SB-41 Pharmacy benefits. (2025-2026)

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Senate Bill No. 41

CHAPTER 605

An act to amend Section 4441 of the Business and Professions Code, to amend Sections 1385.001, 1385.0011, 1385.0021, 1385.0022, and 1385.0023 of, and to add Sections 1367.2075, 1385.0026, 1385.0027, 1385.0028, 1385.0029, 1385.0031, 1385.0032, 1385.0033, and 1385.0034 to, the Health and Safety Code, and to amend Section 10125.2 of, and to add Section 10123.2045 to, the Insurance Code, relating to pharmacy benefits.

[Approved by Governor October 11, 2025. Filed with Secretary of State October 11, 2025.]

LEGISLATIVE COUNSEL'S DIGEST

SB 41, Wiener. Pharmacy benefits.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a pharmacy benefit manager engaging in business with a health care service plan or health insurer to secure a license from the Department of Managed Health Care on or after January 1, 2027, or the date on which the department has established the licensure process, whichever is later.

This bill would prohibit a pharmacy benefit manager from, among other things, requiring use of only an affiliated pharmacy, as specified, and from imposing requirements, conditions, or exclusions that discriminate against a nonaffiliated pharmacy in connection with dispensing drugs. The bill would limit a pharmacy benefit manager's income to that derived from a pharmacy benefit management fee for pharmacy benefit management services provided, and would require a pharmacy benefit manager to use a passthrough pricing model. The bill would authorize the Attorney General to recover specified civil penalties and receive equitable relief for violations of the pharmacy benefit manager licensing provisions. Because a violation of these provisions would be a crime, the bill would impose a state-mandated local program. The bill would also require a contract between a health insurer and a pharmacy benefit manager issued, amended, or renewed on or after January 1, 2027, or the date on which the Department of Managed Health Care has established the pharmacy benefit manager licensure process, whichever is later, to require the pharmacy benefit manager to be licensed and in good standing with the Department of Managed Health Care.

Existing law requires a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drugs to cover medically necessary prescription drugs and subjects those policies to certain limitations on cost sharing and the placement of drugs on formularies. Existing law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price, and requires that payment apply to the applicable deductible.

This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, that provides prescription drug coverage from calculating an enrollee's or insured's cost sharing at an amount that exceeds the actual rate paid by the plan or insurer for the prescription drug, except as specified, and would require the

contract or policy to include specified cost-sharing provisions. The bill would prohibit a contract between a pharmacy benefit manager and a health care service plan or health insurer that is executed, amended, or renewed on or after January 1, 2026, from authorizing spread pricing. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

This bill would declare that it does not narrow, abrogate, or otherwise alter the authority of the Attorney General to maintain or restore competitive, fair, and honest markets and prosecute violations of law, and would declare that the provisions of this bill are severable.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 4441 of the Business and Professions Code is amended to read:

4441. (a) For purposes of this section, the following definitions shall apply:

(1) "Labeler" means a person or entity that receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale and who has a labeler code from the federal Food and Drug Administration under Part 207 of Title 21 of the Code of Federal Regulations.

(2) "Proprietary information" means information on pricing, costs, revenue, taxes, market share, negotiating strategies, customers, and personnel that is held by a pharmacy benefit manager and used for its business purposes.

(3) "Purchaser" means a health benefit plan sponsor or other third-party payer with whom a pharmacy benefit manager contracts to provide the administration and management of prescription drug benefits, except for a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(b) This section shall apply to pharmacy benefit manager contracts that are entered into, amended, or renewed on or after January 1, 2019.

(c) (1) A pharmacy benefit manager shall exercise good faith and fair dealing.

(2) A pharmacy benefit manager has 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.

(d) A pharmacy benefit manager shall notify a purchaser in writing of any activity, policy, or practice of the pharmacy benefit manager that directly or indirectly presents a conflict of interest that interferes with the discharge of the pharmacy benefit manager's duty to the purchaser to exercise good faith and fair dealing pursuant to subdivision (c).

