

[Second Reprint]

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, No. 1502

STATE OF NEW JERSEY
222nd LEGISLATURE

ADOPTED MARCH 19, 2026

Sponsored by:

Assemblyman ROY FREIMAN
District 16 (Hunterdon, Mercer, Middlesex and Somerset)
Assemblyman LOUIS D. GREENWALD
District 6 (Burlington and Camden)
Assemblyman GARY S. SCHAER
District 36 (Bergen and Passaic)
Assemblyman DAN HUTCHISON
District 4 (Atlantic, Camden and Gloucester)
Assemblywoman LUANNE M. PETERPAUL
District 11 (Monmouth)
Assemblyman ALEXANDER "AVI" SCHNALL
District 30 (Monmouth and Ocean)
Assemblyman STERLEY S. STANLEY
District 18 (Middlesex)
Assemblywoman HEATHER SIMMONS
District 3 (Cumberland, Gloucester and Salem)

Co-Sponsored by:

Assemblywoman Reynolds-Jackson, Assemblymen Singh, Venezia,
Assemblywoman Quijano, Assemblymen Calabrese, Angelozzi,
Karabinchak, Assemblywoman Park, Assemblyman Sampson,
Assemblywomen Brennan, McCoy, Assemblyman Moen, Assemblywoman
Murphy and Assemblyman Verrelli

SYNOPSIS

Creates "Patient and Provider Protection Act."

CURRENT VERSION OF TEXT

As reported by the Senate Commerce Committee on October 5, 2026, with amendments.

(Sponsorship Updated As Of: 5/18/2026)

1 AN ACT concerning pharmacy benefits managers²**[.]** and²
2 amending ²and supplementing² various parts of the statutory
3 law²**[** and supplementing P.L.2015, c.179 (C.17B:27F-1 et
4 seq.)**]**².

5
6 **BE IT ENACTED** *by the Senate and General Assembly of the State*
7 *of New Jersey:*

8
9 1. (New section) The Legislature finds and declares:

10 a. Pharmacy benefits managers administer prescription drug
11 benefits for health insurers, employers, union health plans, and public
12 programs, and exercise substantial authority over formulary design,
13 rebate negotiations, pharmacy reimbursement, and patient access to
14 medications within the State of New Jersey.

15 b. Pharmacy benefits managers occupy a central position in the
16 prescription drug supply chain, negotiating rebates and discounts with
17 drug manufacturers, determining pharmacy network participation, and
18 influencing the out-of-pocket costs borne by patients.

19 c. The 2024 bipartisan report issued by the U.S. House
20 Committee on Oversight and ²**[Accountability]** Government Reform²
21 entitled ²“The Role of Pharmacy Benefit Managers in Prescription
22 Drug Markets”² found that the largest pharmacy benefits managers
23 control a dominant share of prescription drug claims, are frequently
24 vertically integrated with major insurers and affiliated pharmacies, and
25 derive significant revenue from manufacturer-paid rebates and price
26 concessions tied to formulary placement and list prices.

27 d. The Federal Trade Commission, in its first interim report
28 ²“Pharmacy Benefit Managers: The Powerful Middlemen Inflating
29 Drug Costs and Squeezing Main Street Pharmacies,”² released in
30 2024, found that pharmacy benefits managers exercise significant
31 market power, operate through opaque rebate and spread pricing
32 arrangements, and may reimburse independent pharmacies at rates that
33 threaten their viability while charging plans higher amounts.

34 e. In the Federal Trade Commission’s second interim report,
35 released in 2025 and entitled ²“Specialty Generic Drugs: A Growing
36 Profit Center for Vertically Integrated Pharmacy Benefit Managers,”²
37 the commission found that vertically integrated pharmacy benefits
38 managers may generate substantial profits through affiliated specialty
39 pharmacies, including markups on specialty generic drugs, creating
40 financial incentives to steer patients internally and maximize margin
41 rather than minimize net cost.

42 f. The Federal Trade Commission documented that pharmacy
43 steering, restrictive network design, differential cost-sharing, and

EXPLANATION – Matter enclosed in bold-faced brackets **[thus]** in the above bill is
not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹Assembly AAP committee amendments adopted May 14, 2026.

²Senate SCM committee amendments adopted October 5, 2026.

1 internal transfer pricing arrangements may reduce patient choice,
2 disadvantage independent and community pharmacies, and create
3 conflicts of interest inconsistent with fiduciary standards.

4 g. Pharmacy benefits managers frequently receive compensation
5 calculated as a percentage of a drug's list price, rebate amount,
6 wholesale acquisition cost, or utilization volume, thereby linking
7 pharmacy benefits manager revenue directly to higher list prices and
8 larger rebates^{2, 2}.

9 h. Compensation structures tied to rebates, discounts, list prices,
10 or affiliated pharmacy margins create inherent conflicts of interest and
11 may incentivize pharmacy benefits managers to favor higher-cost
12 drugs or preferred internal dispensing channels over lower-cost or
13 clinically appropriate alternatives^{2, 2}.

14 i. An article published in the Oxford Health Affairs Scholar,
15 entitled ^{2, 2}"The cost of misaligned incentives in the pharmaceutical
16 supply chain,"^{2, 2} discusses how research conducted by the University
17 of Southern California's Schaeffer Center for Health Policy &
18 Economics estimates that delinking pharmacy benefits manager and
19 other supply chain compensation from drug list prices and rebate-
20 based incentives could reduce national prescription drug spending by
21 approximately \$95.4 billion annually, or nearly 15 percent of net
22 spending, without undermining pharmaceutical innovation.

23 j. That research further concludes that fixed, transparent
24 administrative fee models would eliminate incentives tied to list-price
25 inflation and rebate magnitude, align pharmacy benefits manager
26 incentives with lowest net cost objectives, and generate substantial
27 savings for employers, public programs, and patients.

28 k. Congress enacted comprehensive pharmacy benefits manager
29 reforms under the bipartisan "Consolidated Appropriations Act, 2026,"
30 Pub. L. No. 119-75, to address compensation distortions, transparency
31 deficiencies, and conflicts of interest in federal prescription drug
32 programs.

33 l. The "Consolidated Appropriations Act, 2026" established a
34 "bona fide service fee" model for Medicare prescription drug
35 coverage, requiring pharmacy benefits manager compensation to
36 consist solely of flat, fair-market-value administrative fees not
37 contingent on list price, rebate value, utilization, or formulary
38 placement, and requiring 100 percent pass-through of manufacturer
39 rebates and price concessions.

40 m. The "Consolidated Appropriations Act, 2026" also
41 strengthened transparency requirements, enhanced audit rights for plan
42 sponsors, and reinforced "any willing pharmacy" protections to
43 prevent discriminatory pharmacy steering and preserve access to
44 community and rural pharmacies.

