CALIFORNIA HIV / AIDS POLICY RESEARCH CENTERS

Law and Policy Interventions Addressing Pharmacy Benefit Manager (PBM) Practices: Impact on Pharmacy-based HIV Prevention Services

Pharmacy Benefit Managers (PBMs) function as gatekeeping "middlemen" among health insurers, health or drug plan sponsors, pharmacies, and drug manufacturers. PBMs emerged in the late 1950s to manage prescription drug benefits, initially helping to process claims and pay pharmacies (Mattingly et al., 2023). Over time, **PBMs evolved to negotiate drug prices** with wholesalers and drug manufacturers on behalf of client payers, such as health plans and insurers, and determine reimbursement rates for pharmacies (House Committee on Oversight and Accountability Staff [hereafter House], 2024). **PBMs play a pivotal role in formulary design**, deciding on the list of medications and products to be covered by health plans (BRG Healthcare, n.d.). PBMs negotiate to place individual pharmacies in health plan networks and reimburse them for dispensing prescriptions (House, 2024), **and administer pharmacy networks** that include independent, chain, and specialty pharmacies and physician-dispensing practices (BRG Healthcare, n.d.). Many large PBMs themselves are part of vertically integrated companies that also own health insurers, large pharmacy chains, mail-order pharmacy services, and group purchasing organizations (House, 2024).

PBMs generate revenues in multiple ways. These include:

- **Administrative fees** paid by parties they contract with, in exchange for deciding that specific drugs are included in the formularies or lists of drugs covered by health plans or insurers.
- **Rebates or discounts** calculated as a percentage of drug list prices, from drug manufacturers. This creates a perverse incentive for PBMs to choose higher-priced drugs over similarly effective, lower-cost options (NAIC, 2023).
- **Spread pricing** which involves PBMs pocketing the spread or the difference between what insurers and plans reimburse for drugs and what pharmacies are actually paid for dispensing the drugs.
- **Copay clawbacks** whereby PBMs instruct pharmacies to charge patients a copay that exceeds the actual cost of the prescription and the PBM subsequently collects the extra profit from the pharmacy. The term "clawback" also refers to a PBM practice of charging a pharmacy a fee long after it has dispensed and sold a prescription, reclaiming from it some part of a previous reimbursement (Allen, 2023).

- **Patient steering** where PBMs encourage or require patients to use pharmacies they own, are a part of their network or otherwise favor, regardless of drug costs or patient preferences.

In this policy brief, we describe the impact of PBMs on community pharmacies, state and federal legislation to address PBM practices, and California pharmacists' experience with current PBM drug reimbursement practices.

Role of PBMs in community pharmacies

Community pharmacies, also known as retail pharmacies, provide patient-centered medication services that is accessible to most of the U.S. population. They are especially beneficial in rural areas where around 76.5% of pharmacies are either regional franchises or independently owned pharmacies (Smith et al., 2023). The scarcity of pharmacies in rural areas creates large gaps in access to care, particularly for the elderly and uninsured (Casey et al., 2002).

Unfortunately, nearly one in three community pharmacies has closed since 2010. This reduction in local pharmacies has been concentrated in certain states (Illinois, New York, Maine, and Pennsylvania) and in Black and Latino neighborhoods (Millman, 2024). In 2020 to 2021, almost one drugstore per week went out of business because the cost of drugs paid by pharmacies to fill patient prescriptions was greater than the amount that pharmacies were reimbursed by PBMs for those drugs. Such closures may widen health disparities and access to essential health services and prescriptions such as vaccinations and contraceptives (UC Berkeley School of Public Health, 2024). PBMs have been cited as a driver behind such closures as they have significant control over the cost of drugs and the reimbursement processes for pharmacies, including access to payment for both drugs and dispensing services (Martin, 2025). Large pharmacy chains with dominant PBMs have also steered patients to its preferred pharmacies while imposing higher out-of-pocket costs at other non-affiliated locations leaving community pharmacies behind (UC Berkeley School of Public Health, 2024).

