State PBM Reform Inventory

Updated October 2026

New York

Issue	Summary	Citation
Licensing/Registration	Every PBM that performs pharmacy benefit management services shall register with the Superintendent of Insurance in a manner acceptable to the superintendent and shall pay a fee of $4,000 each year. The superintendent, in consultation with the Commissioner of Health, may establish minimum registration standards required for a PBM. No person shall acquire control of any licensed PBM, whether by purchase of its securities or otherwise, unless such person receives the superintendent's prior approval. The superintendent shall disapprove such acquisition if the superintendent determines, after notice and an opportunity to be heard, that such action is reasonably necessary to protect the interests of the people of this State.	N.Y. Ins. Law § 2903; N.Y. Ins. Law 29 § 2905
Reporting Requirements	On or before July 1 of each year, every PBM shall report to the superintendent: • Any pricing discounts, rebates of any kind, inflationary payments, credits, claw backs, fees, grants, chargebacks, reimbursements, other financial or other reimbursements, incentives, inducements, refunds or other benefits received by the PBM; • The terms and conditions of any contract or arrangement, including other financial or other reimbursement incentives, inducements, or refunds between the PBM and any other party relating to pharmacy benefit management services provided to a health plan, including dispensing fees paid to pharmacies; The aggregated dollar amount of rebates, fees, price protection payments and any other payments the PBM received from drug manufacturers through rebate contracts; • The portion of aggregated rebates that were passed on to health plans or retained by the PBM; • For each rebate contract in effect during the reporting period, the names of the contracting parties; the execution	N.Y. Ins. Law § 2904.28.29

	date and the term of the contract, including extensions; and the name of the drugs and the associated NDCs covered by the rebate contract, and for each drug: ○ A summary of the contract terms regarding formulary placement, formulary exclusion, or prior authorization requirements or step edits, of any drugs considered to compete with each drug; ○ A summary of all terms requiring or incentivizing volume or market share for each drug, including base rebate amounts, bundled rebates and incremental rebates, stated separately, and price concession, stated separately for each drug; and ○ The total number of prescriptions filled and units dispensed for which a rebate, discount, price concession or other consideration was received by the PBM for each drug; • The rebate percentage and dollar amount retained by the PBM for every rebate, discount, price concession or other consideration under each rebate contract; and • The dollar amount of any other compensation paid by a drug manufacturer to a PBM for services including distribution management services, data or data services, marketing or promotional services, research programs, or other ancillary services, under each rebate contract. The superintendent may require the filing of quarterly or other statements, which shall be in such form and shall contain such matters as the superintendent shall prescribe.	
PBM Income	**Spread Pricing (Medicaid):** In Medicaid, a PBM shall not utilize any form of spread pricing in any contract or other arrangement with health care plans. **Rebate Pass-Through (Medicaid):** Any contract or other arrangement entered into by a health care plan for the provision and administration of pharmacy benefit management services on behalf of individuals enrolled in a managed Medicaid plan shall be based on a pass-through pricing model. Payment to the PBM for pharmacy benefit management services shall be limited to the actual ingredient costs, dispensing fees paid to pharmacies, and an administrative fee	N.Y. Pub. Health L § 4406-C(10a)

