[First Reprint]

ASSEMBLY, No. 4676

STATE OF NEW JERSEY

217th LEGISLATURE

INTRODUCED MARCH 16, 2017

Sponsored by:
Assemblyman CRAIG J. COUGHLIN
District 19 (Middlesex)
Assemblyman RAJ MUKHERJI
District 33 (Hudson)
Assemblyman DANIEL R. BENSON
District 14 (Mercer and Middlesex)
Assemblywoman JOANN DOWNEY
District 11 (Monmouth)
Assemblyman ERIC HOUGHTALING
District 11 (Monmouth)

Co-Sponsored by:
Assemblyman Giblin

SYNOPSIS

Regulates pharmacy benefits managers as organized delivery systems and limits use of prior authorization.

CURRENT VERSION OF TEXT

As reported by the Senate Commerce Committee on December 14, 2017, with amendments.

(Sponsorship Updated As Of: 6/9/2017)

AN ACT concerning pharmacy benefits managers and amending P.L.1999, c.409 and supplementing P.L.2015, c.179 (C.17B:27F-1 et seq.).

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

[1][1. (New section) This act shall be known and may be cited as the "Prescription Drug Patient Protection Act."]**[1]**

[1][2. (New section) a. After the effective date of this act, no person, corporation, partnership or other entity shall operate as a pharmacy benefits manager in this State except in accordance with the provisions of this act.

b. (1) A pharmacy benefits manager operating in this State on the effective date of this act shall submit an application, as provided in section 3 of this act, to the Commissioner of Banking and Insurance for a certificate of authority to operate as a pharmacy benefits manager no later than nine months after the effective date of this act.

(2) The pharmacy benefits manager may continue to operate during the pendency of its application, but in no event more than 18 months after the effective date of this act unless the commissioner has approved the application.

(3) If the commissioner denies the application, the applicant shall then be treated as a pharmacy benefits manager whose certificate has been revoked pursuant to paragraph (2) of subsection c. of section 3 of this act.

(4) Nothing in this act shall operate to impair any contract which was entered into by a pharmacy benefits manager before the effective date of this act.

c. A pharmacy benefits manager that seeks to commence operations in this State after the effective date of this act shall submit an application, as provided in section 3 of this act, to the Commissioner of Banking and Insurance for a certificate of authority to operate as a pharmacy benefits manager.]**[1]**

[1][3. (New section) a. A pharmacy benefits manager shall submit an application for a certificate of authority on a form and in a manner to be prescribed by the commissioner by regulation. The application shall be signed under oath by the chief executive officer of the pharmacy benefits manager or by a legal representative of the pharmacy benefits manager, and shall include the following:

(1) the name, address, telephone number, and normal business

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.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Senate SCM committee amendments adopted December 14, 2017.

hours of the pharmacy benefits manager;

(2) the name, address, and telephone number of a person who is employed by, or otherwise represents, the pharmacy benefits manager and who is available to answer questions concerning the application that may be posed by representatives of the Department of Banking and Insurance;

(3) the proposed plan of operation for the pharmacy benefits manager, including the manner in which pharmacy benefits management services will be provided;

(4) a copy of the most recent financial statement audited by an independent certified public accountant; and

(5) such other information as the commissioner may require to ensure that the pharmacy benefits manager can and will comply with the provisions of this act.

If there is a material change in any of the information included in the application for a certificate of authority subsequent to its initial submission, including a change subsequent to the issuance or renewal of the certificate, the pharmacy benefits manager shall inform the commissioner of the change on a form and in a manner to be prescribed by the commissioner by regulation.

b. The commissioner shall issue a certificate of authority to operate in this State to a pharmacy benefits manager if, in the determination of the commissioner, the application demonstrates that the pharmacy benefits manager:

(1) will provide pharmacy benefits management services in compliance with the provisions of this act and P.L.2015, c.179;

(2) will provide a complaint resolution mechanism that includes reasonable procedures for the resolution of complaints by pharmacists, prescribers, and covered persons;

(3) is financially sound and may reasonably be expected to meet its obligations to purchasers and covered persons;

(4) has a procedure to establish and maintain a uniform system of cost accounting approved by the commissioner and a uniform system of reporting and auditing, which meet the requirements of the commissioner; and

(5) has adopted procedures to ensure compliance with all State and federal laws governing the confidentiality of its records with respect to pharmacists, prescribers, and covered persons.

c. (1) If the commissioner rejects an application by a pharmacy benefits manager for a certificate of authority, the commissioner shall specify in what respect the application fails to comply with the requirements for certification.