(e) The pharmacy benefit manager shall, on a quarterly basis, disclose, upon the request of the purchaser, the following information with respect to prescription product benefits specific to the purchaser:

(1) The aggregate wholesale acquisition costs from a pharmaceutical manufacturer or labeler for each therapeutic category of drugs containing three or more drugs, as outlined in the state's essential health benefits benchmark plan pursuant to Section 1367.005 of the Health and Safety Code.

(2) The aggregate amount of rebates received by the pharmacy benefit manager by therapeutic category of drugs containing three or more drugs, as outlined in the state's essential health benefits benchmark plan pursuant to Section 1367.005 of the Health and Safety Code. The aggregate amount of rebates shall include any utilization discounts the pharmacy benefit manager receives from a pharmaceutical manufacturer or labeler.

(3) Any administrative fees received from the pharmaceutical manufacturer or labeler.

(4) Whether the pharmacy benefit manager has a contract, agreement, or other arrangement with a pharmaceutical manufacturer to exclusively dispense or provide a drug to a purchaser's employees, insureds, or enrollees, and the application of all consideration or economic benefits collected or received pursuant to that arrangement.

(5) Prescription drug utilization information for the purchaser's enrollees or insureds that is not specific to any individual enrollee or insured.

(6) The aggregate of payments, or the equivalent economic benefit, made by the pharmacy benefit manager to pharmacies owned or controlled by the pharmacy benefit manager.

(7) The aggregate of payments made by the pharmacy benefit manager to pharmacies not owned or collected by the pharmacy benefit manager.

(8) The aggregate amount of the fees imposed on, or collected from, network pharmacies or other assessments against network pharmacies, and the application of those amounts collected pursuant to the contract with the purchaser.

(f) The information disclosed pursuant to subdivision (e) shall apply to all retail, mail order, specialty, and compounded prescription products.

(g) Except for utilization information specified in paragraph (5) of subdivision (e), a pharmacy benefit manager is not required to make the disclosures required by subdivision (e) unless and until the purchaser agrees, in writing, to maintain as confidential any proprietary information.

(h) A pharmacy benefit manager shall not impose a penalty or offer an inducement to a purchaser for the purpose of deterring the purchaser from requesting the information set forth in subdivision (e).

(i) A pharmacy benefit manager shall disclose to a pharmacy network provider or its contracting agent any material change to a contract provision that affects the terms of reimbursement, the process for verifying benefits and eligibility, dispute resolution, procedures for verifying drugs included on the formulary, and contract termination at least 30 days before the date of the change to the provision.

(j) A pharmacy benefit manager shall not notify an individual receiving benefits through the pharmacy benefit manager that a pharmacy has been terminated from the pharmacy benefit manager's network until the notification of termination has been provided to that pharmacy pursuant to subdivision (i).

(k) A pharmacy benefit manager shall not include in a contract with a pharmacy network provider or its contracting agent a provision that prohibits the provider from informing a patient of a less costly alternative to a prescribed medication.

(l) This section shall not apply to the following:

(1) A health care service plan or health insurer, if the health care service plan or health insurer offers, provides, or administers pharmacy benefit management services and if those services are offered, provided, or administered only to enrollees, subscribers, policyholders, or insureds who are also covered by health benefits offered, provided, or administered by that health care service plan or health insurer.

(2) An affiliate, subsidiary, related entity, or contracted medical group of a health care service plan or health insurer that would otherwise qualify as a pharmacy benefit manager, but offers, provides, or administers services only to enrollees, subscribers, policyholders, or insureds who are also covered by health benefits offered, provided, or administered by the health care service plan or health insurer.

(3) A contract authorized by Section 4600.2 of the Labor Code.

(m) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 2. Section 1367.2075 is added to the Health and Safety Code, immediately following Section 1367.207, to read:

1367.2075. (a) A health care service plan contract issued, amended, or renewed on or after January 1, 2026, that provides prescription drug coverage shall not calculate an enrollee's cost sharing at an amount that exceeds the actual rate paid by the plan for the prescription drug, and shall include cost-sharing provisions consistent with Section 4079 of the Business and Professions Code. Cost sharing shall include deductibles and copayments.

(b) To the extent that a health care service plan contract with a pharmacy benefit manager issued, amended, or renewed on or after January 1, 2026, includes disclosure on the net price paid by the pharmacy benefit manager or group purchasing organization, then an enrollee's cost share shall not be calculated at an amount that exceeds that net price paid.