45 n. The bipartisan congressional reforms under the "Consolidated
46 Appropriations Act, 2026" reflect a national consensus that pharmacy
47 benefits manager compensation must be structurally delinked from

1 rebates and price inflation, must be transparent and auditable, and must
2 not reward spread pricing or conflicted pharmacy steering practices.

3 o. Pharmacy benefits managers owe a financial responsibility to
4 clients, including employers; insurers; union plans; and public
5 programs, to act in the best interests of plan participants and
6 beneficiaries.

7 p. Aligning pharmacy benefits manager revenue with rebate
8 magnitude, list price inflation, or affiliated pharmacy profit centers
9 may materially conflict with those fiduciary obligations.

10 q. There exists a compelling State interest in ensuring that
11 pharmacy benefits manager compensation is transparent, delinked
12 from rebate and discount volume, free from conflicts of interest,
13 protective of pharmacy access, and structured to reduce prescription
14 drug costs for New Jersey residents.

15
16 2. Section 1 of P.L.2015, c.179 (C.17B:27F-1) is amended to read
17 as follows:

18 1. As used in P.L.2015, c.179 (C.17B:27F-1 et seq.):

19 ²“Affiliated pharmacy” means a contract pharmacy that directly, or
20 indirectly through one or more intermediaries, controls, is controlled
21 by, or is under common control with a pharmacy benefit manager.²

22 "Anticipated loss ratio" means the ratio of the present value of the
23 future benefits payments, including claim offsets after the point of
24 sale, to the present value of the future premiums of a policy form over
25 the entire period for which rates are computed to provide health
26 insurance coverage.

27 "Average wholesale price" means the average wholesale price of a
28 prescription drug determined by a national drug pricing publisher
29 selected by a carrier. The average wholesale price shall be identified
30 using the national drug code published by the National Drug Code
31 Directory within the United States Food and Drug Administration.

32 "Brand-name drug" means a prescription drug marketed under a
33 proprietary name or registered trademark name, including a biological
34 product.

35 "Carrier" means an insurance company, health service corporation,
36 hospital service corporation, medical service corporation, or health
37 maintenance organization authorized to issue health benefits plans in
38 this State.

39 "Contracted pharmacy" means a pharmacy that participates in the
40 network of a pharmacy benefits manager through a contract with² [

41 a.]² the pharmacy benefits manager directly² [

42 b.] or an intermediary, including but not limited to,² a pharmacy
43 services administration organization; or

44 ²[c.]² a pharmacy group purchasing organization², including
45 rebate aggregators².

1 "Cost-sharing amount" means the amount paid by a covered person
2 as required under the covered person's health benefits plan for a
3 prescription drug at the point of sale.

4 "Covered person" means a person on whose behalf a carrier or
5 other entity, who is the sponsor of the health benefits plan, is obligated
6 to pay benefits pursuant to a health benefits plan.

7 "Department" means the Department of Banking and Insurance.

8 "Drug" means a drug or device as defined in R.S.24:1-1.

9 "Health benefits plan" means a benefits plan which pays hospital
10 or medical expense benefits for covered services, or prescription drug
11 benefits for covered services, and is delivered or issued for delivery in
12 this State by or through a carrier or any other sponsor. For the
13 purposes of P.L.2015, c.179 (C.17B:27F-1), health benefits plan shall
14 not include the following plans, policies or contracts: accident only,
15 credit disability, long-term care, Medicare supplement coverage;
16 TRICARE supplement coverage, coverage for Medicare services
17 pursuant to a contract with the United States government, the State
18 Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1
19 et seq.), coverage arising out of a worker's compensation or similar
20 law, the State Health Benefits Program, the School Employees' Health
21 Benefits Program, or **■**a self-insured health benefits plan governed by
22 the provisions of the federal "Employee Retirement Income Security
23 Act of 1974," 29 U.S.C. s.1001 et seq., **■**²a self-insured health benefits
24 plan governed by the provisions of the federal "Employee Retirement
25 Income Security Act of 1974," 29 U.S.C. s.1001 et seq.,² coverage
26 under a policy of private passenger automobile insurance issued
27 pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), or hospital
28 confinement indemnity coverage. ²**■**For the purposes of P.L. , c.
29 (C.) (pending before the Legislature as this bill), "health benefits
30 plan" shall include the State Medicaid program established pursuant to
31 P.L.1968, c.413 (C.30:4D-1 et seq.), the State Health Benefits
32 Program, and the School Employees' Health Benefits Program.]

33 "Manufacturer" means an entity that creates, makes, or produces
34 drugs by compounding, growing, or other process. This definition shall
35 apply to persons engaged in the drug manufacturing business who do
36 not maintain a manufacturing location in this State. "Manufacturer"
37 shall not apply to licensed pharmacies or to licensed professional
38 individuals such as, but not limited to, pharmacists, physicians,
39 dentists, or veterinarians when engaged in the lawful pursuit of their
40 professions.²

41 "Maximum allowable cost" means the maximum amount a health
42 insurer will pay for a generic drug or brand-name drug that has at least
43 one generic alternative available.

44 "Network pharmacy" means a licensed retail pharmacy or other
45 pharmacy provider that contracts with a pharmacy benefits manager
46 either directly or by and through ²**■**a contract with **■** an intermediary,

1 including but not limited to,² a pharmacy services administrative
2 organization.

3 "Pharmacy" means any place in the State, either physical or
4 electronic, where drugs are dispensed or pharmaceutical care is
5 provided by a licensed pharmacist, but shall not include a medical
6 office under the control of a licensed physician.

7 "Pharmacy benefits manager" means a corporation, business, or
8 other entity, or unit within a corporation, business, or other entity, that,
9 pursuant to a contract or under an employment relationship with a
10 carrier, a self-insurance plan or other third-party payer, either directly
11 or through an intermediary, administers prescription drug benefits on
12 behalf of a purchaser.

13 "Pharmacy benefits manager **[compensation]** ²**[fee]**
14 compensation²" means **[the difference between: (1) the amount of**
15 **payments made by a carrier of a health benefits plan to its pharmacy**
16 **benefits manager; and (2) the value of payments made by the**
17 **pharmacy benefits manager to dispensing pharmacists for the**
18 **provision of prescription drugs or pharmacy services with regard to**
19 **pharmacy benefits covered by the health benefits plan]** ²**[a payment**
20 **that covers the cost of providing one or more pharmacy benefits**
21 **management services and does not exceed the value of the service or**
22 **services actually performed by the pharmacy benefits manager]** the
23 difference between: (1) the amount of payments made by a carrier of a
24 health benefits plan to its pharmacy benefits manager; and (2) the
25 value of payments made by the pharmacy benefits manager to
26 dispensing pharmacists for the provision of prescription drugs or
27 pharmacy services with regard to pharmacy benefits covered by the
28 health benefits plan².

