CHAPTER 107

AN ACT concerning pharmacy benefits managers, supplementing P.L.2015, c.179, and amending various parts of the statutory law.

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

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

C.17B:27F-1 Definitions.

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

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

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

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

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

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

a. the pharmacy benefits manager directly;

b. a pharmacy services administration organization; or

c. a pharmacy group purchasing organization.

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

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

“Department” means the Department of Banking and Insurance.

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

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

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

"Network pharmacy" means a licensed retail pharmacy or other pharmacy provider that contracts with a pharmacy benefits manager either directly or by and through a contract with a pharmacy services administrative organization.

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

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

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

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

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

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

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

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

C.17B:27F-1.1 Pharmacy benefits manager, license, pharmacy services administrative, registration.

2. a. A corporation, business, or other entity shall not act as a pharmacy benefits manager without first obtaining a license from the department or as a pharmacy services administrative organization without first obtaining registration from the department. An applicant for licensure or registration shall provide to the department information that includes, but is not limited to, the following:

(1) the name of the applicant;

(2) the address and telephone number of the applicant;

(3) the name and address of the applicant's agent for service of process in the State;

(4) the name and address of each person owning 10 percent or greater interest in the applicant;

(5) the name and address of each person with management or control over the applicant;

(6) for pharmacy benefits managers, the information required under section 4 of P.L.1999, c.409 (C.17:48H-4);

(7) for pharmacy benefits managers, all contracts and documents between pharmacies, pharmacy benefits managers, and pharmacy services administrative organizations; and

(8) for pharmacy services administrative organizations, upon the department's request, any contracts and documents between pharmacies, pharmacy benefits managers, and pharmacy services administrative organizations.

b. A license or registration issued pursuant to this section shall be valid for a period of three years and may be renewed at the end of the three-year period. The commissioner shall establish fees for a license or registration issued or renewed pursuant to this section.

c. The department may issue a pharmacy benefits manager license to an applicant only if the department is satisfied that the applicant possesses the necessary organization, expertise, and financial integrity to supply the services sought to be offered. The department shall establish, by regulation, minimum standards for the issuance of a license to a pharmacy benefits manager. The minimum standards established pursuant to this subsection shall contain both prerequisites for the issuance of a license to a pharmacy benefits manager and requirements for maintenance of a license by a pharmacy benefits manager and shall address, without limitation:

(1) conflicts of interest between pharmacy benefits managers and health benefits plans;

(2) deceptive practices in connection with the performance of pharmacy benefits management services;

(3) anti-competitive practices in connection with the performance of pharmacy benefits management services;

(4) unfair claims practices in connection with the performance of pharmacy benefits management services;

(5) pricing models used by pharmacy benefits managers both for their services and for the payment of services to the pharmacy benefits manager;

(6) 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

(7) protection of consumers.

d. The department may issue a license to a pharmacy benefits manager subject to restrictions or limitations, including the type of services that may be supplied or the activities in which the pharmacy benefits manager may engage.

e. A license or registration issued pursuant to this section shall not be transferable.

f. The department may suspend, revoke or place on probation a licensee or registered entity if:

(1) the pharmacy benefits manager or pharmacy services administrative organization has engaged in fraudulent activity or any activity that constitutes a violation of State or federal law;

(2) the department has received consumer complaints that justify an action under this subsection to protect the safety and interests of consumers;

(3) the pharmacy benefits manager or pharmacy services administrative organization fails to pay the original issuance or renewal fee for the license or registration; or

(4) the pharmacy benefits manager or pharmacy services administrative organization fails to comply with any requirement set forth in P.L.2023, c.107 (C.17B:27F-1.1 et al.).

g. If a corporation, business, or other entity acts as a pharmacy benefits manager or pharmacy services administrative organization without obtaining a license or registration pursuant to this section, the corporation, business, or other entity shall be subject to the provisions of section 7 of P.L.2019, c.274 (C.17B:27F-10).

h. (1) Notwithstanding the provisions of subsection a. of this section, a pharmacy benefits manager that applied for, or received, certification or licensure as an organized delivery system prior to the effective date of P.L.2023, c.107 (C.17B:27F-1.1 et al.), in accordance with P.L.1999, c.409 (C.17:48H-1 et seq.), may continue to operate during the pendency of its application submitted pursuant to this section, but no more than 24 months after the effective date of this act.