(c) (1) Commencing January 1, 2026, if a preexisting contract between a pharmacy benefit manager licensed pursuant to Article 6.1 (commencing with Section 1385.001) and a health care service plan authorizes spread pricing, as that term is defined by Section 1385.001, any subsequent amendment or renewal of that contract shall not authorize spread pricing.

(2) A contract that is executed on or after January 1, 2026, between a pharmacy benefit manager licensed pursuant to Article 6.1 (commencing with Section 1385.001) and a health care service plan shall not authorize spread pricing, as that term is defined by Section 1385.001.

SEC. 3. Section 1385.001 of the Health and Safety Code, as added by Section 11 of Chapter 21 of the Statutes of 2025, is amended to read:

1385.001. For the purposes of this article:

(a) “Affiliated entity” means any of the following:

(1) An applicable group purchasing organization, drug manufacturer, distributor, wholesaler, rebate aggregator or other purchasing entity designed to aggregate rebates, or associated third party.

(2) A subsidiary, parent, affiliate, or subcontractor of a health care service plan or health insurer, an entity that provides pharmacy benefit management services on behalf of a health care service plan or health insurer, or an entity described in paragraph (1).

(3) Any other entity as designated by the department.

(b) “Affiliated pharmacy” means a contract pharmacy that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with a pharmacy benefit manager.

(c) “Claim” means a request for payment for administering, filling, or refilling a drug or for providing a pharmacy service or a medical supply or device to an enrollee or insured.

(d) “Contract pharmacy” means a pharmacy that contracts directly or through a pharmacy services administration organization with a pharmacy benefit manager.

(e) “Department” means the Department of Managed Health Care.

(f) “Director” means the Director of the Department of Managed Health Care.

(g) “Drug” has the same meaning as defined in Section 4025 of the Business and Professions Code.

(h) “Group purchasing organization” means a third party or affiliated person, including an out-of-state or international organization, employed by, contracted with, affiliated with, under common ownership or control by, or otherwise utilized by an entity that provides pharmacy benefit management services or by a pharmacy benefit manager to negotiate, obtain, or otherwise procure rebates from drug manufacturers or wholesalers.

(i) “Health insurer” means an entity licensed to provide health insurance, as defined in Section 106 of the Insurance Code.

(j) “Manufacturer” has the same meaning as defined in Section 4033 of the Business and Professions Code.

(k) “Nonaffiliated pharmacy” means 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 pharmacy benefit manager.

(l) “Passthrough pricing model” means a payment model used by a pharmacy benefit manager in which the payments made by the health care service plan or health insurer client to the pharmacy benefit manager for the covered outpatient drugs are both of the following:

(1) Equivalent to the payments the pharmacy benefit manager makes to a pharmacy or provider for those drugs, including any contracted professional dispensing fee between the pharmacy benefit manager and its network of pharmacies. That dispensing fee would be paid if the health care service plan or health insurer was making the payments directly.

(2) Passed through in their entirety by the health care service plan or health insurer client or by the pharmacy benefit manager to the pharmacy or provider that dispenses the drugs, and the payments are made in a manner that is not offset by any reconciliation.

(m) “Payer” means a health care service plan licensed by the department or a health insurer licensed by the Department of Insurance.

(n) “Person” has the same meaning as defined in Section 4035 of the Business and Professions Code.

(o) “Personal representative” means an individual who has authority to make a health care decision on behalf of another individual pursuant to Division 4.7 (commencing with Section 4600) of the Probate Code.

(p) “Pharmacist” has the same meaning as defined in Section 4036 of the Business and Professions Code.

(q) “Pharmacist services” means products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy.

(r) “Pharmacy” has the same meaning as defined in Section 4037 of the Business and Professions Code.

(s) “Pharmacy benefit management fee” means a flat, defined, dollar-amount fee that covers the cost of providing one or more pharmacy benefit management services and that does not exceed the bona fide value of the itemized service or services actually performed by the pharmacy benefit manager on behalf of the payer, that the payer would otherwise perform or contract for in the absence of the service arrangement, whether or not the payer takes title to the prescription drug. The value of the service or services shall be based on the value to the health insurer or health care service plan. A pharmacy benefit management fee may not directly or indirectly be based on or contingent upon any of the following:

(1) The price of prescription drugs, including direct or indirect rebates, discounts, wholesale acquisition cost, drug benchmark price, such as average wholesale price, or other price concessions.

