CHAPTER 380

AN ACT concerning prepaid prescription service organizations and supplementing Title 17 of the Revised Statutes.

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

C.17:48F-1 Definitions relative to prepaid prescription service organizations.

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 prepaid prescription service organization.

"Commissioner" means the Commissioner of Banking and Insurance.

"Consumer Price Index" means the medical component of the Consumer Price Index for All Urban Consumers, as reported by the United States Department of Labor, shown as an average index for the New York-Northern New Jersey-Long Island region and the Philadelphia-Wilmington-Trenton region combined.

"Contract holder" means the person or organization which contracts with the prepaid prescription service provider.

"Enrollee" means a person and his dependents who are entitled to benefits provided under a prepaid prescription service organization contract.

"Evidence of coverage" means the certificate, agreement or contract issued pursuant to this act which sets forth the benefits or services to which the enrollee or contract holder is entitled.

"Net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner.

"Prepaid prescription service organization" or "organization" means any person, corporation, partnership, or other entity which, in return for a prepayment by a contract holder, undertakes to provide or arrange for the provision of prescription services to enrollees or contract holders. Prepaid prescription service organization shall not include: an entity otherwise authorized or licensed pursuant to the laws of this State or an entity that contracts with such an otherwise authorized or licensed entity,to provide a prescription service on a prepayment or other basis in connection with a health benefits plan; an entity licensed under Title 17 of the Revised Statutes or Title 17B of the New Jersey Statutes to do the business of insurance in this State; a provider or other entity who provides prescription services pursuant to a contract with a prepaid prescription service organization; or an entity which, for a fee, acts as administrator of a self-insured prescription plan on behalf of the self insurer.

"Prescription service" means any benefit or service to be provided to an enrollee or a contract holder by a provider pursuant to a contract with a prepaid prescription service organization. Prescription service includes, but is not limited to, the provision of prescription drugs, utilization review and durable medical goods.

"Provider" means a pharmacist or pharmacy which provides benefits under a prepaid prescription services contract.

"Tangible net equity" means net equity reduced by the value assigned to intangible assets, including, but not limited to, goodwill, going concern value, organizational expense, start-up costs, long-term prepayments of deferred charges, nonreturnable deposits, and obligations of officers, directors, owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not past due.

C.17:48F-2 Prepaid prescription service organization, certificate of authority.

2. a. Beginning one year after the date of enactment of this act, no person, corporation, partnership, or other entity shall operate a prepaid prescription service organization in this State except in accordance with the provisions of this act. No person shall sell, offer to sell or solicit offers to purchase or receive advance or periodic consideration for prescription services without obtaining a certificate of authority pursuant to this act.

b. A prepaid prescription service organization operating in this State on the effective date of this act shall submit an application for a certificate of authority to the commissioner within nine months of the date of enactment of this act. The organization may continue to operate during the pendency of its application, but in no case longer than 18 months after the date of

enactment of this act. In the event the application is denied, the applicant shall then be treated as a prepaid prescription service organization whose certificate of authority has been revoked pursuant to section 18 of this act. Nothing in this subsection shall operate to impair any contract which was entered into before the effective date of this act.

c. Any person offering prescription services in a manner substantially provided for in this act shall be presumed to be subject to the provisions of the act unless the person is otherwise regulated under State law.

C.17:48F-3 Application for certificate of authority, requirements.

3. Each application for a certificate of authority to operate a prepaid prescription service organization shall be made to the commissioner on a form prescribed by the commissioner, shall be certified by an officer or authorized representative of the applicant, and shall include the following:

a. A copy of the applicant's basic organizational document, such as the articles of incorporation, if a corporation, articles of association, partnership agreement, management agreement, trust agreement, or other applicable documents and all amendments to such documents;

b. A copy of the executed bylaws, rules and regulations, or similar documents, regulating the conduct of the applicant's internal affairs;

c. A list, in a form approved by the commissioner, of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including, but not limited to, the members of the board of directors, executive committee or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire 10% or more of the voting securities of the applicant; in the case of a partnership or association, the names of the partners or members; each person who has loaned funds to the applicant for the operation of its business; and a statement of any criminal convictions or enforcement or regulatory action taken against any person who is a member of the board, the executive committee or other governing board or committee, or the principal officers;

d. A statement generally describing the applicant, its facilities, personnel, and the prescription services to be offered by the organization;

e. A copy of the standard form of any contract made or to be made between the applicant and any providers relative to the provision of prescription services to enrollees or contract holders;

f. A copy of the form of any contract made or to be made between the applicant and contract holders or prospective contract holders;