29 "Pharmacy benefits management services" means **[the provision of**
30 **any of the following services on behalf of a purchaser: the**
31 **procurement of prescription drugs at a negotiated rate for dispensation**
32 **within this State; the processing of prescription drug claims; or the**
33 **administration of payments related to prescription drug claims]**;

34 (1) negotiating the price of prescription drugs, including
35 negotiating and contracting for direct or indirect rebates, discounts, or
36 other price concessions;

37 (2) managing any aspects of a prescription drug benefit, including
38 but not limited to, the processing and payment of claims for
39 prescription drugs, the performance of utilization review, the
40 processing of drug prior authorization requests, the adjudication of
41 appeals or grievances related to the prescription drug benefit,
42 contracting with network pharmacies, controlling the cost of covered
43 prescription drugs, managing data relating to the prescription drug
44 benefit, or the provision of services related thereto;

45 (3) performing any administrative, managerial, clinical, pricing,
46 financial, reimbursement, data administration or reporting, or billing
47 service; and

1 (4) any other services as the department may define pursuant to
2 rule or regulation.

3 "Pharmacy services administrative organization" means an entity
4 operating within the State that contracts with independent pharmacies
5 to conduct business on their behalf with third-party payers.

6 "Prescription" means a prescription as defined in section 5 of
7 P.L.1977, c.240 (C.24:6E-4).

8 "Prescription drug benefits" means the benefits provided for
9 prescription drugs and pharmacy services for covered services under a
10 health benefits plan contract.

11 "Purchaser" means any sponsor of a health benefits plan who
12 enters into an agreement with a pharmacy benefits management
13 company for the provision of pharmacy benefits management services
14 to covered persons.

15 ²"Rebate aggregator" means a person or entity that provides
16 formulary management and formulary rebate administrative
17 services, or aggregates prescription drug utilization volume and
18 distributes rebates to pharmacy benefit managers, or both.

19 "Spread pricing" means the model of prescription drug pricing
20 in which the pharmacy benefits manager or an affiliated
21 intermediary, including a rebate aggregator, charges a health
22 benefits plan, carrier, or purchaser a contracted price for
23 prescription drugs, and the contracted price for the prescription
24 drugs differs from the amount the pharmacy benefits manager
25 directly or indirectly pays the pharmacist or pharmacy.²

26 (cf: P.L.2023, c.107, s.1)

27
28 ²3. Section 2 of P.L.2015, c.179 (C.17B:27F-2) is amended to read
29 as follows:

30 2. a. Upon execution or renewal of each contract, or at such a
31 time when there is any material change in the term of the contract, a
32 pharmacy benefits manager shall, with respect to contracts between a
33 pharmacy benefits manager and a pharmacy services administrative
34 organization, or between a pharmacy benefits manager and a
35 contracted pharmacy:

36 **【a.】** (1) include in the contract the sources utilized to determine
37 multiple source generic drug pricing, brand drug pricing, and the
38 wholesaler in the State of New Jersey where pharmacies may acquire
39 the product, including, but not limited to, the brand effective rate,
40 generic effective rate, dispensing fee effective rate, maximum
41 allowable cost or any other pricing formula for pharmacy
42 reimbursement;

43 (2) update that pricing information every seven calendar days;
44 **【and】**

45 (3) establish a reasonable process by which contracted pharmacies
46 have a method to access relevant maximum allowable cost pricing
47 lists, brand effective rate, generic effective rate, and dispensing fee

1 effective rate, or any other pricing formulas for pharmacy
2 reimbursement; and

3 (4) provide a reasonable administrative appeal procedure,
4 including a right to appeal in accordance with section 4 of P.L.2015,
5 c.179 (C.17B:27F-4), to allow pharmacies with which the carrier or
6 pharmacy benefits manager has a contract to challenge maximum
7 allowable costs for a specified drug.

8 b. **【Additionally, a pharmacy benefits manager shall:】** Upon
9 execution or renewal of each contract, or at such a time when there is
10 any material change in the term of the contract, a pharmacy benefits
11 manager shall, with respect to contracts between a pharmacy benefits
12 manager and a carrier:

13 (1) maintain a procedure to eliminate drugs from the list of drugs
14 subject to multiple source generic drug pricing and brand drug pricing,
15 or modify maximum allowable cost rates, brand effective rate, generic
16 effective rate, dispensing fee effective rate or any other applicable
17 pricing formula in a timely fashion and make that procedure easily
18 accessible to the pharmacy services administrative organizations or the
19 pharmacies that they are contractually obligated with to provide that
20 information according to the requirements of this section; and

21 (2) provide an internal appeal mechanism to resolve any dispute
22 raised by a carrier **【or pharmacy】**, regardless of whether the carrier
23 **【or】** and pharmacy benefits manager has a contract to challenge
24 maximum allowable costs for a specified drug. Any dispute regarding
25 the determination of an internal appeal conducted pursuant to this
26 subsection concerning reimbursements may be referred to binding
27 arbitration. The Commissioner of Banking and Insurance shall
28 contract with a nationally recognized, independent organization that
29 specializes in arbitration to conduct the arbitration proceedings.

30 c. The binding arbitration shall adhere to the following
31 requirements:

32 (1) the party requesting arbitration shall notify the other party that
33 arbitration has been initiated and state its final offer before arbitration;

34 (2) arbitration shall be initiated by filing a request with the
35 department;

36 (3) the arbitration shall consist of a review of the written
37 submissions by both parties, which shall include the final offer for the
38 payment; and

39 (4) the arbitrator's decision shall be one of the two amounts
40 submitted by the parties as their final offers and shall be binding on
41 both parties. The decision of the arbitrator shall include detailed
42 written findings and shall be issued within 30 days after the request is
43 filed with the department. The detailed written findings shall be an
44 analysis of the decision including, but not limited to, information
45 concerning any databases, previous awards, or other documentation or
46 arguments that contributed to the arbitrator's decision. The arbitrator's
47 expenses and fees shall be split equally among the parties except in
48 situations in which the arbitrator determines that the payment made by

1 the pharmacy benefits manager was not made in good faith, in which
2 case the pharmacy benefits manager shall be responsible for all the
3 arbitrator's expenses and fees. Each party shall be responsible for its
4 own costs and fees, including legal fees if any.

5 d. (1) The department may adopt rules and regulations governing
6 the arbitration process, including setting minimum qualifications and
7 conflict standards for arbitrators; establishing arbitration fees and
8 minimum dispute thresholds for arbitration; and prohibiting bundling
9 multiple disputes to meet such thresholds.

10 (2) Arbitration outcomes shall be reported to the department.

11 e. Nothing in this section shall be construed to diminish the
12 department's oversight or authority over licensed pharmacy benefits
13 managers.²

14 (cf: P.L.2023, c.107, s.4)

15
16 ²4. Section 3 of P.L.2023, c.107 (C.17B:27F-3.1) is amended to
17 read as follows:

18 3. a. A carrier shall:

19 (1) monitor all activities carried out on behalf of the carrier by a
20 pharmacy benefits manager if the carrier contracts with a pharmacy
21 benefits manager and is related to a carrier's prescription drug benefits;
22 and

23 (2) ensure that all requirements of this section are met.

