

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 2345

STATE OF NEW JERSEY
222nd LEGISLATURE

ADOPTED OCTOBER 5, 2026

Sponsored by:

Senator JOHN F. MCKEON
District 27 (Essex and Passaic)
Senator VIN GOPAL
District 11 (Monmouth)

Co-Sponsored by:

Senators McKnight, Burzichelli, Moriarty, Tiver, Singleton, Mukherji,
Cruz-Perez, Turner, Steinhardt, Greenstein, Singer, Burgess and
Bramnick

SYNOPSIS

Creates “Patient and Provider Protection Act.”

CURRENT VERSION OF TEXT

Substitute as adopted by the Senate Commerce Committee.



(Sponsorship Updated As Of: 10/8/2026)

1 **AN ACT** concerning pharmacy benefits managers and amending and
2 supplementing various parts of the statutory law.

3

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

6

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

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

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

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

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

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

42 f. The Federal Trade Commission documented that pharmacy
43 steering, restrictive network design, differential cost-sharing, and
44 internal transfer pricing arrangements may reduce patient choice,

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.

- 1 disadvantage independent and community pharmacies, and create
2 conflicts of interest inconsistent with fiduciary standards.
- 3 g. Pharmacy benefits managers frequently receive
4 compensation calculated as a percentage of a drug’s list price,
5 rebate amount, wholesale acquisition cost, or utilization volume,
6 thereby linking pharmacy benefits manager revenue directly to
7 higher list prices and larger rebates.
- 8 h. Compensation structures tied to rebates, discounts, list
9 prices, or affiliated pharmacy margins create inherent conflicts of
10 interest and may incentivize pharmacy benefits managers to favor
11 higher-cost drugs or preferred internal dispensing channels over
12 lower-cost or clinically appropriate alternatives.
- 13 i. An article published in the Oxford Health Affairs Scholar,
14 entitled “The cost of misaligned incentives in the pharmaceutical
15 supply chain,” discusses how research conducted by the University
16 of Southern California’s Schaeffer Center for Health Policy &
17 Economics estimates that delinking pharmacy benefits manager and
18 other supply chain compensation from drug list prices and rebate-
19 based incentives could reduce national prescription drug spending
20 by approximately \$95.4 billion annually, or nearly 15 percent of net
21 spending, without undermining pharmaceutical innovation.
- 22 j. That research further concludes that fixed, transparent
23 administrative fee models would eliminate incentives tied to list-
24 price inflation and rebate magnitude, align pharmacy benefits
25 manager incentives with lowest net cost objectives, and generate
26 substantial savings for employers, public programs, and patients.
- 27 k. Congress enacted comprehensive pharmacy benefits
28 manager reforms under the bipartisan “Consolidated Appropriations
29 Act, 2026,” Pub. L. No. 119-75, to address compensation
30 distortions, transparency deficiencies, and conflicts of interest in
31 federal prescription drug programs.
- 32 l. The “Consolidated Appropriations Act, 2026” established a
33 “bona fide service fee” model for Medicare prescription drug
34 coverage, requiring pharmacy benefits manager compensation to
35 consist solely of flat, fair-market-value administrative fees not
36 contingent on list price, rebate value, utilization, or formulary
37 placement, and requiring 100 percent pass-through of manufacturer
38 rebates and price concessions.
- 39 m. The “Consolidated Appropriations Act, 2026” also
40 strengthened transparency requirements, enhanced audit rights for
41 plan sponsors, and reinforced “any willing pharmacy” protections to
42 prevent discriminatory pharmacy steering and preserve access to
43 community and rural pharmacies.
- 44 n. The bipartisan congressional reforms under the
45 “Consolidated Appropriations Act, 2026” reflect a national
46 consensus that pharmacy benefits manager compensation must be
47 structurally delinked from rebates and price inflation, must be

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

3 o. Pharmacy benefits managers owe a financial responsibility
4 to 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
17 read as follows:

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

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

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

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

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

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

41 "Contracted pharmacy" means a pharmacy that participates in the
42 network of a pharmacy benefits manager through a contract with【:

43 a.】 the pharmacy benefits manager directly【;

44 b.】 or an intermediary, including but not limited to, a pharmacy
45 services administration organization【;】 or

46 【c.】 a pharmacy group purchasing organization, including rebate
47 aggregators.