g. A copy of the applicant's most recent financial statements audited by an independent certified public accountant. If the financial affairs of the applicant's parent company are audited by an independent certified public accountant but those of the applicant are not, then a copy of the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which are consolidating financial statements of the applicant, shall satisfy this requirement unless the commissioner determines that additional or more recent financial information is required for the proper administration of this act;

h. A copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of working capital, and any other sources of funding and provisions for contingencies;

i. A list of any affiliate of the applicant which provides services to the applicant in this State and a description of any material transaction between the affiliate and the applicant;

j. A schedule of rates and charges;

k. A description of the proposed method of marketing;

l. A description of the complaint procedures instituted by the applicant;

m. A description of the quality control and utilization review procedures established by the applicant;

n. A power of attorney, if the applicant is not domiciled in this State, duly executed by the applicant, appointing the commissioner and his successors in office as the true and lawful

attorney of the applicant in and for this State upon whom all lawful process in any legal action or proceeding against the organization on a cause of action arising in this State may be served;

o. A description of the means which will be utilized to assure the availability and accessibility of the services to enrollees;

p. A plan, in the event of insolvency, for continuation of the benefits to be provided for under the contract; and

q. Such other information as may be required by the commissioner.

C.17:48F-4 Review of application.

4. Following receipt of an application, the commissioner shall review it and notify the applicant of any deficiencies contained therein.

a. The commissioner shall issue a certificate of authority to an applicant in a timely manner, if the following conditions are met:

(1) All of the material required by section 3 of this act has been filed;

(2) The persons responsible for conducting the applicant's affairs are competent, trustworthy and possess good reputations, and have had appropriate experience, training and education;

(3) The applicant is financially sound and may reasonably be expected to meet its obligations to enrollees and the contract holder. In making this determination, the commissioner shall consider:

(a) The financial soundness of the applicant's arrangements for prescription services and the minimum standard rates, deductibles, copayments and other enrollee charges used in connection therewith;

(b) The adequacy of working capital, other sources of funding and provisions for contingencies;

(c) Whether any deposit of cash or securities, or any other evidence of financial protection submitted meets the requirements set forth in this act or by the commissioner; and

(d) The applicant's rates and rating methodology;

(4) The agreements with providers for the provision of prescription services comply with the provisions of this act;

(5) Any deficiencies identified by the commissioner have been corrected; and

(6) Any other factors determined by the commissioner to be relevant have been addressed to the satisfaction of the commissioner.

b. If the certificate of authority is denied, the commissioner shall notify the applicant and shall set forth the reasons for the denial in writing. The applicant may request a hearing by notice to the commissioner within 30 business days of receiving the notice of denial. Upon such denial, the applicant shall submit to the commissioner a plan for bringing the prepaid prescription service organization into compliance or providing for the closing down of its business.

C.17:48F-5 Modification of matter, document, filing required; fixing of charges; filing of benefits offered.

5. a. An organization, unless otherwise provided for in this act, shall not materially modify any matter or document furnished to the commissioner pursuant to section 3 of this act, including any change in rates or charges offered or to be offered under the contract, unless the organization files with the commissioner at least 60 days prior to use or adoption of the change, a notice of the change or modification, together with such information as may be required by the commissioner to explain the change or modification. If the commissioner fails to affirmatively approve or disapprove the change or modification within 60 days of submission of the notice, the notice of modification shall be deemed approved. The commissioner may extend the 60-day review period for not more than an additional 30 days by giving written notice of the extension before the expiration of the 60-day period. If a change or modification is disapproved, the commissioner shall notify the organization in writing and specify the reason for the disapproval.

b. Charges under any contract shall be established in accordance with sound actuarial principles and shall not be excessive, inadequate, or unfairly discriminatory. If at any time the commissioner finds that the rates or benefits offered under the plan are inadequate, excessive,

or unfairly discriminatory, he may order that they be rescinded or modified. If the commissioner orders that the plans be rescinded or modified, he shall notify the organization and specify the reasons for the order. The organization may, within 30 business days of receiving the order, request a hearing, which shall be held no later than 45 days after the receipt of the request by the commissioner.

c. Prior to entering into any contract with a contract holder, an organization shall file with the commissioner, for his approval, any benefits which are offered or proposed to be offered under the plan, as well as any modifications which may be made thereto. The filing shall be made no later than 60 days prior to the date that the benefits are intended to be in force. The commissioner shall either approve the benefits or state in writing his reasons for their disapproval within 60 days of receipt of the filing.

C.17:48F-6 FIling for approval by other insurers, etc.

6. Any insurer, hospital, medical or health service corporation or health maintenance organization which is not otherwise authorized to offer prescription services on a fixed prepayment basis may do so by filing for approval with the commissioner such information as shall be required by the commissioner pursuant to section 3 of this act.

C.17:48F-7 Rights of prepaid prescription service organization.

