State PBM Reform Inventory

Updated October 2026

New Jersey

Issue	Summary	Citation
Licensing/Registration	PBMs must obtain a license from the Department of Banking and Insurance before operating in the state. A license shall be valid for 3 years and may be renewed for an additional 3-year period. Initial licensing fees and renewal fees are both set at $10,000. The department shall set minimum standards for granting or renewing a PBM license, and shall address: • Conflicts of interest between PBMs and health benefits plans; • Deceptive practices in connection with the performance of pharmacy benefits management services; • Anti-competitive practices in connection with the performance of pharmacy benefits management services; • Unfair claims practices in connection with the performance of pharmacy benefits management services; • Pricing models used by PBMs both for their services and for the payment of services to the PBM; • Standards and practices used in the creation of pharmacy networks and contracting with network pharmacies and other providers, including promotion and use of independent and community pharmacies and patient access and minimizing excessive concentration and vertical integration of markets; and • Protection of consumers. PBMs must also register as TPAs in New Jersey and comply with reporting requirements in ss. 11:23-2.1 to 11:23-2.6.	NJ Rev Stat § 17B:27F-1.1; N.J.A.C. 11:23-2.1-2.6
Reporting Requirements	Starting March 1, 2025, and each year thereafter, a carrier shall file with the department a report explaining how it has complied with the requirements regarding uses of manufacturer compensation. The report shall be written in a manner and determined by the department. By June 1 of each year, PBMs must file with the department a report containing:	NJ Rev Stat § 17B:27F-3.2

	• The PBM's gross and net revenue in the state; • The total amount of rebates received by the PBM and the amount of rebates passed through to health plans or third parties; • The total amount the PBM charged health plans for claims processed by the PBM and the total amount the PBM paid to pharmacies; • The total amount collected by the PBM from pharmacies for overpayments; • The total amount of audit fees, recoupments, and withholds collected by the PBM from pharmacies as a result of audits; • The total amount of per-claim, PMPM, and other administrative fees charged by the PBM to health plans; and • The total amount of administrative fees paid by manufacturers to the PBM.	
PBM Income	**Rebate Pass-Through:** Compensation remitted by or on behalf of a pharmaceutical manufacturer, developer or labeler, directly or indirectly, to a carrier or to a PBM under contract with a carrier related to prescription drug benefits shall be: • Remitted directly to the covered person at the point of sale to reduce the out-of-pocket cost to the covered person associated with a particular prescription drug; or • Remitted to, and retained by, the carrier. Compensation remitted to the carrier shall be applied by the carrier to offset the premium for covered persons. "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 health benefits plan or enrollment in a health benefits plan, regardless of how the benefits are otherwise characterized by a PBM and relevant third parties.	NJ Rev Stat § 17B:27F-3.2
Pharmacy Contracting	MAC Pricing: Upon execution or renewal of each contract, a PBM shall, with respect to contracts between a PBM and a contracted pharmacy: • Include in the contract the sources utilized to determine multiple source generic drug pricing, including, if applicable, the MAC or any successive pricing formula, of the PBM; • Update that pricing information every 7 calendar days; and	N.J.A.C. 11:4-62.3; N.J.A.C. 11:4-62.4; NJ Rev Stat § 17B:27F-3

	• Establish a reasonable process by which contracted pharmacies have a method to access relevant MAC pricing lists and any successive pricing formulas in a timely manner. A PBM shall maintain a procedure to eliminate drugs from the list of drugs subject to multiple source generic drug pricing or modify MAC rates in a timely fashion, but in no event any later than 15 days from the date of any change. To place a particular prescription drug on a multiple-source generic list, the PBM shall, at a minimum, ensure that: • The drug is listed as therapeutically and pharmaceutically equivalent or "A," "B," "NR," or "NA" rated in the Food and Drug Administration's most recent version of the Approved Drug Products with Therapeutic Equivalence Evaluations, commonly known as the "Orange Book"; and • The drug is available for purchase without limitations by all pharmacies in the State from national or regional wholesalers and is not obsolete or temporarily unavailable. Carriers and PBMs under a contract with a carrier, must use a single MAC list, to establish the maximum amount to be paid by a health benefits plan to a pharmacy provider for a generic drug or a brand- name drug that has at least one generic equivalent available. The same MAC list must be used for each pharmacy provider. For brand-name drugs without a generic equivalent, or a prescription drug not included on a MAC list, carriers or PBMs must use the AWP to establish the maximum payment. All contracts between a PBM and a contracted pharmacy shall include a process to appeal, investigate, and resolve disputes regarding multiple source generic drug pricing. The contract provision establishing the process shall include the following: • The right to appeal shall be limited to 14 calendar days following the initial claim; • The appeal shall be investigated and resolved by the PBM through an internal process within 14 calendar days of receipt of the appeal by the PBM; and	

	• A telephone number at which a pharmacy may contact the PBM and speak with an individual who is involved in the appeals process. • If the appeal is denied, the PBM shall provide the reason for the denial and identify the NDC of a drug product that is available for purchase by contracted pharmacies in this State from wholesalers at a price which is equal to or less than the MAC for the appealed drug as determined by the PBM; and • If the appeal is approved, the PBM shall make the price correction, permit the reporting pharmacy to reverse and rebill the appealed claim, and make the price correction effective for all similarly situated pharmacies from the date of the approved appeal.	
Patient Cost-Sharing	**Maximum Cost-Sharing Levels:** A carrier or PBM shall not require a covered person to make a payment at the point of sale for a covered prescription drug in an amount greater than the lesser of: • The applicable cost-sharing amount for the prescription drug; or • The amount a covered person would pay for the prescription medication if the covered person purchased the prescription medication without using a health benefits plan. **Copay Adjustment Programs:** For plans, policies, and contracts that are delivered, issued, executed, or renewed after April 10, 2026, a carrier or TPA shall not directly or indirectly set, alter, implement, or condition the terms of health benefit plan coverage based in part of entirely on the availability or amount of financial assistance available for a prescription drug. When calculating an enrollee's cost-sharing amount requirement, a carrier or TPA shall give credit for any cost-sharing amount paid by the enrollee or on behalf of the enrollee by another party. For high- deductible health plans, this requirement applies after the enrollee meets the federal minimum deductible.	NJ Rev Stat § 17B:27F-3.1; NJ Rev Stat § 17B:27F-1 (2025); NJ Rev Stat § 17:48-6n

	This does not apply to the following plans, policies, or contracts: accident only, disability, long-term care, Medicare supplemental coverage, TRICARE supplement coverage, Medicare prescription drug coverage, Medicaid, worker's compensation, the State Health Benefits Program, the School Employees' Health Benefits Program, and self- insured health benefits plans governed by ERISA. **Copay Cap:** Coverage for the purchase of a short-acting, intermediate-acting, rapid-acting, long-acting, and pre-mixed insulin product shall not be subject to any deductible, and no copayment or coinsurance for the purchase of insulin shall exceed $35 per 30-day supply.	