(2) The amount of savings, rebates, or other fees charged, realized, or collected by, or generated based on the activity of, the pharmacy benefit manager or its affiliated entities, that is retained by the pharmacy benefit manager or its affiliated entities.

(3) The amount of premiums, deductibles, or other cost sharing or fees charged, realized, or collected by the pharmacy benefit manager or its affiliated entities from patients or other persons on behalf of a patient.

(4) Coverage or formulary placement decisions or the volume or value of any referrals or business generated between the parties to the arrangement.

(5) Any other amounts or methodologies as defined by the director.

(t) (1) “Pharmacy benefit manager” means a person, business, or other entity that, either directly or through an intermediary, affiliate, or both, acts as a price negotiator or group purchaser on behalf of a payer, or manages the prescription drug coverage provided by the payer, including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, or controlling the cost of covered prescription drugs.

(2) “Pharmacy benefit manager” includes an entity performing the duties specified in paragraph (1) that is under common ownership with, or control by, a payer.

(3) “Pharmacy benefit manager” does not include any of the following:

(A) An entity providing services pursuant to a contract authorized by Section 4600.2 of the Labor Code.

(B) A fully self-insured employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 (Public Law 93-406), as amended (29 U.S.C. Sec. 1001 et seq.).

(C) A health care service plan licensed pursuant to this chapter or an individual employee of a health care service plan.

(D) A health insurer licensed to provide health insurance, as defined in Section 106 of the Insurance Code, or an individual employee of a health insurer.

(E) A city or county that develops or manages drug coverage programs for uninsured patients for which no reimbursement is received.

(F) An entity exclusively providing services to patients covered by Part 418 (commencing with Section 418.1) of Subchapter B of Chapter IV of Title 42 of the Code of Federal Regulations.

(G) The State Department of Health Care Services, including any contracts between the State Department of Health Care Services and another entity related to the negotiation and collection of drug or medical supply rebates.

(u) “Plan participant” means an individual who is enrolled in health care coverage provided by a payer.

(v) (1) “Rebates” means compensation or remuneration of any kind received or recovered from a pharmaceutical manufacturer by a pharmacy benefit manager, affiliated entity, or subcontractor, including a group purchasing organization, directly or indirectly, regardless of how the compensation or remuneration is categorized, including incentive rebates, credits, market share incentives,

promotional allowances, commissions, educational grants, market share of utilization, drug pullthrough programs, implementation allowances, clinical detailing, rebate submission fees, and administrative or management fees.

(2) “Rebates” also includes fees, including manufacturer administrative fees or corporate fees, that a pharmacy benefit manager, affiliated entity, or subcontractor, including a group purchasing organization, receives from a pharmaceutical manufacturer.

(3) “Rebates” does not include pharmacy purchase discounts and related service fees a pharmacy benefit manager, affiliated entity, or subcontractor receives from pharmaceutical companies that are attributable to or based on the purchase of product to stock, or the dispensing of products from a pharmacy benefit manager’s affiliated mail order and specialty drug pharmacies. “Rebates” does not include a pharmacy benefit management fee.

(w) “Spread pricing” means the model of prescription drug pricing in which a pharmacy benefit manager charges a health care service plan or health insurer a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefit manager directly or indirectly pays the pharmacist or pharmacy.

(x) “Third party” means a person that is not a plan participant or pharmacy benefit manager.

SEC. 4. Section 1385.0011 of the Health and Safety Code is amended to read:

1385.0011. (a) A pharmacy benefit manager shall submit to the department financial statements prepared as of the close of its fiscal year within 120 days after the close of the fiscal year. These financial statements shall be accompanied by a report, certificate, or opinion of an independent certified public accountant or independent public accountant. An audit shall be conducted in accordance with generally accepted auditing standards and the rules and regulations of the director.