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

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

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

38 "Network pharmacy" means a licensed retail pharmacy or other
39 pharmacy provider that contracts with a pharmacy benefits manager
40 either directly or by and through **【a contract with】** an intermediary,
41 including but not limited to, a pharmacy services administrative
42 organization.

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

47 "Pharmacy benefits manager" means a corporation, business, or
48 other entity, or unit within a corporation, business, or other entity,

1 that, pursuant to a contract or under an employment relationship
2 with a carrier, a self-insurance plan or other third-party payer, either
3 directly or through an intermediary, administers prescription drug
4 benefits on behalf of a purchaser.

5 "Pharmacy benefits manager compensation" means the
6 difference between: (1) the amount of payments made by a carrier
7 of a health benefits plan to its pharmacy benefits manager; and (2)
8 the value of payments made by the pharmacy benefits manager to
9 dispensing pharmacists for the provision of prescription drugs or
10 pharmacy services with regard to pharmacy benefits covered by the
11 health benefits plan.

12 "Pharmacy benefits management services" means [the provision
13 of any of the following services on behalf of a purchaser: the
14 procurement of prescription drugs at a negotiated rate for
15 dispensation within this State; the processing of prescription drug
16 claims; or the administration of payments related to prescription
17 drug claims]:

18 (1) negotiating the price of prescription drugs, including
19 negotiating and contracting for direct or indirect rebates, discounts,
20 or other price concessions;

21 (2) managing any aspects of a prescription drug benefit,
22 including but not limited to, the processing and payment of claims
23 for prescription drugs, the performance of utilization review, the
24 processing of drug prior authorization requests, the adjudication of
25 appeals or grievances related to the prescription drug benefit,
26 contracting with network pharmacies, controlling the cost of
27 covered prescription drugs, managing data relating to the
28 prescription drug benefit, or the provision of services related
29 thereto;

30 (3) performing any administrative, managerial, clinical, pricing,
31 financial, reimbursement, data administration or reporting, or
32 billing service; and

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

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

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

41 "Prescription drug benefits" means the benefits provided for
42 prescription drugs and pharmacy services for covered services
43 under a health benefits plan contract.

44 "Purchaser" means any sponsor of a health benefits plan who
45 enters into an agreement with a pharmacy benefits management
46 company for the provision of pharmacy benefits management
47 services to covered persons.

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

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

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

13
14 3. Section 2 of P.L.2015, c.179 (C.17B:27F-2) is amended to
15 read as follows:

16 2. a. Upon execution or renewal of each contract, or at such a
17 time when there is any material change in the term of the contract, a
18 pharmacy benefits manager shall, with respect to contracts between
19 a pharmacy benefits manager and a pharmacy services
20 administrative organization, or between a pharmacy benefits
21 manager and a contracted pharmacy:

22 **【a.】** (1) include in the contract the sources utilized to determine
23 multiple source generic drug pricing, brand drug pricing, and the
24 wholesaler in the State of New Jersey where pharmacies may
25 acquire the product, including, but not limited to, the brand
26 effective rate, generic effective rate, dispensing fee effective rate,
27 maximum allowable cost or any other pricing formula for pharmacy
28 reimbursement;

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

31 (3) establish a reasonable process by which contracted
32 pharmacies have a method to access relevant maximum allowable
33 cost pricing lists, brand effective rate, generic effective rate, and
34 dispensing fee effective rate, or any other pricing formulas for
35 pharmacy reimbursement; and