(2) A corporation, business, or other entity that acts as a pharmacy benefits manager, and applies for, receives, and maintains a license as an organized delivery system, in accordance with P.L.1999, c.409 (C.17:48H-1 et seq.), shall not be required to maintain that license as an organized delivery system upon the issuance of a license pursuant to P.L.2023, c.107 (C.17B:27F-1.1 et al.), and during any subsequent applications for renewal of the license as a pharmacy benefits manager pursuant to the requirements of P.L.2023, c.107 (C.17B:27F-1.1 et al.).

i. A licensee shall be subject to the following except to the extent inconsistent with this act or where the commissioner determines that any provisions are inappropriate as applied to a pharmacy benefits manager:

(1) the unfair trade practices provisions of N.J.S.17B:30-1 et seq.;

(2) the provisions of P.L.1970, c.22 (C.17:27A-1 et seq.);

(3) the "Life and Health Insurers Rehabilitation and Liquidation Act," P.L.1992, c.65 (C.17B:32-31 et seq.);

(4) investment limitations pursuant to N.J.S.17B:20-1 et seq.; and

(5) the "Health Care Quality Act," P.L.1997, c.192 (C.26:2S-1 et al.).

C.17B:27F-3.1 Carrier duties, responsibilities.

3. a. A carrier shall:

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

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

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

c. (1) A pharmacy benefits manager interacting with a covered person shall have the same duty to a covered person as the health benefits plan or carrier for whom it is performing pharmacy benefits management services.

(2) A pharmacy benefits manager shall have a duty of good faith and fair dealing with all parties, including but not limited to covered persons and pharmacies, with whom it interacts in the performance of pharmacy benefits management services.

d. A carrier or pharmacy benefits manager 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:

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

(2) 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.

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

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

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

C.17B:27F-2 Duties, pharmacy benefits manager, contracts.

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

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

(2) update that pricing information every seven calendar days; and

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

b. Additionally, a pharmacy benefits manager shall:

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

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

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

C.17B:27F-3 Carrier, pharmacy benefits manager under contract, single maximum allowable cost list; prescription drug, source generic list, requirements.

3. a. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use a single maximum allowable cost 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. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use the same maximum allowable cost list for each pharmacy provider.

b. A maximum allowable cost may be set for a prescription drug, or a prescription drug may be allowed to continue on a maximum allowable cost list, only if:

(1) 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

(2) 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.

c. A pharmacy benefits manager shall not penalize a pharmacist or pharmacy on audit if the pharmacist or pharmacy performs a generic substitution pursuant to the "Prescription Drug Price and Quality Stabilization Act," P.L.1977, c.240 (C.24:6E-1 et seq.).

d. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use the average wholesale price to establish the maximum payment for a brand-name drug for which a generic equivalent is not available or a prescription drug not included on a maximum allowable cost list. In order to use the average wholesale price of a brand-name drug or prescription drug not included on a maximum allowable cost list, a carrier, or a pharmacy benefits manager under contract with a carrier, shall use only one national drug pricing source during a calendar year, unless the original drug pricing source is no longer available. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use the same national drug pricing source for each pharmacy provider and identify on its publicly accessible website the name of the national drug pricing source used to determine the average wholesale price of a prescription drug not included on the maximum allowable cost list.

e. The amount paid by a carrier or a carrier's pharmacy benefits manager to a pharmacy provider under contract with the carrier or the carrier's pharmacy benefits manager for dispensing a prescription drug shall be the ingredient cost plus the dispensing fee less any cost-sharing amount paid by a covered person.