California pharmacists' perspectives on implementing HIV prevention services

In 2022–2023, we conducted an online, cross-sectional survey of California pharmacists and pharmacy students (n = 919). Our study found that only 11% of participants reported their pharmacy had initiated PrEP (Hunter, 2023). Follow-up interviews were conducted with pharmacists (n = 30) using a semi-structured interview guide which was developed and reviewed by members of the research team, including pharmacists with clinical experience providing HIV prevention services. Interview questions focused on challenges participants faced when providing and administering oral and long-acting injectable PrEP (pre-exposure prophylaxis to prevent HIV infection). The interviews, which lasted approximately 60 minutes each, were audio-recorded and transcribed verbatim, and analyses were guided by the Rapid Qualitative Approach to Health Services Research (Hamilton, 2019).

Of the 30 California pharmacists interviewed, 22 practiced at an independent pharmacy. Ninety percent (27 of 30 participants) identified financial concerns as a barrier to implementing pharmacist-initiated PrEP services authorized under California Senate Bill (SB) 159/339. At the time of the interviews, only four of the 30 pharmacists reported implementing PrEP services at their pharmacy practice site. The financial concerns included challenges with drug reimbursement by PBMs, and these were identified as significant for all those who were ***not*** implementing PrEP services at the time of the interview. Below are excerpts, edited for clarity, from California pharmacists who describe some of the challenges they experienced with PBMs.

PBM practices generally

Participants reported that PBM practices affected initial decision-making on whether to implement PrEP services in community pharmacy settings.

> ***[T]here are so many nuances that when a person makes [the] decision [to implement services]. [T]hey need to think about the PBM, the insurance company. The way they provide care or the way they think about everything is the bottom line first. I think honestly, the independent pharmacies will have more of like, "I care about my patient" [perspective] above the cost. A lot of us fill prescriptions at a loss because we care about the patient, it's hard for us to turn away. But I think every decision that the insurance company or PBM makes is very much profit-driven.***

Participant 3, community pharmacist, experience serving people with HIV, serves many unhoused and under/uninsured individuals

PBM Business Practices

PBM practices created financial barriers to implementing PrEP services. This includes **spread pricing**.

> ***We were losing twenty-five dollars below what we bought it for…I don't get it. I don't understand why the state is not covering our cost…There's some drugs we just don't even carry… because that NADAC[1] line is so low.***

Participant 1, community pharmacist, 42 years of experience, serves rural communitie

> ***But then the disparity of the payment plan – what do they pay us pharmacists at the independent? So, the cost of the medication may be $1000. They pay you $550. So as a pharmacist, you have to make a decision, especially small independent pharmacies, because there's a huge difference.***

Participant 21, community pharmacist, 37 years of experience, serves urban communities including racial/ethnic minorities

1 NADAC refers to a price index that is used to set prices based on the average price pharmacies pay for prescription drugs in the United States.

PBM practices hindered community pharmacists' ability to deliver the latest biomedical innovations, including long-acting injectable PrEP.

> ***I've had several patients that have come here and wanted to get [injectable PrEP]. I have one on my desk that I'm trying to figure out how I can link him up with care because his doctor's office got the prescription approved. But it's a $150 loss on the cost of the medication, so I can't spend, you know, $3700 on the drug, and have [the PBM] pay me $3550 and lose $150 on him every time he walks in the door to get a shot. It's not financially feasible.***

Participant 2, community pharmacist, 16 years of experience, serves LGBTQ+ individuals and a high number of patients with HIV or who are currently on PrEP

In this situation, the patient had brought an outside provider's prescription to the pharmacy. Though SB 159/339 expanded scope of practice for trained pharmacists to prescribe such medications on their own, financial barriers exist even when pharmacies are dispensing HIV prevention medications prescribed by other healthcare providers.

Another participant shared how PBMs find other ways to disincentivize patients from utilizing their community pharmacy. This practice is known as **patient steering**.

> ***And the way they [PBMs] do it, they'll penalize the patient for coming to us with higher co-pays, but at [the pharmacy they own], [patients] pay zero copays. So obviously if I was the patient, I'd rather not pay a co-pay. But that's another issue… But if the patient doesn't pay anything, if there's zero co-pay, that's fine, that's not a hardship on the patient.***

Participant 21, community pharmacist, 37 years of experience, serves urban communities including racial/ethnic minorities

Ultimately, PBM practices discouraged community pharmacists from implementing PrEP services.