(b) Within 45 days after the close of each quarter of its fiscal year, a pharmacy benefit manager shall submit its quarterly unaudited financial statement, prepared in accordance with generally accepted accounting principles and consisting of at least a balance sheet, statement of income, statement of cash flows, statement of changes in equity, and notes to financial statements as of the date and for the period specified by the director. The director may require the submission of these reports on a monthly or other periodic basis.

(c) A pharmacy benefit manager shall make special reports to the director as the director may require.

(d) For good cause and upon written request, the director may extend the time for compliance with subdivisions (a) to (c), inclusive.

(e) If the report, certificate, or opinion of the independent accountant required pursuant to subdivision (a) is qualified, the director may require the pharmacy benefit manager to take action that the director deems appropriate to permit an independent accountant to remove the qualification from the report, certificate, or opinion.

(f) The director may reject a financial statement, report, certificate, or opinion filed pursuant to this section by notifying the pharmacy benefit manager of the rejection and its cause. Within 30 days after the receipt of the notice, the pharmacy benefit manager shall correct the deficiency, and the failure so to do shall be deemed a violation of this chapter. The director shall retain a copy of all rejected filings.

(g) The director may make rules and regulations specifying the form and content of the reports and financial statements required by this section, and may require that these reports and financial statements be verified by the pharmacy benefit manager in a manner as the director may prescribe. Revenue reported by pharmacy benefit managers shall include revenue from manufacturers, payers, and other sources, including from affiliates. Types of revenue reported shall be inclusive of rebates of any type or form. Expenses reported by pharmacy benefit managers shall include payments to pharmacies, claims processing, special programs, administrative costs, and all other expenses. The director may require the reporting of any additional revenue, expenses, or related information that the department requires to assist in determining the overall impact of pharmacy benefit manager business practices on the cost of drugs in this state.

(h) To the extent applicable, the department may direct licensure applicants to use the forms and processes available to and required of health care service plans and other entities reporting financial data created pursuant to this chapter and their implementing regulations, including Section 1384 and the forms and exhibits described in regulations, as amended, implementing that section.

(i) Financial and other records produced, disclosed, or otherwise made available by an organization pursuant to this section shall be received and maintained on a confidential basis and protected from public disclosure as provided in Section 1385.0021.

SEC. 5. Section 1385.0021 of the Health and Safety Code is amended to read:

1385.0021. (a) Notwithstanding the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code), the director is not required to disclose any of the following records, or any portion thereof, that are filed by a pharmacy benefit manager with the director in compliance with the requirements of this article, that have not previously been made public:

(1) Corporate financial records, including trade secrets, the information has been confidentially maintained by the business entity, and the release of the information would be damaging or prejudicial to the business concern.

(2) Any application, including an application for an interpretive opinion, including all records that are submitted with the application that are necessary for purposes of the application.

(3) Any record the disclosure of which is exempt under express provisions of the California Public Records Act, the disclosure of which is exempt or prohibited pursuant to federal or state law, including, but not limited to, provisions of the Evidence Code relating to privilege, or that, on the facts of the particular case, the public interest served by not disclosing the record clearly outweighs the public interest served by disclosure of the record.

(b) Notwithstanding any request for confidentiality of information submitted to and processed by the department consistent with regulations adopted and amended pursuant to this chapter relating to the request for confidentiality of information, the disclosure of records, or any portion thereof, is governed by this section.

(c) Notwithstanding any other provision of this article, the director shall disclose information or records submitted to the director in compliance with this article to the Attorney General, upon request, in order to investigate, prosecute, or defend any legal claim or cause or action related to this article, or to use the reports in any court or proceeding related to this article.

SEC. 6. Section 1385.0022 of the Health and Safety Code is amended to read:

1385.0022. A pharmacy benefit manager has a fiduciary duty to its payer client that includes a duty to be fair and truthful toward the payer, to act in the payer's best interests, to avoid conflicts of interest, and to perform its duties with care, skill, prudence, and diligence. This section does not limit a payer's obligations under applicable law with respect to the administration of health care coverage for plan participants.

SEC. 7. Section 1385.0023 of the Health and Safety Code is amended to read:

1385.0023. (a) The department may conduct periodic routine and nonroutine surveys of a pharmacy benefit manager. These surveys shall be conducted in accordance with Section 1380, as applicable.