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

41 b. **【Additionally, a pharmacy benefits manager shall:】** Upon
42 execution or renewal of each contract, or at such a time when there
43 is any material change in the term of the contract, a pharmacy
44 benefits manager shall, with respect to contracts between a
45 pharmacy benefits manager and a carrier:

46 (1) maintain a procedure to eliminate drugs from the list of drugs
47 subject to multiple source generic drug pricing and brand drug
48 pricing, or modify maximum allowable cost rates, brand effective

1 rate, generic effective rate, dispensing fee effective rate or any other
2 applicable pricing formula in a timely fashion and make that
3 procedure easily accessible to the pharmacy services administrative
4 organizations or the pharmacies that they are contractually
5 obligated with to provide that information according to the
6 requirements of this section; and

7 (2) provide an internal appeal mechanism to resolve any dispute
8 raised by a carrier **【or pharmacy】**, regardless of whether the carrier
9 **【or】** and pharmacy benefits manager has a contract to challenge
10 maximum allowable costs for a specified drug. Any dispute
11 regarding the determination of an internal appeal conducted
12 pursuant to this subsection concerning reimbursements may be
13 referred to binding arbitration. The Commissioner of Banking and
14 Insurance shall contract with a nationally recognized, independent
15 organization that specializes in arbitration to conduct the arbitration
16 proceedings.

17 c. The binding arbitration shall adhere to the following
18 requirements:

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

22 (2) arbitration shall be initiated by filing a request with the
23 department;

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

27 (4) the arbitrator's decision shall be one of the two amounts
28 submitted by the parties as their final offers and shall be binding on
29 both parties. The decision of the arbitrator shall include detailed
30 written findings and shall be issued within 30 days after the request
31 is filed with the department. The detailed written findings shall be
32 an analysis of the decision including, but not limited to, information
33 concerning any databases, previous awards, or other documentation
34 or arguments that contributed to the arbitrator's decision. The
35 arbitrator's expenses and fees shall be split equally among the
36 parties except in situations in which the arbitrator determines that
37 the payment made by the pharmacy benefits manager was not made
38 in good faith, in which case the pharmacy benefits manager shall be
39 responsible for all the arbitrator's expenses and fees. Each party
40 shall be responsible for its own costs and fees, including legal fees
41 if any.

42 d. (1) The department may adopt rules and regulations
43 governing the arbitration process, including setting minimum
44 qualifications and conflict standards for arbitrators; establishing
45 arbitration fees and minimum dispute thresholds for arbitration; and
46 prohibiting bundling multiple disputes to meet such thresholds.

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

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

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

5
6 4. Section 3 of P.L.2023, c.107 (C.17B:27F-3.1) is amended to
7 read as follows:

8 3. a. A carrier shall:

9 (1) monitor all activities carried out on behalf of the carrier by a
10 pharmacy benefits manager if the carrier contracts with a pharmacy
11 benefits manager and is related to a carrier's prescription drug
12 benefits; and

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

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

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

33 (2) A pharmacy benefits manager shall have a **【duty of good**
34 **faith and fair dealing with all parties, including but not limited to**
35 **covered persons and pharmacies, with whom it interacts in the**
36 **performance of pharmacy benefits management services】** fiduciary
37 duty to act in the best interests of a carrier with which it contracts to
38 allow that carrier to design plans in a manner that reduces premiums
39 and out-of-pocket costs paid by covered persons.

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

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

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

3 (2) the amount a covered person would pay for the prescription
4 medication if the covered person purchased the prescription
5 medication without using a health benefits plan.

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

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

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

17
18 5. Section 7 of P.L.2023, c.107 (C.17B:27F-3.3) is amended to
19 read as follows:

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

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

26 A carrier, or a pharmacy benefits manager under contract with a
27 carrier, shall require that its pharmacy and therapeutics committee
28 meet the requirements for conflict of interest as set by the Centers
29 for Medicare and Medicaid Services or meets the accreditation
30 standards of the National Committee for Quality Assurance or
31 another independent accrediting organization.