> ***So, for example, [X insurance company] owns [Y pharmacy] so they have [their] own insurance and have their own pharmacy. Same thing with [Z company]. They're all like that now. They're really big, so it's almost kind of like a monopolistic type thing. Basically, they make a lot of important decisions about reimbursement and who gets accepted to the contract…The other component that is important to understand is that before, when the drug was reimbursed a little better, more pharmacies were interested in filling these drugs. Now, I think that a majority of my colleagues are not interested in filling these drugs.***

Participant 3, community pharmacist, experience serving people with HIV, serves many unhoused and under/uninsured individuals

These financial challenges blocked the initiation of novel HIV prevention strategies, such as pharmacist-initiated PrEP. They occur in a context where the three largest PBMs markup specialty generic drugs, including critical drugs to prevent and treat HIV. From 2017 to 2022, HIV drugs as a class accounted for 8% of PBM revenues in excess of estimated acquisition costs (FTC, 2025). Some of those drugs dispensed at PBMs' affiliated pharmacies were sold at prices ranging from more than 100% to more than 1,000% of their acquisition cost. At the same time, unaffiliated pharmacies were reimbursed at lower rates for almost every specialty drug. PBM regulation is, thus, salient to HIV-related care (Manint, 2025).

Current state-level PBM regulations

Interventions to address PBM practices include the following areas of focus:

- **Licensure & Registration**: A process where PBMs formally register with a state or federal agency to be licensed or regulated.
- **Reporting Requirements**: A process of disclosing information about the financial means between PBMs and drug manufacturers, which includes sharing the amount of rebates received and shared. Rebates are refunds or credits given to a buyer after they have paid full price for a product or service.
- **Pricing & Reimbursement**: Practices that PBMs utilize to charge health plans or other payers more for prescription drugs than the amount they pay pharmacies for the same medications, where PBMs retain the difference or "spread" for profit. Other practices include PBMs reclaiming money already paid out to pharmacies, which are commonly referred to as "clawbacks."
- **Patient Steering**: A practice where a PBM or related health plan compels plan members or consumers to fill their prescriptions at a pharmacy affiliated with or owned by the PBM or plan. Laws to address patient steering include "any willing provider" provisions to ensure that any pharmacy willing to abide by the same terms as others must be admitted into PBM networks allowing for greater patient choice.
- **Antitrust laws**: Laws that address issues related to price-fixing, market control, and unfair rebate practices through PBMs leveraging a dominant position in the pharmaceutical supply chain. Efforts include addressing PBMs that are held under the same ownership as an insurance company and a pharmacy network, something referred to as "vertical integration."

All 50 states have implemented regulations to address PBM practices. However, it is unclear whether the intended effects of these regulations, such as overall cost savings and improved patient health outcomes, have been achieved (Mattingly et al., 2023). In March 2024, the U.S. Government Accountability Office released a report identifying state regulations of PBMs in selected states that had enacted a wide range of laws focused on PBM practices (GAO, 2024). These states included Arkansas, California, Louisiana, Maine, and New York.

Current California law requires a PBM under contract with a health care service plan to register with the Department of Managed Health Care (DMHC) and under Assembly Bill (AB) 315 (2019), this requires reporting on the aggregate amount of some rebates received. SB 17 (2018) requires little to no reporting by PBMs but requires health plans to report on its use of PBMs and the names of the PBMs used to the Department of Insurance. The failure of health care service plans to comply with PBM reporting requirements can be grounds for disciplinary action to the plan. However, these penalties do not apply to the PBMs themselves. DMHC has the authority to periodically evaluate contracts between health care service plans and PBMs to determine if an audit, evaluation, or enforcement action should be undertaken under AB 315. Under recent changes in SB 786 (2023) the law prohibits PBMs from interfering with an individual's choice to receive a covered drug from a covered entity or specified pharmacy, whether they do so in person, via direct delivery mail, or using other form of shipment.

Although California's recently enacted PBM regulations may seem comprehensive compared to those from GAO-selected states, they are not as far-reaching as they appear. *See* **Table 1**.