24 b. A carrier that contracts with a pharmacy benefits manager to
25 perform any activities related to the carrier's prescription drug benefits
26 shall ensure that, under the contract, the pharmacy benefits manager
27 acts as the carrier's agent in **【good faith and fair dealing in】** the
28 performance of all of its contractual duties. All funds received by the
29 pharmacy benefits manager in relation to providing pharmacy benefits
30 management services shall be used or distributed only pursuant to the
31 pharmacy benefits manager's contract with the health benefits plan or
32 carrier or applicable law; including any administrative fee or payment
33 to the pharmacy benefits manager expressly provided for in the
34 contract to compensate the pharmacy benefits manager for its services.
35 **【Any funds received by the pharmacy benefits manager through**
36 **spread pricing shall be subject to this subsection.】**

37 c. (1) A pharmacy benefits manager interacting with a covered
38 person shall have **【the same duty to】** a duty of good faith and fair
39 dealing with the covered person **【as the health benefits plan or carrier**
40 **for whom it is】** in performing pharmacy benefits management
41 services.

42 (2) A pharmacy benefits manager shall have a **【duty of good faith**
43 **and fair dealing with all parties, including but not limited to covered**
44 **persons and pharmacies, with whom it interacts in the performance of**
45 **pharmacy benefits management services】** fiduciary duty to act in the
46 best interests of a carrier with which it contracts to allow that carrier to

1 design plans in a manner that reduces premiums and out-of-pocket
2 costs paid by covered persons.

3 (3) A pharmacy benefits manager shall not engage in any
4 marketing activity that uses inaccurate or misleading information to
5 convince or attempt to convince covered persons to use a contracted or
6 network pharmacy.

7 d. A carrier or pharmacy benefits manager shall not require a
8 covered person to make a payment at the point of sale for a covered
9 prescription drug in an amount greater than the lesser of:

10 (1) the applicable cost-sharing amount for the prescription drug; or

11 (2) the amount a covered person would pay for the prescription
12 medication if the covered person purchased the prescription
13 medication without using a health benefits plan.

14 e. A carrier shall provide a reasonably adequate retail pharmacy
15 network for the provision of prescription drugs for its covered persons.

16 f. For the purposes of this section, "health benefits plan" shall
17 include the State Health Benefits Plan, the School Employees' Health
18 Benefits Plan, the State Medicaid program established pursuant to
19 P.L.1968, c.413 (C.30:4D-1 et seq.), or a self-insured health benefits
20 plan governed by the provisions of the federal "Employee Retirement
21 Income Security Act of 1974," 29 U.S.C., ss.1001 et seq.²

22 (cf: P.L.2023, c.107, s.3)

23
24 ²**[3.] 5.**² Section 7 of P.L.2023, c.107 (C.17B:27F-3.3) is
25 amended to read as follows:

26 7. a. A carrier, or a pharmacy benefits manager under contract
27 with a carrier, shall establish a pharmacy and therapeutics committee
28 responsible for managing the formulary system.

29 b. A carrier, or a pharmacy benefits manager under contract with
30 a carrier, shall not allow a person with a conflict of interest to be a
31 member of its pharmacy and therapeutics committee.

32 A carrier, or a pharmacy benefits manager under contract with a
33 carrier, shall require that its pharmacy and therapeutics committee
34 meet the requirements for conflict of interest as set by the Centers for
35 Medicare and Medicaid Services or meets the accreditation standards
36 of the National Committee for Quality Assurance or another
37 independent accrediting organization.

38 c. ²**[A pharmacy benefits manager shall not provide**
39 recommendation, advice, or counsel to a plan sponsor or carrier
40 concerning the inclusion of a prescription drug in a formulary system,
41 or in a particular tier of the formulary system, that places a
42 prescription drug with a higher cost to the patient, including but not
43 limited to coinsurance, copayments, deductibles, and other cost-
44 sharing, in a more favorable position than a generic or biosimilar
45 prescription drug with a lower cost, if the recommendation, advice, or
46 counsel is based solely on the cost of the prescription drug and not on
47 another factor.

1 d. The provisions of this section shall apply to contracts between
2 a pharmacy benefits manager and the State Health Benefits Program or
3 School Employees' Health Benefits Program.】 A pharmacy and
4 therapeutics committee shall ensure that no decision concerning the
5 inclusion of a prescription drug in a formulary system, or in a
6 particular tier of the formulary system, places a prescription drug with
7 a higher cost in a more favorable position than a generic or biosimilar
8 prescription drug with a lower cost.²

9 (cf: P.L.2023, c.107, s.7)

10
11 ²**【4.】** 6.² Section 9 of P.L.2023, c.107 (C.17B:27F-3.4) is
12 amended to read as follows:

13 9. a. If a carrier uses a pharmacy benefits manager to administer
14 or manage the prescription drug benefits of covered persons, any
15 pharmacy benefits manager **【compensation】** fee, for purposes of
16 calculating a carrier's anticipated loss ratio or any loss ratio calculated
17 as part of any applicable medical loss ratio filing or rate filing, shall:

18 (1) constitute an administrative cost incurred by the carrier in
19 connection with a health benefits plan; and

20 (2) not constitute a benefit provided under a health benefits plan.
21 A carrier shall claim only the amounts paid by the pharmacy benefits
22 manager to a pharmacy or pharmacist as an incurred claim.

23 b. Any rate filing submitted by a carrier with respect to a health
24 benefits plan that provides coverage for prescription drugs or
25 pharmacy services and that is administered or managed by a pharmacy
26 benefits manager shall include:

27 (1) a memorandum prepared by a qualified actuary describing the
28 calculation of the pharmacy benefits manager **【compensation】** fee; and

29 (2) any records and supporting information as the department
30 reasonably determines is necessary to confirm the calculation of the
31 pharmacy benefits manager **【compensation】** fee.

32 c. Upon request, a carrier shall provide any records to the
33 department that relate to the calculation of the pharmacy benefits
34 manager and pharmacy services administrative organization
35 **【compensation】** fee.

36 d. A pharmacy benefits manager and pharmacy services
37 administrative organization shall provide any necessary documentation
38 requested by a carrier that relates to pharmacy benefits manager
39 **【compensation】** fees in order to comply with the requirements of this
40 section.

41 e. No pharmacy benefit manager may derive income from
42 pharmacy benefits services provided to a carrier or health benefits plan
43 in this State except for income derived from a pharmacy benefits
44 manager fee. The amount of any pharmacy benefits manager fees
45 shall be set forth in the agreement between the pharmacy benefits
46 manager and the carrier or health benefits plan.