(b) The department may conduct periodic routine and nonroutine examinations of the fiscal and administrative affairs of a pharmacy benefit manager. These examinations shall be conducted in accordance with Section 1382, as applicable.

(c) A complaint made by an enrollee that includes potential violations by a pharmacy benefit manager of the terms of this article shall be considered by the department to be a complaint against the health care service plan. A complaint made by an insured that includes potential violations by a pharmacy benefit manager of the terms of this article may be considered by the Department of Insurance to be a complaint against the insurer.

SEC. 8. Section 1385.0026 is added to the Health and Safety Code, to read:

1385.0026. (a) A pharmacy benefit manager shall not impose any requirements, conditions, or exclusions that discriminate against a nonaffiliated pharmacy in connection with dispensing drugs.

(b) Discrimination prohibited pursuant to subdivision (a) includes all of the following:

(1) Terms or conditions applied to nonaffiliated pharmacies based on their status as a nonaffiliated pharmacy.

(2) Refusing to contract with 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.

(3) Retaliation against a nonaffiliated pharmacy based on its exercise of any right or remedy under this article.

(4) Engaging in an unlawful action against a covered entity, including a violation of Section 127471.

(5) Reimbursing a nonaffiliated pharmacy less for a pharmacist service than the pharmacy benefit manager would reimburse an affiliated pharmacy for the same pharmacist service.

(c) This article does not preclude a pharmacy benefit manager or a purchaser of pharmacy benefit manager services from establishing a network of contracting pharmacies.

SEC. 9. Section 1385.0027 is added to the Health and Safety Code, to read:

1385.0027. A pharmacy benefit manager shall not do any of the following:

(a) Require a plan participant to use only an affiliated pharmacy if there are nonaffiliated pharmacies in the network.

(b) Financially induce a plan participant to transfer a prescription only to an affiliated pharmacy if there are nonaffiliated pharmacies in the network.

(c) Require a nonaffiliated pharmacy to transfer a prescription to an affiliated pharmacy if there are nonaffiliated pharmacies in the network. This section does not prevent a purchaser or pharmacy benefit manager from offering to plan participants financial incentives to use a particular pharmacy, such as lower copays, coinsurance, or any other cost sharing for a prescription when the prescription is dispensed.

(d) Unreasonably restrict 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) Communicate to or mislead 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.

(f) Deny a nonaffiliated contract pharmacy the opportunity to participate in a pharmacy benefit manager network as preferred participation status if the pharmacy is willing to accept the same terms and conditions that the pharmacy benefit manager has established for affiliated pharmacies as a condition of preferred network participation status.

SEC. 10. Section 1385.0028 is added to the Health and Safety Code, to read:

1385.0028. (a) A contract issued, amended, or renewed on or after January 1, 2026, between a nonaffiliated pharmacy and a pharmacy benefit manager shall not prohibit the pharmacy from offering either of the following as an ancillary service of the pharmacy:

(1) 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.

(2) The delivery of a prescription to a patient or personal representative by an employee or contractor of the pharmacy.

(b) Except as otherwise provided in a contract described in subdivision (a), the pharmacy shall not charge a pharmacy benefit manager for the delivery service described in subdivision (a). This section 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.

(c) Contracts entered into pursuant to this section shall be open for inspection by the department.

SEC. 11. Section 1385.0029 is added to the Health and Safety Code, to read:

1385.0029. (a) A pharmacy benefit manager shall not derive income from pharmacy benefit management services provided to a payer in this state except for income derived from a pharmacy benefit management fee for pharmacy benefit management services provided. The amount of any pharmacy benefit management fee shall be set forth in the agreement between the pharmacy benefit manager and the payer. The pharmacy benefit manager shall disclose the amount and types of the pharmacy benefit management fees to the payer.

(b) A pharmacy benefit manager shall use a passthrough pricing model.

(c) A pharmacy benefit manager, group purchasing organization, and affiliated entity shall direct 100 percent of all prescription drug manufacturer rebates received to the payer or program, if the contractual arrangement delegates the negotiation of rebates to the pharmacy benefit manager, group purchasing organization, or affiliated entity, for the sole purpose of offsetting defined cost sharing, deductibles, and coinsurance contributions and reducing premiums of plan participants.