32 c. A pharmacy and therapeutics committee shall ensure that no
33 decision concerning the inclusion of a prescription drug in a
34 formulary system, or in a particular tier of the formulary system,
35 places a prescription drug with a higher cost in a more favorable
36 position than a generic or biosimilar prescription drug with a lower
37 cost.

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

39
40 6. Section 9 of P.L.2023, c.107 (C.17B:27F-3.4) is amended to
41 read as follows:

42 9. a. If a carrier uses a pharmacy benefits manager to
43 administer or manage the prescription drug benefits of covered
44 persons, any pharmacy benefits manager **【compensation】** fee, for
45 purposes of calculating a carrier's anticipated loss ratio or any loss
46 ratio calculated as part of any applicable medical loss ratio filing or
47 rate filing, shall:

- 1 (1) constitute an administrative cost incurred by the carrier in
2 connection with a health benefits plan; and
- 3 (2) not constitute a benefit provided under a health benefits plan.
- 4 A carrier shall claim only the amounts paid by the pharmacy
5 benefits manager to a pharmacy or pharmacist as an incurred claim.
- 6 b. Any rate filing submitted by a carrier with respect to a health
7 benefits plan that provides coverage for prescription drugs or
8 pharmacy services and that is administered or managed by a
9 pharmacy benefits manager shall include:
- 10 (1) a memorandum prepared by a qualified actuary describing
11 the calculation of the pharmacy benefits manager **【compensation】**
12 fee; and
- 13 (2) any records and supporting information as the department
14 reasonably determines is necessary to confirm the calculation of the
15 pharmacy benefits manager **【compensation】** fee.
- 16 c. Upon request, a carrier shall provide any records to the
17 department that relate to the calculation of the pharmacy benefits
18 manager and pharmacy services administrative organization
19 **【compensation】** fee.
- 20 d. A pharmacy benefits manager and pharmacy services
21 administrative organization shall provide any necessary
22 documentation requested by a carrier that relates to pharmacy
23 benefits manager **【compensation】** fees in order to comply with the
24 requirements of this section.
- 25 e. No pharmacy benefit manager may derive income from
26 pharmacy benefits services provided to a carrier or health benefits
27 plan in this State except for income derived from a pharmacy
28 benefits manager fee. The amount of any pharmacy benefits
29 manager fees shall be set forth in the agreement between the
30 pharmacy benefits manager and the carrier or health benefits plan.
- 31 f. The pharmacy benefits manager fee charged or paid to a
32 pharmacy benefits manager from a carrier or health benefits plan
33 shall not be directly or indirectly based or contingent upon:
- 34 (1) the acquisition cost or any other price metric of a drug;
35 (2) the amount of savings, rebates, or other fees charged,
36 realized, or collected by or generated based on the activity of the
37 pharmacy benefits manager; or
- 38 (3) the amount of premiums, deductibles, or other cost sharing
39 or fees charged, realized, or collected by the pharmacy benefits
40 manager from patients or other persons on behalf of a patient.
- 41 g. Upon request by the department or a purchaser, a pharmacy
42 benefits manager shall disclose to the department or purchaser the
43 amount of any fees paid by the pharmacy benefits manager to a
44 third party broker.
- 45 h. Subsections e. and f. of this section shall also apply to a
46 contract between a pharmacy benefits manager and the State Health
47 Benefits Program, the School Employees' Health Benefits Program,

1 or the State Medicaid program established pursuant to P.L.1968,
2 c.413 (C.30:4D-1 et seq.).