1 f. The pharmacy benefits manager fee charged or paid to a
2 pharmacy benefits manager from a carrier or health benefits plan shall
3 not be directly or indirectly based or contingent upon:

4 (1) the acquisition cost or any other price metric of a drug;

5 (2) the amount of savings, rebates, or other fees charged, realized,
6 or collected by or generated based on the activity of the pharmacy
7 benefits manager; or

8 (3) the amount of premiums, deductibles, or other cost sharing or
9 fees charged, realized, or collected by the pharmacy benefits manager
10 from patients or other persons on behalf of a patient.

11 g. Upon request by the department or a purchaser, a pharmacy
12 benefits manager shall disclose to the department or purchaser the
13 amount of any fees paid by the pharmacy benefits manager to a third
14 party broker.

15 h. Subsections e. and f. of this section shall also apply to a
16 contract between a pharmacy benefits manager and the State Health
17 Benefits Program ²[or] ² the School Employees' Health Benefits
18 Program², or the State Medicaid program established pursuant to
19 P.L.1968, c.413 (C.30:4D-1 et seq.)².

20 i. Each pharmacy benefits manager authorized to operate in this
21 State pursuant to P.L.2015, c.179 (C.17B:27F-1 et seq.) shall certify to
22 the commissioner, by December 31st of each year, that the pharmacy
23 benefits manager has fully and completely complied with the
24 requirements of this section during the prior calendar year. Each
25 certification submitted pursuant to this subsection shall be signed by
26 the chief executive officer or chief financial officer of the pharmacy
27 benefits manager.

28 ²j. As used in this section, "pharmacy benefits manager fee"
29 means a payment that covers the cost of providing one or more
30 pharmacy benefits management services and shall not exceed the
31 bona fide value of the itemized service or services actually
32 performed by the pharmacy benefits manager on behalf of the
33 carrier or health benefits plan that the carrier or health benefits plan
34 would otherwise perform or contract for in the absence of the
35 service arrangement, whether or not the carrier or health benefits
36 plan takes title to the prescription drug. The value of the service or
37 services shall be based on the value to the carrier or health benefits
38 plan.²

39 (cf: P.L.2023, c.107, s.9)

40
41 ²5.a. A pharmacy benefits manager shall have a fiduciary duty
42 to act in the best interests of a carrier with which it contracts. A
43 pharmacy benefits manager shall also, in connection with a
44 contract, have a fiduciary duty to act in the best interests of the
45 State Health Benefits Program ¹[and] ¹ School Employees' Health
46 Benefits Program¹, and State Medicaid program¹. Nothing in this
47 subsection shall be construed as creating, establishing, or

1 authorizing a private cause of action by an aggrieved subscriber,
2 enrollee, or covered person against a pharmacy benefits manager
3 who has violated, or is alleged to have violated, the provisions of
4 this subsection.

5 b. A pharmacy benefits manager shall not engage in any
6 marketing activity that uses inaccurate or misleading information to
7 convince or attempt to convince covered persons to use a contracted
8 or network pharmacy.²

9
10 ²[6.(New section) An agreement between a pharmacy benefits
11 manager and a manufacturer shall not be valid if the contract
12 conditions any rebate on the exclusion of generic drugs from
13 coverage.]²

14
15 ²[7. (New section) a. A contract between a pharmacy
16 benefits manager and a contracted pharmacy or network pharmacy
17 shall, in the event of a dispute, be presumed to be a “contract of
18 adhesion.”

19 b. ¹(1)¹ A pharmacy benefits manager shall, for a prescription
20 drug, reimburse ¹pharmacies at¹ the State fee-for-service benchmark
21 of the National Average Drug Acquisition Cost (NADAC) plus the
22 prevailing State defined Medicaid professional dispensing fee. ¹[If
23 the NADAC is not established for a specific national drug code, the
24 ingredient reimbursement rate shall default to the Wholesale Average
25 Cost (WAC), or the Suggested Wholesale Price (SWP). The
26 provisions of this subsection shall not apply to a pharmacy in which
27 the]

28 (2) If a¹ pharmacy benefits manager or its affiliate maintains an
29 ownership interest or control ¹of a pharmacy, the pharmacy benefits
30 manager shall reimburse the pharmacy, for a prescription drug, at the
31 State fee-for-service benchmark of the NADAC.

32 (3) Pursuant to paragraphs (1) and (2) of this subsection, if the
33 NADAC is not established for a specific national drug code, the
34 ingredient reimbursement rate shall default to the Wholesale Average
35 Cost (WAC) or the Suggested Wholesale Price (SWP)¹.

36 c. A pharmacy benefits manager shall not engage in differential
37 payment pricing, including differential payment pricing based on
38 ownership or affiliation.

39 d. A pharmacy benefits manager shall not deny a pharmacy or
40 pharmacist the right to participate as a contract pharmacy under a
41 policy or plan if the pharmacy or pharmacist agrees to the terms and
42 conditions established for participation in the network of the carrier,
43 pharmacy benefits manager, health plan, or other administrator.

44 e. A pharmacy benefits manager shall not:

45 (1) require a covered person to use a pharmacy, including a mail-
46 order or specialty pharmacy, in which the pharmacy benefits manager
47 or its affiliate maintains an ownership interest or control; or

1 (2) offer or implement a plan design that encourages a covered
2 person to use a pharmacy, including a mail-order or specialty
3 pharmacy, in which the pharmacy benefits manager or an affiliate
4 maintains an ownership interest or control.

5 ¹f. The provisions of subsections d. and e. of this section shall not
6 apply to a self-insured health benefits plan governed by the provisions
7 of the federal “Employee Retirement Income Security Act of 1974,”
8 29 U.S.C. s.1001 et seq.¹²

9
10 ²[8. This act shall take effect on the first day of the seventh
11 month next following the date of enactment and shall apply to
12 contracts and agreements entered into, renewed, modified, or
13 amended on or after the effective date, but the Commissioner of
14 Banking and Insurance may take such anticipatory administrative
15 action in advance thereof as shall be necessary for the
16 implementation of the act.]²

17
18 ²7. Section 4 of P.L.2015, c.179 (C.17B:27F-4) is amended to
19 read as follows:

20 4. All contracts between a pharmacy benefits manager and
21 intermediaries, including a rebate aggregator, and a pharmacy
22 services administrative organization, or its contracted pharmacies,
23 and all contracts directly between a pharmacy benefits manager and
24 a pharmacy shall include a process to appeal, investigate, and
25 resolve disputes regarding brand and multiple source generic drug
26 pricing, including, if applicable, brand effective rate, generic
27 effective rate, dispensing fee effective rate, and any other pricing
28 formula for pharmacy reimbursement. The contract provision
29 establishing the process shall include the following:

30 a. The right to appeal shall be limited to 14 calendar days
31 following the initial claim;