(d) (1) This section does not preclude a payer from paying performance bonuses to a pharmacy benefit manager based on savings to the payer that decrease premiums paid by the plan participant or that result in plan participants 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 any of 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 pharmacy benefit manager or its affiliated entities that is retained by the pharmacy benefit manager.

(C) The amount of premiums, deductibles, or other cost sharing or fees charged, realized, or collected by the pharmacy benefit manager or its affiliated entities 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.

(2) Compensation arrangements governed by this section shall be open for inspection by the department.

(e) A pharmacy benefit manager shall not make or permit any reduction of payment for pharmacist services by a pharmacy benefit manager or a payer 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.

(f) A claim or aggregate of claims for pharmacist services shall not be directly or indirectly retroactively denied or reduced after adjudication of the claim or aggregate of claims unless any of the following have occurred:

(1) The original claim was submitted fraudulently.

(2) The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacist services.

(3) The pharmacist services were not properly rendered by the pharmacy or pharmacist.

(g) A pharmacy benefit manager shall not reverse and resubmit the claim of a contract pharmacy under any of the following circumstances:

(1) Without prior written notification to the contract pharmacy.

(2) Without just cause or attempt to first reconcile the claim with the pharmacy.

(3) More than 90 days after the claim was first affirmatively adjudicated.

(h) A pharmacy benefit manager shall not charge a pharmacy or pharmacist a fee to process a claim electronically.

(i) The termination of a contract with a nonaffiliated pharmacy by a pharmacy benefit manager shall not release the pharmacy benefit manager from the obligation to make a payment due to the pharmacy for an affirmatively adjudicated claim unless payments are withheld because of an investigation relating to insurance fraud.

(j) A pharmacy benefit manager shall not retaliate against a pharmacist or pharmacy based on the pharmacist's or pharmacy's exercise of a right or remedy under this chapter. Prohibited retaliation includes any of the following:

(1) Terminating or refusing to renew a contract with the pharmacist or pharmacy.

(2) Subjecting the pharmacist or pharmacy to increased audits without cause.

(3) Failing to promptly pay the pharmacist or pharmacy money owed by the pharmacy benefit manager to the pharmacist or pharmacy.

SEC. 12. Section 1385.0031 is added to the Health and Safety Code, to read:

1385.0031. Commencing January 1, 2026, a pharmacy benefit manager shall not conduct spread pricing in this state. If a preexisting contract between a pharmacy benefit manager and a payer authorizes spread pricing, a subsequent amendment or renewal of that contract shall not contain that authorization. Spread pricing contract terms shall be void on and after January 1, 2029.

SEC. 13. Section 1385.0032 is added to the Health and Safety Code, to read:

1385.0032. (a) Notwithstanding any other law, a pharmacy benefit manager shall not enter into, amend, enforce, or renew a contract on or after January 1, 2026, with manufacturers that do business in California that implement implicit or express exclusivity for those manufacturers' drugs, unless the pharmacy benefit manager can demonstrate the extent to which exclusivity results in the lowest cost to the payer, and the lowest cost sharing for the plan participant.

(b) Notwithstanding any other law, a pharmacy benefit manager shall not enter into, amend, enforce, or renew a contract on or after January 1, 2026, with pharmacies or pharmacy services administration organizations that do business in California that

expressly or implicitly restrict, or impose implicit or express exclusivity on, nonaffiliated pharmacies' ability to contract with employers and payers.

(c) Contracts entered into pursuant to this section shall be open for inspection and audit by the department.

SEC. 14. Section 1385.0033 is added to the Health and Safety Code, to read:

1385.0033. (a) A person that violates this article shall be subject to an injunction and liable for a civil penalty of not less than one thousand dollars ($1,000) or more than seven thousand five hundred dollars ($7,500) for each violation, which shall be assessed and recovered in a civil action brought in the name of the people of the State of California by the Attorney General.

(b) Notwithstanding any other law, the Attorney General shall be entitled to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for enforcement of this article and shall be entitled to recover attorney's fees and costs incurred in remedying each violation.