Table 1. State Regulation PBM Regulation Comparisons

State	Licensure & Registration	Reporting Requirements	Pricing & Reimbursement	Patient Steering	Antitrust laws
California	Yes	Yes	None	Yes, prohibits PBMs from interfering with patient's choice to receive a covered drug	None
Arkansas	Yes	Yes	Yes, prohibits spread pricing	None	Yes, first-ever law to prohibit PBMs from owning pharmacies, including mail order pharmacies
Louisiana	Yes	Yes	Yes, prohibits spread pricing without written biannual notice to policyholders	Yes, prohibits patient steering without a written disclosure and acknowledgment form from enrollees	None
Maine	Yes	Yes	Yes, requires use of 1 Maximum Allowable Cost List for pharmacies and insurers ensuring transparency and requires PBMs to remit the proceeds of spread pricing to the enrollee or issuer like rebates	None	Yes, state has determined PBMs have a fiduciary duty to address vertical consolidation
New York	Yes	Yes	Yes, prohibits spread pricing by requiring HMOs to include in their contracts with PBMs	None	Yes, state has determined PBMs have a fiduciary duty to address vertical consolidation

Proposed State and Federal PBM Regulations

California Senate Bill 41 and proposed federal PBM regulations have similarities and differences. *See* Table 2. Proposed federal legislation on PBMs seeks to address business practices that drive up drug costs for consumers, reduce reimbursements for independent pharmacies, and disadvantage healthcare system payers. The key PBM-related bills being considered in the current session of the U.S. Congress include:

» Bipartisan Health Care Act, S. 891

» Pharmacy Benefit Manager Transparency Act of 2025, S. 526

» Delinking Revenue from Unfair Gouging (DRUG) Act, H.R. 2214

» Patients Before Middlemen Act, S. 882

» Protecting Pharmacies in Medicaid Act, S. 927

These proposals address PBM practices in one of three ways:

- Address revenue-generating practices of PBMs
  - Spread pricing
  - Clawbacks
  - Service fees
- Establish reporting requirements on various healthcare actors for more transparency
  - Responsibility for regular reporting by PBMs
  - Scope of reporting
- Enhance enforcement mechanisms
  - Compelling the return of payments in violation of the law to affected payers
  - Penalties

Notably, SB 41 addresses PBM practices in all three ways described above.

- It explicitly prohibits **spread pricing**.
- It **sets a floor** for pharmacy reimbursement for a drug by PBMs at the NADAC line or the pharmacy's wholesale acquisition cost (WAC).
- PBMs must also pay the pharmacy a **dispensing fee** that is at least equal to the Medi-Cal rate.
- It prohibits **patient steering**, and PBMs cannot require patients to use only affiliated pharmacies or offer inducements to transfer prescriptions to affiliated pharmacies if non-affiliated pharmacies are included in the network.
- PBM services can be paid through **service fees**, and PBMs must pass any drugmaker rebates to the payer plan or program.

Table 2. Proposed California and Federal PBM Regulations

	Licensure & Registration	Reporting Requirements	Pricing & Reimbursement	Patient Steer-ing	Civil Penalties
California Senate Bill 41	Yes	Yes, requires reporting to DOI	Yes, prohibits spread pricing and sets pricing floor	Yes, prohibits patient steering	Yes, establishes civil penalties
Federal S. 526	Yes	Yes, requires annual reporting to the FTC and DHHS Secretary	Yes, prohibits spread pricing and arbitrary, unfair, or deceptive clawbacks of payments to pharmacies	None	Yes, establishes civil penalties, aside from FTC penalties
S. 882	None	Yes, requires annual reporting to the PDP sponsor and DHHS Secretary	Yes, permits PBM remuneration only by flat fees for services related to Medicare Part D prescription drug plans (PDPs)	Yes, widens Medicare beneficiaries' choice by allowing any pharmacy willing to meet standard terms to participate in a pharmacy network	Yes, establishes civil penalties on PDP sponsors that PBM must return to the sponsor
S. 927	None	Yes, requires reporting to the state and the DHHS Secretary on request	Yes, prohibits spread pricing in Medicaid and limits PBM remuneration for services to Medicaid managed care entities and related covered outpatient drugs to ingredient costs and a professional dispensing fee	None	None
H.R. 2214	None	None	Yes, permits PBM remuneration only by fees for services related to prescription drug benefits under group health plans or insurers	None	Yes, establishes civil penalties and PBM must also return to health plan or insurer any amount received in violation of the Act
S. 891	None	Yes, requires semi-annual reporting to group health plans, insurers offering group health coverage, including employer-sponsored health plans	Yes, prohibits spread pricing in Medicaid and limits PBM remuneration for services to Medicaid managed care entities to ingredient costs and a professional dispensing fee. For Medicare Part D, permits PBM remuneration only by flat fees for services	Yes, widens Medicare beneficiaries' choice by allowing any pharmacy willing to meet standard terms to participate in a pharmacy network	Yes, establishes civil penalties for Medicare Part D for failing to disclose required information and providing false information