32 b. The appeal shall be investigated and resolved by the
33 pharmacy benefits manager through an internal process within 14
34 calendar days of receipt of the appeal by the pharmacy benefits
35 manager;

36 c. A telephone number at which a pharmacy services
37 administrative organization, or a pharmacy may contact the
38 pharmacy benefits manager and speak with an individual who is
39 involved in the appeals process; and

40 d. (1) If the appeal is denied, the pharmacy benefits manager
41 shall:

42 (a) provide the reason for the denial to the pharmacy services
43 administrative organization and its contracted pharmacies, and the
44 pharmacy services administrative organization shall inform its
45 contracted pharmacies of the availability, location and pricing of the
46 appealed drug in the State;

1 (b) provide the reason for the denial directly to a pharmacy, if it
2 contracts directly with a pharmacy benefits manager;

3 (c) identify the national drug code of a drug product that is
4 available for purchase by the specific contracted pharmacy
5 appealing the claim in this State from wholesalers registered
6 pursuant to P.L.1961, c.52 (C.24:6B-1 et seq.) at a price which is
7 available to the specific contracted pharmacy appealing the claim
8 and which is equal to or less than the maximum allowable cost or
9 the brand effective rate, generic effective rate or other pricing for
10 the appealed drug as determined by the pharmacy benefits manager;
11 and

12 (d) provide the name of wholesalers registered under P.L.1961,
13 c.52 (C.24:6B-1 et seq.) from which the appealing pharmacy can
14 obtain the brand or multiple source generic drug at or below the
15 brand effective rate, generic effective rate, dispensing fee effective
16 rate, maximum allowable cost or any other pricing formula for
17 pharmacy reimbursement;

18 (2) If the appeal is approved, the pharmacy benefits manager
19 shall make the price correction, permit the reporting pharmacy to
20 reverse and rebill the appealed claim, and make the price correction
21 effective for all similarly situated pharmacies from the date of the
22 approved appeal.

23 e. A pharmacy benefits manager shall not terminate a
24 pharmacy licensed in the State of New Jersey solely on the basis
25 that the pharmacy offers and provides store direct delivery and mail
26 prescriptions to an insured as an ancillary service.

27 f. Any dispute regarding the determination of an appeal
28 conducted pursuant to this section may be referred to binding
29 arbitration conducted in a manner consistent with the provisions of
30 subsection b. of section 2 of P.L.2015, c.179 (C.17B:27F-2). The
31 Commissioner of Banking and Insurance shall contract with a
32 nationally recognized, independent organization that specializes in
33 arbitration to conduct the arbitration proceedings.²

34 (cf: P.L.2019, c.274, s.4)

35
36 ²8. Section 1 of P.L.2019, c.257 (C.17B:27F-6) is amended to
37 read as follows:

38 1. a. A pharmacy benefits manager, in connection with any
39 contract or arrangement with a private health insurer, prescription
40 benefit plan, or the State Health Benefits Program or School
41 Employees' Health Benefits Program, shall not require a covered
42 person to make a payment at the point of sale for any amount for a
43 deductible, coinsurance payment, or a copayment for a prescription
44 drug benefit in an amount that exceeds the amount permitted
45 pursuant to subsection d. of section 3 of P.L.2023, c.107
46 (C.17B:27F-3.1).

- 1 b. A pharmacy benefits manager shall not prohibit a network
2 pharmacy from, and shall not apply a penalty or any other type of
3 disincentive to a network pharmacy for:
- 4 (1) disclosing to a covered person lower cost prescription drug
5 options, including those that are available to the covered person if
6 the covered person purchases the prescription drug without using
7 health insurance coverage;
- 8 (2) providing a covered person with the option of paying the
9 pharmacy provider's cash price for the purchase of a prescription
10 drug and not filing a claim with the covered person's health benefits
11 plan if the cash price is less than the covered person's cost-sharing
12 amount;
- 13 (3) providing information to a State or federal agency, law
14 enforcement agency, or the department when such information is
15 required by law; or
- 16 (4) applying a discounted price generated by a healthcare
17 platform, as defined pursuant to section 2 of P.L.2003, c.280
18 (C.45:14-41), to the payment of a covered person with an account
19 or membership to the healthcare platform for a prescription drug,
20 even if the covered person maintains health insurance coverage.
- 21 c. A pharmacy benefits manager, in connection with any
22 contract or arrangement with a carrier, health benefits plan, or
23 prescription benefit plan, shall not:
- 24 (1) transfer or share records relative to prescription information
25 containing patient-identifiable or prescriber-identifiable data to an
26 affiliated pharmacy for any commercial purpose; provided,
27 however, that nothing in this paragraph shall be construed to
28 prohibit the exchange of prescription information between a
29 pharmacy benefits manager and an affiliated pharmacy for the
30 limited purposes of providing or administering pharmaceutical
31 benefit services for a covered person, providing pharmacy
32 reimbursement, engaging in formulary compliance, or conducting
33 permitted utilization review;
- 34 (2) knowingly make a misrepresentation to a covered person,
35 pharmacist, or pharmacy;
- 36 (3) charge a fee to a pharmacy in connection with network
37 enrollment;
- 38 (4) remove a drug from a formulary or deny coverage of a drug
39 for the purpose of incentivizing a covered person to seek coverage
40 from a different health benefits plan;
- 41 (5) require a covered person to utilize an affiliate pharmacy or
42 otherwise offer or implement a plan design that encourages a
43 covered person to use an affiliated pharmacy unless the pharmacy
44 benefits manager can show that the pharmacy delivers lower costs
45 or higher quality services to covered persons; or
- 46 (6) withhold coverage or require prior authorization for a lower
47 cost, therapeutically equivalent drug available to a covered person

1 or fail to reduce a covered person's cost sharing amount when a
2 covered person selects a lower cost, therapeutically equivalent drug.

3 d. Any provision of a contract that conflicts with the provisions
4 of subsection b. or c. of this section shall be void and
5 unenforceable.