The ingredient cost shall not exceed the maximum allowable cost or average wholesale price, as applicable, and shall be disclosed by a carrier's pharmacy benefits manager to the carrier.

Only the pharmacy provider that dispensed the prescription drug shall retain the payment described in this subsection.

C.17B:27F-3.2 Compensation remitted, pharmaceutical manufacturer, developer, labeler, carrier, pharmacy benefits manager under contract; report.

6. a. Compensation remitted by or on behalf of a pharmaceutical manufacturer, developer or labeler, directly or indirectly, to a carrier or to a pharmacy benefits manager under contract with a carrier related to prescription drug benefits shall be:

(1) 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

(2) remitted to, and retained by, the carrier. Compensation remitted to the carrier shall be applied by the carrier in its plan design and in future plan years to offset the premium for covered persons.

b. Beginning on March 1 next following the effective date of P.L.2023, c.107 (C.17B:27F-1.1 et al.), and annually thereafter, a carrier shall file with the department a report explaining how the carrier has complied with the provisions of this section. The report shall be written in a manner and form determined by the department.

c. Nothing in this section shall preclude a carrier or pharmacy benefits manager under contract with a carrier from implementing a program designed to lower a covered person's out-of-pocket cost or decreasing a covered person's out-of-pocket cost by an amount greater than that required under subsection a. of this section.

d. 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 health benefits plan or enrollment in a health benefits plan, regardless of how the benefits are otherwise characterized by a pharmacy benefits manager and relevant third parties.

C.17B:27F-3.3 Carrier, pharmacy benefits manager under contract, pharmacy and therapeutics committee, established, formulary system management.

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

b. A carrier, or a pharmacy benefits manager under contract with a carrier, shall not allow a person with a conflict of interest to be a member of its pharmacy and therapeutics committee. A carrier, or a pharmacy benefits manager under contract with a carrier, shall require that its pharmacy and therapeutics committee meet the requirements for conflict of interest as set by the Centers for Medicare and Medicaid Services or meets the accreditation standards of the National Committee for Quality Assurance or another independent accrediting organization.

C.17B:27F-9.1 Carrier, health benefits plan, access data, administration, provision, prescription drug benefits; penalties.

8. a. A carrier or health benefits plan, including the State Health Benefits Program, the School Employees' Health Benefits Program, the State Medicaid program, and a self-insured health benefits plan governed by the provisions of the federal "Employee Retirement Income Security Act of 1974," 29 U.S.C. s.1001 et seq., shall have the ability to access all data related to the administration and provision of prescription drug benefits administered by a pharmacy benefits manager under the health benefits plan, including, but not limited to:

(1) the names, addresses, member identification numbers, protected health information and other personal information of covered persons; and

(2) any contracts, documentation, and records, including transaction and pricing data and post point-of-sale information, related to the dispensing of prescription drugs to covered persons under the health benefits plan.

b. A sale or transaction involving the transfer of any records, information or data described in subsection a. of this section must comply with the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and the federal Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, and any regulations adopted pursuant to those laws.

c. A carrier or health benefits plan, including the State Health Benefits Program, the School Employees' Health Benefits Program, the State Medicaid program, or a self-insured health benefits plan may audit all transaction records related to the dispensing of prescription drugs to covered persons under a health benefits plan. A carrier or health benefits plan, including the State Health Benefits Program, the School Employees' Health Benefits Program, the State Medicaid program, or a self-insured health benefits plan may conduct audits at a location of its choosing and with an auditor of its choosing.

d. A carrier shall maintain all records, information and data described in subsection a. of this section and all audit records described in subsection c. of this section for a period of no less than five years.

e. (1) Upon request, a carrier or pharmacy benefits manager shall provide to the department any records, contracts, documents or data held by the carrier or the carrier's pharmacy benefits manager for inspection, examination or audit purposes. The department shall keep confidential all information submitted pursuant to this section and shall protect it from public disclosure. Any records, documents, or data provided to the department pursuant to this subsection shall not be considered a government record under P.L.1963, c.73 (C.47:1A-1 et seq.) or the common law concerning access to government records.