(2) If the commissioner revokes a certificate of authority for a pharmacy benefits manager, the pharmacy benefits manager shall proceed, immediately following the effective date of the order of revocation, to pay all outstanding pharmacy benefits claims of covered persons and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the

pharmacy benefits manager. The commissioner may permit such further operation of the pharmacy benefits manager as the commissioner may find to be in the best interest of the purchaser and covered persons.

d. A certificate of authority issued pursuant to this act shall be valid for three years from the date of issuance by the commissioner, and shall be renewed every three years thereafter.

e. The commissioner shall establish fees for an application for a certificate of authority and for a renewal of a certificate of authority, the amounts of which shall be no greater than is reasonably necessary to enable the Department of Banking and Insurance to carry out the provisions of this act.

f. The provisions of this act shall not apply to a pharmacy benefits manager that is an affiliate of a carrier and provides pharmacy benefits management services solely to that carrier.**]**[1]

[1][4.**]** 1.[1] Section 1 of P.L.1999, c.409 (C.17:48H-1) is amended to read as follows:

1. As used in this act:

"Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the organized delivery system.

"Capitation" means a fixed per member, per month, payment or percentage of premium payment for which the provider assumes the risk for the cost of contracted services without regard to the type, value or frequency of the services provided.

"Carrier" means an insurer authorized to transact the business of health insurance as defined at N.J.S.17B:17-4, a hospital service corporation authorized to transact business in accordance with P.L.1938, c.366 (C.17:48-1 et seq.), a medical service corporation authorized to transact business in accordance with P.L.1940, c.74 (C.17:48A-1 et seq.), a health service corporation authorized to transact business in accordance with P.L.1985, c.236 (C.17:48E-1 et seq.) or a health maintenance organization authorized to transact business pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.).

"Certified organized delivery system" means an organized delivery system that is compensated on a basis which does not entail the assumption of financial risk by the organized delivery system and that is certified in accordance with this act.

"Comprehensive health care services" means the basic benefits provided under a health benefits plan, including medical and surgical services provided by licensed health care providers who may include, but are not limited to, family physicians, internists, cardiologists, psychiatrists, rheumatologists, dermatologists, orthopedists, obstetricians, gynecologists, neurologists, endocrinologists, radiologists, nephrologists, emergency services physicians, ophthalmologists, pediatricians, pathologists, general surgeons, osteopathic physicians, physical therapists and

chiropractors. Basic benefits may also include inpatient or outpatient services rendered at a licensed hospital, covered services performed at an ambulatory surgical facility and ambulance services.

"Financial risk" means exposure to financial loss that is attributable to the liability of an organized delivery system for the payment of claims or other losses arising from covered benefits for treatment or services other than those performed directly by the person or organized delivery system liable for payment, including a loss sharing arrangement. A payment method wherein a provider accepts reimbursement in the form of a capitation payment for which it undertakes to provide health care services on a prepayment basis shall not be considered financial risk.

"Health benefits plan" means a [1]**[**benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, **[**CHAMPUS**]** TRICARE supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) or hospital confinement indemnity coverage**]** hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. Health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Health benefits plan shall not include hospital confinement indemnity

coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. s.1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. s.1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan[1].

"Licensed organized delivery system" means an organized delivery system that is compensated on a basis which entails the assumption of financial risk by the organized delivery system and that is licensed in accordance with this act.

"Limited health care services" means a health service or benefit which a carrier has elected to subcontract for as a separate service, which may include, but shall not be limited to, substance [1]**[**abuse**]** use disorder[1] services, vision care services, mental health services, podiatric care services, chiropractic services, pharmaceutical services or rehabilitation services. Limited health care services shall not include **[**pharmaceutical services,**]** case management services or employee assistance plan services.

"Organized delivery system" or "system" means an organization with defined governance that:

a. is organized for the purpose of and has the capability of contracting with a carrier to provide, or arrange to provide, under its own management substantially all or a substantial portion of the comprehensive health care services or benefits under the carrier's benefits plan on behalf of the carrier, which may or may not include the payment of hospital and ancillary benefits; or

b. is organized for the purpose of acting on behalf of a carrier to provide, or arrange to provide, limited health care services that the carrier elects to subcontract for as a separate category of benefits and services apart from its delivery of benefits under its comprehensive benefits plan, which limited services are provided on a separate contractual basis and under different terms and conditions than those governing the delivery of benefits and services under the carrier's comprehensive benefits plan.

An organized delivery system shall not include an entity otherwise authorized or licensed in this State to provide comprehensive or limited health care services on a prepayment or other basis in connection with a health benefits plan or a carrier.

"Provider" means a physician, health care professional, health care facility, or any other person who is licensed or otherwise authorized to provide health care services or other benefits in the state or jurisdiction in which they are furnished.
(cf: P.L.1999, c.409, s.1)

[1]**[**5.**]** 2.[1] (New section) [1]**[**The Commissioner of Banking and Insurance shall adopt, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), rules and regulations, including any penalty provisions the commissioner deems to be necessary, to effectuate the purposes of this act.**]** A pharmacy benefits manager shall not require prior authorization for any prescription drug, unless there is an alternative drug that has a lower cost and is of equal quality and effectiveness to the prescribed drug, which alternative drug shall be provided without prior authorization.[1]

[1]**[**6.**]** 3.[1] This act shall take effect on the 90th day next following enactment.