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

11 j. As used in this section, “pharmacy benefits manager fee”
12 means a payment that covers the cost of providing one or more
13 pharmacy benefits management services and shall not exceed the
14 bona fide value of the itemized service or services actually
15 performed by the pharmacy benefits manager on behalf of the
16 carrier or health benefits plan that the carrier or health benefits plan
17 would otherwise perform or contract for in the absence of the
18 service arrangement, whether or not the carrier or health benefits
19 plan takes title to the prescription drug. The value of the service or
20 services shall be based on the value to the carrier or health benefits
21 plan.

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

23
24 7. Section 4 of P.L.2015, c.179 (C.17B:27F-4) is amended to
25 read as follows:

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

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

38 b. The appeal shall be investigated and resolved by the
39 pharmacy benefits manager through an internal process within 14
40 calendar days of receipt of the appeal by the pharmacy benefits
41 manager;

42 c. A telephone number at which a pharmacy services
43 administrative organization, or a pharmacy may contact the
44 pharmacy benefits manager and speak with an individual who is
45 involved in the appeals process; and

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

1 (a) provide the reason for the denial to the pharmacy services
2 administrative organization and its contracted pharmacies, and the
3 pharmacy services administrative organization shall inform its
4 contracted pharmacies of the availability, location and pricing of the
5 appealed drug in the State;

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

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

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

23 (2) If the appeal is approved, the pharmacy benefits manager
24 shall make the price correction, permit the reporting pharmacy to
25 reverse and rebill the appealed claim, and make the price correction
26 effective for all similarly situated pharmacies from the date of the
27 approved appeal.

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

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

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

40
41 8. Section 1 of P.L.2019, c.257 (C.17B:27F-6) is amended to
42 read as follows:

43 1. a. A pharmacy benefits manager, in connection with any
44 contract or arrangement with a private health insurer, prescription
45 benefit plan, or the State Health Benefits Program or School
46 Employees' Health Benefits Program, shall not require a covered
47 person to make a payment at the point of sale for any amount for a
48 deductible, coinsurance payment, or a copayment for a prescription

1 drug benefit in an amount that exceeds the amount permitted
2 pursuant to subsection d. of section 3 of P.L.2023, c.107
3 (C.17B:27F-3.1).

4 b. A pharmacy benefits manager shall not prohibit a network
5 pharmacy from, and shall not apply a penalty or any other type of
6 disincentive to a network pharmacy for:

7 (1) disclosing to a covered person lower cost prescription drug
8 options, including those that are available to the covered person if
9 the covered person purchases the prescription drug without using
10 health insurance coverage;

11 (2) providing a covered person with the option of paying the
12 pharmacy provider's cash price for the purchase of a prescription
13 drug and not filing a claim with the covered person's health benefits
14 plan if the cash price is less than the covered person's cost-sharing
15 amount;

16 (3) providing information to a State or federal agency, law
17 enforcement agency, or the department when such information is
18 required by law; or

19 (4) applying a discounted price generated by a healthcare
20 platform, as defined pursuant to section 2 of P.L.2003, c.280
21 (C.45:14-41), to the payment of a covered person with an account
22 or membership to the healthcare platform for a prescription drug,
23 even if the covered person maintains health insurance coverage.

24 c. A pharmacy benefits manager, in connection with any
25 contract or arrangement with a carrier, health benefits plan, or
26 prescription benefit plan, shall not:

27 (1) transfer or share records relative to prescription information
28 containing patient-identifiable or prescriber-identifiable data to an
29 affiliated pharmacy for any commercial purpose; provided,
30 however, that nothing in this paragraph shall be construed to
31 prohibit the exchange of prescription information between a
32 pharmacy benefits manager and an affiliated pharmacy for the
33 limited purposes of providing or administering pharmaceutical
34 benefit services for a covered person, providing pharmacy
35 reimbursement, engaging in formulary compliance, or conducting
36 permitted utilization review;

37 (2) knowingly make a misrepresentation to a covered person,
38 pharmacist, or pharmacy;

39 (3) charge a fee to a pharmacy in connection with network
40 enrollment;

