

SENATE COMMERCE COMMITTEE

STATEMENT TO

[First Reprint]

ASSEMBLY COMMITTEE SUBSTITUTE FOR **ASSEMBLY, No. 1502**

with committee amendments

STATE OF NEW JERSEY

DATED: OCTOBER 5, 2026

The Senate Commerce Committee reports favorably and with committee amendments Assembly Bill No. 1502 (1R) ACS.

As amended, this bill creates the “Patient and Provider Protection Act,” which establishes certain requirements for pharmacy benefits managers relating to contractual agreements with manufacturers and pharmacies. Specifically, the bill requires a pharmacy benefits manager to have a fiduciary duty to act in the best interests of a carrier with which it contracts to allow the carrier to design plans in a manner that reduces premiums and out-of-pocket costs paid by covered persons. Under the bill, a pharmacy benefits manager is prohibited from engaging in any marketing activity that uses inaccurate or misleading information to convince or attempt to convince covered persons to use a contracted or network pharmacy.

Additionally, under the bill, a pharmacy benefits manager is prohibited from deriving income from pharmacy benefits management services provided to a carrier or health benefits plan in this State except for income derived from a pharmacy benefits manager fee that is agreed upon between the pharmacy benefits manager and carrier or health benefits plan. The pharmacy benefits manager fee charged or paid to a pharmacy benefits manager from a carrier or health benefits plan must not be directly or indirectly based or contingent upon:

- (1) the acquisition cost or any other price metric of a drug;
- (2) the amount of savings, rebates, or other fees charged, realized, or collected by or generated based on the activity of the pharmacy benefits manager; or
- (3) the amount of premiums, deductibles, or other cost sharing or fees charged, realized, or collected by the pharmacy benefits manager from patients or other persons on behalf of a patient.

Furthermore, as amended, the bill provides that a pharmacy benefits manager may not enter into an agreement a manufacturer or intermediary, such as a rebate aggregator, that conditions any rebate on the exclusion of therapeutically equivalent generic drugs from cover,

or if the contract conditions any rebate on the inclusion of any other unrelated drugs.

In the event of a dispute between a pharmacy and a pharmacy benefits manager, the bill requires a contract to contain an internal appeal procedure for the pharmacy. If there is a dispute regarding the determination of an internal appeal conducted pursuant to the bill, the dispute may be referred to binding arbitration.

The bill prohibits a pharmacy benefits manager, in connection with any contract or arrangement with a carrier, health benefits plan, or prescription benefit plan from:

(1) transferring or sharing records relative to prescription information containing patient-identifiable or prescriber-identifiable data to an affiliated pharmacy for any commercial purpose; provided, however, that nothing in the bill should be construed to prohibit the exchange of prescription information between a pharmacy benefits manager and an affiliated pharmacy for the limited purposes of providing or administering pharmaceutical benefit services for a covered person, providing pharmacy reimbursement, engaging in formulary compliance, or conducting permitted utilization review;

(2) knowingly making a misrepresentation to a covered person, pharmacist, or pharmacy;

(3) charging a pharmacy a fee in connection with network enrollment;

(4) removing a drug from a formulary or denying coverage of a drug for the purpose of incentivizing a covered person to seek coverage from a different health plan;

(5) requiring a covered person to utilize an affiliate pharmacy or otherwise offering or implementing a plan design that encourages a covered person to use an affiliated pharmacy unless the pharmacy benefits manager can show that such a pharmacy delivers lower costs or higher quality services to covered persons; or

(6) withholding coverage or requiring prior authorization for a lower cost, therapeutically equivalent drug available to a covered person or failing to reduce a covered person's cost sharing amount when a covered person selects a lower cost, therapeutically equivalent drug.

Additionally, the bill establishes requirements for a pharmacy benefits manager to follow when conducting an audit, including, but not limited to, generally limiting the number of prescriptions audited to no more than 250 prescriptions selected in a 12-month period and providing the pharmacy with the ability to provide documentation to address a discrepancy or audit finding.