7. A prepaid prescription service organization may:

a. Purchase, lease, construct, renovate, operate and maintain such facilities, ancillary equipment and property which may be required for its principal office or for any other purposes deemed necessary in the business transactions of the organization;

b. Borrow money;

c. Loan funds to any person for the purpose of acquiring or constructing facilities or in furtherance of a program providing services to enrollees, or for any other purpose reasonably related to the business of the organization;

d. Furnish prescription services to enrollees or contract holders through providers which are under contract with or employed by the organization;

e. Contract with any person for the performance of certain functions such as marketing, enrollment and administration, subject to the provisions of section 8 of this act;

f. Contract with an insurer licensed in this State for the provision of insurance, indemnity coverage, or reimbursement against the cost of services provided by the organization; and

g. In addition to basic services provided by the organization to contract holders and enrollees, may provide:

(1) Additional services as approved by the commissioner;

(2) Indemnity benefits covering urgent care or emergency services;

(3) Coverage for services from providers other than participating providers, when referred in accordance with the terms of the contract; and

(4) Any other function provided by law, in the organization’s articles of incorporation or in the certificate of authority.

C.17:48F-8 Contract for provision of services.

8. A prepaid prescription service organization may contract with any person to provide some or all of the services it normally performs in providing prescription services and supplemental services to its enrollees and contract holders, but no such contract shall be made effective until it has been approved by the commissioner. The services may include consultative and administrative services. In granting approval, the commissioner may impose any limitations he deems necessary for the protection of the organization’s enrollees and contract holders, and the actual and potential effect of providing such services on the financial condition of the organization. Before entering into such a contract, the organization shall provide the commissioner with notice of the contract and such supporting documentation as the commissioner determines necessary. If the commissioner does not affirmatively approve or disapprove the contract within 60 days of the date of submission, the contract shall be deemed approved. The commissioner may extend the 60-day review period for not more than 30

additional days by giving written notice of the extension before the expiration of the initial 60-day period. If the contract is disapproved, the commissioner shall notify the organization in writing and specify the reasons for disapproval.

C.17:48F-9 Issuance of evidence of coverage.

9. Every contract holder and enrollee shall be issued an evidence of coverage, which shall contain a clear and complete statement of:

a. The coverage to which each enrollee is entitled;

b. Any limitation to which covered services are subject, including, but not limited to, exclusions, deductibles, copayments or other charges;

c. Where information is available as to where and how services may be obtained; and

d. The method for resolving complaints.

If any part of the benefits offered under the contract are subcontracted, the document issued to the contract holder by the organization may contain the information required herein on behalf of the subcontractor.

C.17:48F-10 Prepaid prescription service organization deemed domestic insurer.

10. a. A prepaid prescription service organization which is organized under the laws of this State shall be deemed to be a domestic insurer for the purposes of P.L.1970, c.22 (C.17:27A-1 et seq.).

b. An organization shall be subject to the provisions of N.J.S.17B:30-1 et seq.

c. The capital, surplus and other funds of an organization shall be invested in accordance with the provisions of N.J.S.17B:20-1 et seq. and guidelines established by the commissioner by regulation.

C.17:48F-11 Complaint system established.

11. A prepaid prescription service organization shall establish and maintain a complaint system providing reasonable procedures for resolving written complaints which are initiated by enrollees and providers, in accordance with minimum standards established by the commissioner by regulation. The complaint procedure shall be in writing and filed with the commissioner, and shall be made available to providers as well as contract holders and enrollees as provided for in this act.

C.17:48F-12 Examination by commissioner.

12. The commissioner may conduct an examination of a prepaid prescription service organization as often as he deems necessary in order to protect the interests of providers, contract holders, enrollees, and the residents of this State. An organization shall make its relevant books and records available for examination by the commissioner, and retain its records in accordance with a schedule established by the commissioner by regulation. The reasonable expenses of the examination shall be borne by the organization being examined. In lieu of such examination, the commissioner may accept the report of an examination made by the commissioner of another state.

C.17:48F-13 Terms, conditions required in contracts.

13. All prepaid prescription service organization contracts with providers or with entities subcontracting for the provision of prescription services shall contain the following terms and conditions:

a. In the event that the organization fails to pay for prescription services for any reason whatsoever, including, but not limited to, insolvency or breach of contract, neither the contract holder nor the enrollee shall be liable to the provider for any sums owed to the provider under the contract.

b. No provider, agent, trustee or assignee thereof may maintain an action at law or attempt to collect from the contract holder or enrollee sums owed to the provider by the organization, but this shall not be construed to prohibit collection of uncovered charges consented to or lawfully owed to providers by a contract holder or enrollee.

C.17:48F-14 Maintenance of tangible net equity.