41 (4) remove a drug from a formulary or deny coverage of a drug
42 for the purpose of incentivizing a covered person to seek coverage
43 from a different health benefits plan;

44 (5) require a covered person to utilize an affiliate pharmacy or
45 otherwise offer or implement a plan design that encourages a
46 covered person to use an affiliated pharmacy unless the pharmacy
47 benefits manager can show that the pharmacy delivers lower costs
48 or higher quality services to covered persons; or

1 (6) withhold coverage or require prior authorization for a lower
2 cost, therapeutically equivalent drug available to a covered person
3 or fail to reduce a covered person's cost sharing amount when a
4 covered person selects a lower cost, therapeutically equivalent drug.

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

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

14 (cf: P.L.2023, c.221, s.1)
15

16 9. (New section) After the effective date of P.L. , c.
17 (C.) (pending before the Legislature as this bill), a pharmacy
18 benefits manager shall not enter into an agreement with a
19 manufacturer or intermediary, such as a rebate aggregator, that
20 conditions any rebate on the exclusion of therapeutically equivalent
21 generic drugs from coverage, or if the contract conditions any
22 rebate on the inclusion of any other unrelated drugs.
23

24 10. (New section) a. When conducting an audit of a pharmacy
25 under contract with the network of a pharmacy benefits manager, a
26 pharmacy benefits manager shall:

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

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

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

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

42 (5) limit the number of prescriptions audited to no more than
43 250 prescriptions selected in a 12-month period, unless fraudulent
44 activity or systemic abuse is reasonably suspected;

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

(7) provide the pharmacy, or pharmacy services administrative 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.

11. (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.

12. (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 of Human Services discounts, dispensing

1 fees, reimbursements, and other fees negotiated in the prior calendar
2 year with pharmacies, prescription drug networks, or pharmacy
3 services administrative organizations for each drug and drug group
4 identified for that year by the Division of Consumer Affairs in the
5 Department of Law and Public Safety pursuant to P.L.2023, c.106
6 (C.45:14-82.2 et seq.) and set forth the difference, if any, between
7 those discounts, dispensing fees, reimbursements, and other fees
8 and the National Average Drug Acquisition Cost (NADAC) plus the
9 prevailing State defined Medicaid professional dispensing fee.

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

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

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

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

32 c. No later than one year after the department's receipt of the
33 information that a pharmacy benefits manager is required to report
34 pursuant to subsection a. of this section, and annually thereafter, the
35 department shall prepare and submit a report to the Governor, and to
36 the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-
37 19.1), concerning:

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

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

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

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

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

3
4 13. (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.

12
13 14. (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
24 paid, 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.

16
17 15. 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
20 by law, report to the division the following minimum data, and
21 other 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
39 last 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.

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

5
6 16. (New section) The Drug Affordability Council, established
7 pursuant to section 10 of P.L.2023, c.107 (C.45:14-82.11), shall
8 undertake a study of the fee structures utilized by pharmacy benefits
9 managers and develop one or more alternative fee arrangements
10 within 18 months of the date of enactment of P.L. , c. (pending
11 before the Legislature as this bill). The arrangements shall be
12 structured in a manner that ties compensation received by a
13 pharmacy benefits manager to reductions of the total net costs paid
14 by covered persons.

15
16 17. (New section) a. As used in this section:

17 “Compensation” means any direct or indirect financial benefit,
18 including, but not limited to, rebates, discounts, credits, fees, grants,
19 chargebacks or other payments or benefits of any kind, that is
20 attributed to, directly or indirectly, the utilization of a State Health
21 Benefits Plan or School Employees’ Health Benefits Plan or
22 enrollment therein, regardless of how the benefits are otherwise
23 characterized by a pharmacy benefits manager and relevant third
24 parties.

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

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

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

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

46 b. After the effective date of P.L. , c. (pending before the
47 Legislature as this bill), any contract entered by the State Health
48 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
9 paid, 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.

15

16 18. 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.