	that covers the cost of providing pharmacy benefit management services. The department may establish a maximum administrative fee.	
Pharmacy Contracting	**Patient Steering:** A PBM shall not directly or indirectly: • Engage in marketing, advertising, or promotional activities to covered individuals for the purpose of gaining dispensing opportunities at affiliated pharmacies, including providing incentives to a covered individual to use an affiliated pharmacy when unaffiliated pharmacies are available within the same network, provided, however, that nothing in this section shall be construed to restrict a PBM from communicating or operationalizing any element of plan design elected by a health plan; • In any manner on any material produced by the PBM, including identification cards, include the name of any affiliated pharmacy unless it specifically lists two or more unaffiliated pharmacies participating in the relevant pharmacy network, provided unaffiliated pharmacies are participating in the network; • Transfer or share records relative to prescription information containing a covered individual's identifiable or prescriber- identifiable data to an affiliated pharmacy; • Require a covered individual to purchase prescription drugs exclusively through a mail-order pharmacy or refer a covered individual to a mail-order pharmacy or an affiliated pharmacy unless contractually required to do so by the health plan; • Penalize a covered individual for using an in-network unaffiliated pharmacy, including by requiring a covered individual to pay the full cost for a prescription. Nothing in this paragraph shall be construed to prohibit a health plan's election to use a network or networks that only includes affiliated pharmacies; • Prohibit or limit any covered individual from selecting an in-network pharmacy of the individual's choice unless specifically required by the health plan for a particular covered individual.	NY Pub. Health Law 2-D § 238-A; N.Y. Pub. Health Law § 280-A (4)

	MAC Pricing: A PBM shall, with respect to contracts between a PBM and a pharmacy or, alternatively, a PBM and a pharmacy's contracting agent, such as a PSAO, include a reasonable process to appeal, investigate and resolve disputes regarding multi-source generic drug pricing. The appeals process shall include the following provisions: • The right to appeal by the pharmacy and/or the pharmacy's contracting agent shall be limited to 30 days following the initial claim submitted for payment; • A telephone number and email address through which a network pharmacy may contact the PBM for the purpose of filing an appeal; • The PBM shall respond in an electronic message to the pharmacy and/or the pharmacy's contracting agent filing the appeal within 7 business days indicating its determination. If the appeal is determined to be valid, the MAC for the drug shall be adjusted for the appealing pharmacy effective as of the date of the original claim for payment. The PBM shall require the appealing pharmacy to reverse and rebill the claim in question to obtain the corrected reimbursement; • If an update to the MAC is warranted, the PBM or covered entity shall adjust the MAC of the drug effective for all similarly situated pharmacies in its network in the state on the date the appeal was determined to be valid; and • If an appeal is denied, the PBM shall identify the NDC of a therapeutically equivalent drug that is available for purchase by pharmacies in this state at a price which is equal to or less than the MAC for that drug as determined by the PBM.	
Patient Cost-Sharing	**Copay Cap:** Starting January 1, 2025, upon the issuance, renewal, modification, alteration, or amendment of a health insurance policy or contract, cost- sharing for prescription insulin is prohibited. This applies to all state- regulated commercial plans including Essential Plan, individual and family plans, and small and large group plans. This applies to high- deductible health plans, except for individual catastrophic plans.	NY Ins. Law § 3216(15 a)(i)(B); N.Y. Ins. Law § 3216(37); N.Y. Pub. Health Law § 280-A (5)

	Copay Adjustment Programs: Any policy that provides coverage for prescription drugs shall apply any third-party payments, financial assistance, discount, voucher or other price reduction instrument for out-of-pocket expenses made on behalf of an insured individual for the cost of a prescription drug to the insured's deductible, copayment, coinsurance, out-of-pocket maximum, or any other cost-sharing requirement when calculating such insured individual's overall contribution to any out-of-pocket maximum or any cost-sharing requirement. This requirement applies to high-deductible health plans once a covered individual meets the minimum deductible required to remain HSA-eligible. This paragraph only applies to a prescription drug that is either: • A brand-name drug without an AB rated generic equivalent, as determined by the United States Food and Drug Administration; or • A brand-name drug with an AB rated generic equivalent, as determined by the United States Food and Drug Administration, and the insured has access to the • brand-name drug through prior authorization by the insurer or through the insurer's appeal process, including any step-therapy process; or • A generic drug the insurer will cover, with or without prior authorization or an appeal process. **Maximum Cost-Sharing Levels:** No PBM shall require a contracted pharmacy to charge or collect from an individual a copayment that exceeds the total submitted charges by the pharmacy for which the pharmacy is paid.	