facing accountability, and protections for nonaffiliated pharmacies and patients.

By early 2026, every PBM, pharmacy, and plan doing business in California must ensure that contracts, systems, and compliance frameworks embody these new statutory standards.

SB 41's combined tools—contractual prohibitions, operational rules for adjudication and delivery, purchaser disclosure rights, DMHC oversight, and Attorney General enforcement—create legal and commercial leverage

pharmacies can use to secure fairer reimbursement and network parity. Pharmacies that move quickly to operationalize these changes will reduce compliance risk and convert regulatory reform into a competitive advantage.

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