(2) A person who is authorized to access information submitted by a pharmacy benefits manager to the department who willfully discloses such information to any person or entity who is not authorized to access the information shall be subject to a civil penalty in an amount not to exceed $500.

A civil penalty imposed under this subsection shall be collected by the commissioner pursuant to the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

f. A pharmacy benefits manager shall disclose in writing to a carrier or health benefits plan any activity, policy, practice, contract or arrangement of the pharmacy benefits manager that directly or indirectly presents any conflict of interest with the pharmacy benefits manager's relationship with or obligation to the carrier or plan.

C.17B:27F-3.4 Carrier, use of pharmacy benefits manager, administer, manage, prescription drug benefits, claims, parameters.

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

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

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

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

(1) a memorandum prepared by a qualified actuary describing the calculation of the pharmacy benefits manager compensation; and

(2) any records and supporting information as the department reasonably determines is necessary to confirm the calculation of the pharmacy benefits manager compensation.

c. Upon request, a carrier shall provide any records to the department that relate to the calculation of the pharmacy benefits manager and pharmacy services administrative organization compensation.

d. A pharmacy benefits manager and pharmacy services administrative organization shall provide any necessary documentation requested by a carrier that relates to pharmacy benefits manager compensation in order to comply with the requirements of this section.

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

C.17B:27F-6 Regulations, pharmacy benefits managers.

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

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

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

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

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

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

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

11. Section 6 of P.L.2019, c.274 (C.17B:27F-9) is amended to read as follows:

C.17B:27F-9 Applicability of C.17B:27F-1 et seq.

6. The licensing requirements of P.L.2015, c.179 (C.17B:27F-1 et seq.) shall apply to all pharmacy benefits managers operating in the State of New Jersey. Requirements imposed on carriers by the provisions of P.L.2015, c.179 (C.17B:27F-1 et seq.) shall not apply to an agreement by a pharmacy benefits manager to administer prescription drug benefits on behalf of the State Health Benefits Program, the School Employees Health Benefits Program, the State Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), or a self-insured health benefits plan governed by the provisions of the federal "Employee Retirement Income Security Act of 1974," 29 U.S.C., ss.1001 et seq.

12. Section 7 of P.L.2019, c.274 (C.17B:27F-10) is amended to read as follows:

C.17B:27F-10 Violations, penalties.

7. a. A pharmacy benefits manager that violates any provision of P.L.2015, c.179 (C.17B:27F-1 et seq.) shall be subject to a penalty in an amount not exceeding the greater of:

(1) a penalty of $5,000 for a first violation and a penalty of $10,000 for each subsequent violation; or

(2) the aggregate gross receipts attributable to all violations.

b. In addition to any other penalties permitted by law, the Commissioner of Banking and Insurance may require a pharmacy benefits manager that violates the provisions of P.L.2015,

c.179 (C.17B:27F-1 et seq.) to make restitution and pay compensatory damages, in an amount to be determined by the commissioner, to any person injured by the violation.

13. The Drug Affordability Council, established pursuant to P.L.2023, c.106 (C.45:14-82.2 et al.), shall, in the first report issued by the council, examine the existing prescription drug rebate system and evaluate measures and reforms that could reduce the cost of prescription drugs, including, but not limited to, the elimination of rebates and the establishment of rebate transparency provisions.

14. This act shall take effect on the first day of the 18th month next following the date of enactment, and shall apply to contracts and agreements entered into, renewed, modified, or amended on or after the effective date, but the Commissioner of Banking and Insurance may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of the act.

Approved July 10, 2023.