SEC. 15. Section 1385.0034 is added to the Health and Safety Code, to read:

1385.0034. This article does not apply to a collectively bargained Taft-Hartley self-insured prescription drug plan offered pursuant to the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001 et seq.) or to a pharmacy benefit manager's provision of pharmacy benefit management services pursuant to that Taft-Hartley plan. To the extent a pharmacy benefit manager 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 article shall apply to the pharmacy benefit manager in its performance of pharmacy benefit management services pursuant to those other payers.

SEC. 16. Section 10123.2045 is added to the Insurance Code, immediately following Section 10123.204, to read:

10123.2045. (a) A health insurance policy issued, amended, or renewed on or after January 1, 2026, that provides prescription drug coverage shall not calculate an insured's cost sharing at an amount that exceeds the actual rate paid by the insurer for the prescription drug. Cost sharing shall include deductibles and coinsurance.

(b) To the extent that a health insurance policy with a pharmacy benefit manager issued, amended, or renewed on or after January 1, 2026, includes disclosure of the net price paid by the pharmacy benefit manager or group purchasing organization, then an insured's cost sharing shall not be calculated at an amount that exceeds that net price paid.

(c) (1) Commencing January 1, 2026, if a preexisting contract between a pharmacy benefit manager licensed pursuant to Article 6.1 (commencing with Section 1385.001) of Chapter 2.2 of Division 2 of the Health and Safety Code and a health insurer authorizes spread pricing, as that term is defined by Section 1385.001 of the Health and Safety Code, any subsequent amendment or renewal of that contract shall not authorize spread pricing.

(2) A contract that is executed on or after January 1, 2026, between a pharmacy benefit manager licensed pursuant to Article 6.1 (commencing with Section 1385.001) of Chapter 2.2 of Division 2 of the Health and Safety Code and a health insurer shall not authorize spread pricing, as that term is defined by Section 1385.001 of the Health and Safety Code.

SEC. 17. Section 10125.2 of the Insurance Code is amended to read:

10125.2. (a) A pharmacy benefit manager that contracts with a health insurer shall comply with Article 6.1 (commencing with Section 1385.001) of Chapter 2.2 of Division 2 of the Health and Safety Code, including Sections 1385.004 and 1385.006 of the Health and Safety Code.

(b) A complaint made by an insured that includes potential violations by a pharmacy benefit manager of the terms of Article 6.1 (commencing with Section 1385.001) of Chapter 2.2 of Division 2 of the Health and Safety Code may be considered by the department to be a complaint against the health insurer.

(c) If a health insurer delegates functions to a pharmacy benefit manager, the pharmacy benefits manager shall comply with this code, as applicable. A health insurer shall specify by contract the pharmacy benefits manager's responsibilities and shall monitor the pharmacy benefit manager to ensure compliance with this code. Notwithstanding delegation pursuant to this subdivision, the health insurer shall remain responsible for compliance with this code.

(d) A contract between a health insurer and a pharmacy benefit manager issued, amended, or renewed on or after January 1, 2027, or the date on which the Department of Managed Health Care has established the pharmacy benefit manager licensure process, whichever is later, shall require the pharmacy benefit manager to be licensed and in good standing with the Department of Managed Health Care. A contract term that violates Article 6.1 (commencing with Section 1385.001) of Chapter 2.2 of Division 2 of the Health and Safety Code shall be void on and after January 1, 2029.

(e) The department may issue guidance regarding implementation of, and compliance with, this section and Sections 10125.2, 10123.2045, and 10123.205. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 1340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2030. The department shall consult with stakeholders in developing guidance pursuant to this subdivision.

SEC. 18. The authority of the Attorney General to maintain or restore competitive, fair, and honest markets and prosecute violations of state and federal antitrust, consumer protection, unfair competition, unfair practices, or any other related law shall not be narrowed, abrogated, or otherwise altered by this act.

SEC. 19. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 20. The Legislature finds and declares that Section 5 of this act, which amends Section 1385.0021 of the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to protect the confidentiality of information received by state agencies from pharmacy benefit managers and in order to conform this law with existing confidentiality laws in the state, it is necessary that records are exempted from public disclosure in a manner that is consistent with the California Public Records Act.

SEC. 21. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.