6 **[d.] e.** A violation of this section shall be an unlawful
7 practice and a violation of P.L.1960, c.39 (C.56:8-1 et seq.), and
8 shall also be subject to any enforcement action that the
9 Commissioner of Banking and Insurance is authorized to take
10 pursuant to section **[5] 10** of P.L.2015, c.179 **[(C.17B:27F-5)]**
11 **(C.17B:27F-10).**²

12 (cf: P.L.2023, c.221, s.1)

13
14 ²9. (New section) After the effective date of P.L. _____, c.
15 (C. _____) (pending before the Legislature as this bill), a pharmacy
16 benefits manager shall not enter into an agreement with a
17 manufacturer or intermediary, such as a rebate aggregator, that
18 conditions any rebate on the exclusion of therapeutically equivalent
19 generic drugs from coverage, or if the contract conditions any
20 rebate on the inclusion of any other unrelated drugs.²

21
22 ²10. (New section) a. When conducting an audit of a pharmacy
23 under contract with the network of a pharmacy benefits manager, a
24 pharmacy benefits manager shall:

25 (1) notify the pharmacy, or pharmacy services administrative
26 organization, no later than 15 days before the date of the initial
27 audit. Notification to the contracted pharmacy shall be addressed to
28 the supervising pharmacist of record and to the pharmacy corporate
29 office, if applicable, and be sent by a means that allows tracking
30 and delivery;

31 (2) limit the audit period to 24 months after the date a claim is
32 submitted to or adjudicated by the pharmacy benefits manager;

33 (3) include in the written advance notice of the audit the list of
34 masked prescription numbers or the date range to be included in the
35 audit, if applicable;

36 (4) use the written and verifiable records of a licensed hospital,
37 physician, or other health care provider, which are to be transmitted
38 by any means of communication, to validate pharmacy records in
39 accordance with State or federal law;

40 (5) limit the number of prescriptions audited to no more than
41 250 prescriptions selected in a 12-month period, unless fraudulent
42 activity or systemic abuse is reasonably suspected;

43 (6) provide the pharmacy, or pharmacy services administrative
44 organization, with a copy of the preliminary audit report no later
45 than 45 days after the conclusion of the audit;

46 (7) provide the pharmacy, or pharmacy services administrative
47 organization, with the ability to provide documentation to address a

discrepancy or audit finding, provided that the documentation is received by the pharmacy benefits manager no later than the 45th day after the preliminary audit report was provided to the pharmacy or its contracting agent. The pharmacy benefits manager shall consider a reasonable request from the pharmacy, or pharmacy services administrative organization, for an extension of time to submit documentation to address or correct any findings in the report; and

(8) provide the pharmacy, or pharmacy services administrative organization, with the final audit report no later than 60 days after the preliminary audit report was provided to the pharmacy.

b. A pharmacy benefits manager conducting an audit of a contracted pharmacy pursuant to subsection a. of this section shall not:

(1) conduct more than two audits per 12-month period; or

(2) recover costs for clerical or record-keeping errors, including typographical errors; scribes' errors; and computer errors on a required document or record, unless the error resulted in overpayment or clinical harm.

c. This section shall not apply to an audit that involves probable or potential fraud or willful misrepresentation by a pharmacist or pharmacy.²

²11. (New section) a. A contract that is executed on or after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), between a pharmacy benefits manager and a pharmacy, rebate aggregator, or health benefits plan shall not authorize spread pricing and a pharmacy benefits manager or representative of a pharmacy benefits manager shall not engage in spread pricing.

b. A pharmacy benefits manager or its affiliates shall not engage in differential payment pricing based on the ownership or affiliation of an intermediary including a drug manufacturer, a rebate aggregator, a pharmacy services administrative organization, or a contracted pharmacy.

c. Beginning on March 1 next following the effective date of P.L. , c. (pending before the Legislature as this bill), and annually thereafter, a pharmacy benefits manager shall file with the department a report explaining how the pharmacy benefits manager has complied with the provisions of this section. The report shall be written in a manner and form determined by the department.²

²12. (New section) a. Beginning on March 1 next following the effective date of P.L. , c. (pending before the Legislature as this bill), and annually thereafter, a pharmacy benefits manager shall report to the department discounts, dispensing fees, reimbursements, and other fees negotiated in the prior calendar year with pharmacies, prescription drug networks, or pharmacy services

administrative organizations for each drug and drug group identified for that year by the Division of Consumer Affairs in the Department of Law and Public Safety pursuant to P.L.2023, c.106 (C.45:14-82.2 et seq.) and set forth the difference, if any, between those discounts, dispensing fees, reimbursements, and other fees and the National Average Drug Acquisition Cost (NADAC) plus the prevailing State defined Medicaid professional dispensing fee.

b. (1) Within six months of the effective date of P.L. _____, cm, (pending before the Legislature as this bill), and updating annually thereafter, the department shall determine the 10 highest priced prescription drugs relative to the NADAC and publish and maintain the list of those prescription drugs on its Internet website in a manner that is accessible to the public. For any prescription drug included on this list that is prescribed for a person with coverage under the State Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.):

(a) a pharmacy benefits manager shall, for a prescription drug, reimburse pharmacies at the State fee-for-service benchmark of the NADAC plus the prevailing State defined Medicaid professional dispensing fee.

(b) if a pharmacy benefits manager or its affiliate maintains an ownership interest or control of a pharmacy, the pharmacy benefits manager shall reimburse the pharmacy, for a prescription drug, at the State fee-for-service benchmark of the NADAC.

(2) Pursuant to subparagraphs (a) and (b) of paragraph (1) of this subsection, if the NADAC is not established for a specific national drug code, the ingredient reimbursement rate shall default to the Wholesale Average Cost (WAC) or the Suggested Wholesale Price (SWP).

c. No later than one year after the department's receipt of the information that a pharmacy benefits manager is required to report pursuant to subsection a. of this section, and annually thereafter, the department shall prepare and submit a report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), concerning:

(1) reimbursement and fees for all plans and drugs;

(2) the required reimbursement rate or dispensing fee for the prescription drugs identified pursuant to subsection b. of this section;

(3) trends in reimbursement rates and dispensing fees relative to NADAC for all prescription drugs, or if the NADAC is not established for a specific national drug code, the relative to the Wholesale Average Cost (WAC) or the Suggested Wholesale Price (SWP);

(4) information on the efficacy of the requirements of subsection b. of this section and any recommendations to modify or expand those requirements; and

1 (5) any additional information as required by the Commissioner
2 of Human Services.²

3
4 ²13. (New section) In order to carry out the purposes of
5 P.L.2015, c.179 (C.17B:27F-1 et seq.), as amended and
6 supplemented, the commissioner shall assess fees that shall be
7 payable by pharmacy benefits managers and pharmacy services
8 administrative organizations in connection with the performance of
9 the commissioner's duties under P.L.2015, c.179 (C.17B:27F-1 et
10 seq.), as amended and supplemented, and in accordance with
11 regulations adopted by the commissioner.²

12
13 ²14. (New section) a. After the effective date of P.L. , c.
14 (pending before the Legislature as this bill), any contract into
15 entered by the Department of Human Services with a pharmacy
16 benefits manager to administer pharmacy benefits for Medicaid
17 recipients, including those enrolled in a managed care organization
18 by that date with whom the department contracts for the delivery of
19 Medicaid services, shall:

20 (1) require the use of pass-through pricing to be applied by the
21 department to offset the costs of providing the delivery of Medicaid
22 services;

23 (2) require transparency in drug costs, rebates collected and paid,
24 dispensing fees paid, and other compensation; and

25 (3) prohibit the use of spread pricing.

26 b. Upon request by the Department of Human Services, a
27 pharmacy benefits manager shall disclose to the department the
28 amount of any fees paid by the pharmacy benefits manager to
29 affiliates and group purchasing organizations.