Moreover, as amended, the bill prohibits pharmacy benefits managers from authorizing or engaging in spread pricing in contracts with a pharmacy, rebate aggregator, or health benefits plan, including contracts with the State Health Benefits Commission, School Employees' Health Benefits Commission, or for Medicaid recipients.

As amended, the bill also requires, within six months of its effective date, and updating annually thereafter, the Department of Banking and Insurance to determine the ten 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 the 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.), the bill requires pharmacy benefits managers, for a prescription drug, to reimburse pharmacies at the State fee-for-service benchmark of the National Average Drug Acquisition Cost (NADAC) plus the prevailing State defined Medicaid professional dispensing fee. However, if a pharmacy benefits manager, or an affiliate of the pharmacy benefits manager, owns or controls a pharmacy, the pharmacy benefits manager is required to reimburse the pharmacy for a prescription drug at the State fee-for-service benchmark of the National Drug Acquisition Cost (NADAC) and shall exclude the prevailing State defined Medicaid professional dispensing fee. In either circumstance, if the NADAC is not established for a specific national drug code, the ingredient reimbursement rate will default to the Wholesale Average Cost (WAC) or the Suggested Wholesale Price (SWP).

As amended, the bill requires the Department of Human Services to prepare and submit a report to the Governor and the Legislature 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 the bill;
- (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
- (5) any additional information as required by the Commissioner of Human Services.

Lastly, the bill modifies current law by requiring a pharmacy benefits manager to collect and report data to the Division of Consumer Affairs on the fee structures agreed to between the pharmacy benefits manager and the carriers and health benefits plan with which it contracts. The Drug Affordability Council is to also study the fee structures utilized by pharmacy benefits managers and develop one or more alternative fee arrangements.

As amended and reported by the committee, Assembly Bill No. 1502 (1R) ACS is identical to the committee substitute for Senate Bill No. 2345, which was also reported by the committee on this date

COMMITTEE AMENDMENTS:

The committee amended the bill to:

(1) add definitions for the terms “affiliated pharmacy,” “manufacturer,” “rebate aggregator,” “spread pricing,” and “pharmacy benefits manager fee”;

(2) revert the definitions of pharmacy benefits manager compensation and “health benefits plan” to what are currently in the underlying statutory law;

(3) change the definition for the terms “contracted pharmacy,” “network pharmacy,”

(4) provide for an appeal procedure to allow pharmacies with which the carrier or pharmacy benefits manager has a contract to challenge maximum allowable costs for a specified drug;

(5) make referrals to arbitration concerning reimbursement disputes binding and establish certain requirements for the binding arbitration;

(6) provide that a pharmacy benefits manager may not enter into an agreement a manufacturer or intermediary, such as a rebate aggregator, that conditions any rebate on the exclusion of therapeutically equivalent generic drugs from cover, or if the contract conditions any rebate on the inclusion of any other unrelated drugs;

(7) require the Drug Affordability Council to study the fee structures utilized by pharmacy benefits managers and develop one or more alternative fee arrangements;

(8) require, within six months of its effective date, and updating annually thereafter, the Department of Banking and Insurance to determine the ten 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.

(9) require, for any prescription drug included on the department’s list that is prescribed for a person with coverage under the State Medicaid program pharmacy benefits managers, for a prescription drug, to reimburse pharmacies at the State fee-for-service benchmark of the National Average Drug Acquisition Cost (NADAC) plus the prevailing State defined Medicaid professional dispensing fee;

(10) prohibit pharmacy benefits managers from authorizing or engaging in spread pricing in contracts with a pharmacy, rebate aggregator, or health benefits plan, including contracts with the State Health Benefits Commission, School Employees’ Health Benefits Commission, or for Medicaid recipients;

(11) require the Department of Human Services to prepare and submit a report to the Governor and the Legislature concerning:

reimbursement and fees for all plans and drugs;

the required reimbursement rate or dispensing fee for the prescription drugs identified pursuant to the bill;

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);

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

any additional information as required by the Commissioner of Human Services; and

(12) make technical changes.