Note: Acronyms used above include Department of Insurance (DOI), Federal Trade Commission (FTC), Department of Health and Human Services (DHHS), Prescription Drug Plan (PDP).

- Prior existing laws on **licensing and reporting** are further bolstered under SB 41. It includes required reporting by PBMs to the Department of Insurance on the "top 50" drugs.
- Finally, SB 41 proposes an **enforcement** mechanism for PBMs that fail to meet the requirements, including civil penalties where appropriate. Because of licensing rules in SB 41, unlike federal proposals, California would have an additional enforcement mechanism of revoking a PBM's license to operate in the state.

Proposed federal bills would require periodic and detailed reporting by PBMs to the Department of Health and Human Services Secretary, the Federal Trade Commission, a Prescription Drug Plan sponsor, or a group health plan. Information to be reported would include amounts paid to PBMs and pharmacies; comprehensive drug lists and, for each covered drug, related costs, revenues, and prescription data; and additional data for PBMs with pharmacy affiliates. Proposed federal PBM regulations detail approaches to specific programs where they seek to regulate PBM practices. Federal S. 927 focuses on Medicaid, S. 882 on Medicare Part D, and H.R. 2214 on group health plans in the commercial market. A few bills would halt spread pricing in relation to different health plans (i.e., Medicaid, Medicare Part D, or other health plans) and require that PBMs earn only flat administrative fees for their services, severing the link between drug prices and PBM revenues. Aside from barring spread pricing, S. 526 would also prohibit arbitrary, unfair, or deceptive clawbacks of PBM payments to pharmacies and the arbitrary, unfair, or deceptive increases in fees or decreases in reimbursements to pharmacies by PBMs for the purpose of offsetting reimbursement changes in federally-funded plans. The various bills would not prevent a PBM from obtaining rebates, discounts, or concessions on drug prices, as long as it returns or passes along the amount to the corresponding health plan, payer, or PDP sponsor.

Proposed federal legislation would also install certain enforcement mechanisms. Should a PBM earn remuneration in violation of these various laws' provisions, a number of these bills would compel the PBM to disgorge or surrender these amounts to the group health plan, insurer, or PDP sponsor on whose behalf it functions. In the case of S. 882, the PDP sponsor, in turn, must disgorge or surrender these amounts to the DHHS Secretary. Moreover, S. 526 and H.R. 2214 would impose civil monetary penalties for violations of these laws' provisions.

Future Directions

Increasing the number of community pharmacies is crucial for enhancing healthcare accessibility. However, current trends indicate a decline in the overall number of community pharmacies. Regulating PBMs represents a promising intervention to sustain community pharmacies as essential points of access to medications, as community pharmacies are uniquely vulnerable to PBM practices. The most robust efforts seek to address the issue of vertical integration of the U.S.'s leading PBMs, which own 80% of the market (FTC, 2024). This includes both establishing a fiduciary duty of care on PBMs (Maine and New York) and a first-ever outright ban on vertical integration in Arkansas, banning PBMs from owning or operating community/retail or mail-order pharmacies.

For the delivery of HIV-related services, addressing PBM practices that disproportionately impact community pharmacies remains a critical priority. In California, proposals to expand PBM regulations are aligned with efforts at the federal level. Our study captures perspectives of California pharmacists related to PBMs and drug reimbursement. **Evidence suggests financial barriers remain a significant barrier to innovation, including the implementation of pharmacist-initiated HIV prevention services.** Thus, expanding PBM regulations may be one step forward in addressing such implementation barriers.

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