30 c. The Commissioner of Human Services shall apply for any
31 State plan amendments or waivers as may be necessary to
32 implement the provisions of P.L. , c. (C.) (pending before
33 the Legislature as this bill) and to secure federal financial
34 participation for State Medicaid expenditures under the federal
35 Medicaid program.

36 d. As used in this section:

37 "Compensation" means any direct or indirect financial benefit,
38 including, but not limited to, rebates, discounts, credits, fees, grants,
39 chargebacks or other payments or benefits of any kind, that is
40 attributed to, directly or indirectly, the utilization of a health
41 benefits plan or enrollment in a health benefits plan, regardless of
42 how the benefits are otherwise characterized by a pharmacy benefits
43 manager and relevant third parties.

44 "Pass-through pricing" means a transparent pharmacy benefit
45 manager contract model whereby compensation remitted by or on
46 behalf of a pharmaceutical manufacturer, developer or labeler,
47 directly or indirectly through an intermediary such as a rebate
48 aggregator, to a carrier or to a pharmacy benefits manager under

1 contract with a carrier related to prescription drug benefits is
2 directly passed through to the State Medicaid program.

3 “Pharmacy benefits manager” means the same as that term is
4 defined in section 1 of P.L.2015, c.179 (C.17B:27F-1).

5 “Rebate aggregator” means a person or entity that provides
6 formulary management and formulary rebate administrative
7 services, or aggregates prescription drug utilization volume and
8 distributes rebates to pharmacy benefit managers, or both.

9 “Spread pricing” means the model of prescription drug pricing in
10 which the pharmacy benefits manager or an affiliated intermediary,
11 including a rebate aggregator, charges a health benefits plan,
12 carrier, or purchaser a contracted price for prescription drugs, and
13 the contracted price for the prescription drugs differs from the
14 amount the pharmacy benefits manager directly or indirectly pays
15 the pharmacist or pharmacy.²

16
17 ²15. Section 3 of P.L.2023, c.106 (C.45:14-82.4) is amended to
18 read as follows:

19 3. a. A pharmacy benefits manager shall, to the extent allowed by
20 law, report to the division the following minimum data, and other
21 data that may be specified by the division. The division shall
22 annually notify pharmacy benefits managers of the specific drugs or
23 drug groups for which reporting is required and a pharmacy benefits
24 manager shall have 60 days following such notification to report to
25 the division the following:

26 (1) minimum and maximum WAC for each indicated drug and
27 drug group for which the pharmacy benefits manager has negotiated
28 directly with the manufacturer in the last calendar year, related to
29 prescriptions under an insurance policy issued in the State;

30 (2) volume in pricing units of each indicated drug and drug
31 group that the pharmacy benefits manager negotiated directly with
32 the manufacturer in the last calendar year, for business in the State,
33 in total and for each payer type as relevant;

34 (3) total rebates, discounts, and price concessions received or
35 negotiated directly with the manufacturer for each drug and drug
36 group as indicated by the division in the last calendar year, for
37 business in the State, in total and for each payer type as relevant;

38 (4) total discounts, dispensing fees, and other fees negotiated last
39 year with pharmacies, prescription drug networks, or pharmacy
40 services administrative organizations for each drug and drug group
41 as indicated by the division in the last calendar year, for business in
42 the State, in total and for each payer type as relevant; **[and]**

43 (5) total net income received in the last calendar year for each
44 drug and drug group as indicated by the division, for business in the
45 State, in total and for each payer type as relevant; and

46 (6) the fee structures agreed to between a pharmacy benefits
47 manager and the carriers and health benefits plan with which it
48 contracts.

b. Disclosure of all information reported under this section shall be subject to protections defined in section 9 of P.L.2023, c.106 (C.45:14-82.10).²
(cf: P.L.2023, c.106, s.3)

²16. (New section) The Drug Affordability Council, established pursuant to section 10 of P.L.2023, c.107 (C.45:14-82.11), shall undertake a study of the fee structures utilized by pharmacy benefits managers and develop one or more alternative fee arrangements within 18 months of the date of enactment of P.L. , c. (pending before the Legislature as this bill). The arrangements shall be structured in a manner that ties compensation received by a pharmacy benefits manager to reductions of the total net costs paid by covered persons.²

²17. (New section) a. As used in this section:
“Compensation” means any direct or indirect financial benefit, including, but not limited to, rebates, discounts, credits, fees, grants, chargebacks or other payments or benefits of any kind, that is attributed to, directly or indirectly, the utilization of a State Health Benefits Plan or School Employees’ Health Benefits Plan or enrollment therein, regardless of how the benefits are otherwise characterized by a pharmacy benefits manager and relevant third parties.

“Pass-through pricing” means a transparent pharmacy benefit manager contract model whereby compensation remitted by or on behalf of a pharmaceutical manufacturer, developer or labeler, directly or indirectly, through an intermediary such as a rebate aggregator, to a carrier or to a pharmacy benefits manager under contract with a carrier related to prescription drug benefits is directly passed through to the State Health Benefits Program or School Employees’ Health Benefits Program.

“Pharmacy benefits manager” means the same as that term is defined in section 1 of P.L.2015, c.179 (C.17B:27F-1).

“Rebate aggregator” means a person or entity that provides formulary management and formulary rebate administrative services, or aggregates prescription drug utilization volume and distributes rebates to pharmacy benefit managers, or both.

“Spread pricing” means the model of prescription drug pricing in which the pharmacy benefits manager or an affiliated intermediary, including a rebate aggregator, charges a health benefits plan, carrier, or purchaser a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy.

b. After the effective date of P.L. , c. (pending before the Legislature as this bill), any contract entered by the State Health Benefits Commission or the School Employees’ Health Benefits

1 Commission with a pharmacy benefits manager to administer
2 pharmacy benefits for the State Health Benefits Program or School
3 Employees' Health Benefits Program shall:

4 (1) require the use of pass-through pricing to be applied by the
5 division to offset the costs of providing benefits under the State
6 Health Benefits Program or School Employees' Health Benefits
7 Program;

8 (2) require transparency in drug costs, rebates collected and paid,
9 dispensing fees paid, and other compensation; and

10 (3) prohibit the use of spread pricing.

11 c. Upon request by the Division of Pensions and Benefits, a
12 pharmacy benefits manager shall disclose to the division the amount
13 of any fees paid by the pharmacy benefits manager to affiliates and
14 group purchasing organizations.²

15
16 ²18. This act shall take effect immediately, except sections 3
17 through 11 shall remain inoperative until the first day of the seventh
18 month next following the date of enactment and shall apply to
19 contracts and agreements entered into, renewed, modified, or
20 amended on or after the effective date, but the Commissioner of
21 Banking and Insurance may take such anticipatory administrative
22 action in advance thereof as shall be necessary for the
23 implementation of the act.²