14. a. Except as provided in subsection b. of this section, each prepaid prescription service organization shall, at all times, have and maintain tangible net equity equal to the greater of:

(1) $50,000; or

(2) 2% of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an admitted health insurer.

b. An organization which has uncovered expenses in excess of $50,000, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible net equity equal to 25% of the uncovered expense in excess of $50,000, in addition to the tangible net equity required by subsection a. of this section.

c. The dollar amounts specified in subsections a. and b. of this section shall be adjusted annually by the commissioner, by regulation, in accordance with changes in the Consumer Price Index.

C.17:48F-15 Deposit of case, securities; net worth requirement.

15. a. A prepaid prescription service organization shall deposit with the commissioner or with an entity or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to the commissioner in an amount equal to $25,000, which amount shall be adjusted annually by the commissioner, by regulation, in accordance with changes in the Consumer Price Index, plus 25% of the tangible net equity required by section 14 of this act; except that the deposit shall not be required to exceed $100,000, which amount may be adjusted by the commissioner annually in accordance with changes in the Consumer Price Index. The deposit shall be deemed an admitted asset of the organization in the determination of tangible net equity.

b. All income from deposits shall be an asset of the organization. An organization may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value, except that a security may not be substituted unless it has been approved by the commissioner.

c. Amounts on deposit shall be used to protect the interests of the organization's enrollees in the State and to assure continuation of limited health care services to enrollees of an organization which is in rehabilitation or liquidation. If an organization is placed in rehabilitation or liquidation, the deposit shall be treated as an asset subject to the provisions of N.J.S.17B:32-1 et seq.

d. The commissioner may, by regulation, adjust the amount of required net worth that an organization may have in order to provide adequate protection against contingencies affecting the organization's financial position which are not fully covered by reserves and other liabilities and supporting assets.

C.17:48F-16 Maintenance of fidelity bond.

16. A prepaid prescription service organization shall maintain in force a fidelity bond in its own name on its officers and employees, in an amount established by the commissioner by regulation. In lieu of the bond, the organization may deposit with the commissioner cash or securities or other investments approved by the commissioner.

C.17:48F-17 Annual report.

17. A prepaid prescription service organization shall file an annual report with the commissioner, on or before March 1 of each year, attested to by at least two principal officers, which covers the preceding calendar year. The report shall be on a form prescribed by the commissioner and shall include:

a. A financial statement of the organization, including its balance sheet, income statement and statement of changes in financial position for the preceding year, certified by an independent public accountant, or a consolidated audited financial statement of its parent company certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the organization;

b. The number of enrollees at the beginning of the year, the number of enrollees as of the

end of the year, and the number of enrollments during the year;

c. At the discretion of the commissioner, a statement by a qualified actuary setting forth his opinion as to the adequacy of reserves; and

d. Any other information relating to the performance of the organization as may be required by the commissioner.

The commissioner may assess a fine of up to $100 per day for each day a required report is late. The commissioner may require the submission of additional reports from time to time, as he deems necessary.

C.17:48F-18 Suspension, revocation of certificate of authority.

18. The commissioner may suspend or revoke the certificate of authority issued to a prepaid prescription service organization pursuant to this act upon his determination that:

a. The organization is operating significantly in contravention of its basic organizational document;

b. The organization issues an evidence of coverage or uses rates or charges which do not comply with the requirements of this act;

c. The organization is unable to fulfill its obligations to enrollees or prospective enrollees;

d. The tangible net equity of the organization is less than that required by this act, or the organization has failed to correct any deficiency in its tangible net equity as required by the commissioner;

e. The organization has failed to implement in a reasonable manner the complaint system required to be established by this act;

f. The continued operation of the organization would be hazardous to the health and welfare of its enrollees;

g. The organization has failed to file any report required pursuant to this act; or

h. The organization has otherwise failed to comply with this act.

C.17:48F-19 Notification of suspension, revocation of certificate of authority.

19. If the commissioner has cause to believe that grounds exist for the suspension or revocation of a certificate of authority, he shall notify the prepaid prescription service organization in writing, specifically stating the grounds for suspension or revocation and fixing a time for a hearing in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). If a certificate of authority is revoked, the organization shall submit a plan to the commissioner within 15 days of the revocation, for the winding up of its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of its business. The commissioner may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing prescription services.

C.17:48F-20 Maintenance of insurance to cover insolvency.

20. The commissioner may require, in connection with the plan for insolvency required pursuant to subsection p. of section 3 of this act, that a prepaid prescription service organization maintain insurance to cover the expenses to be paid for continued benefits following a determination of insolvency, or make other arrangements to ensure that benefits are continued for the period determined in the insolvency plan.

C.17:48F-21 Rehabilitation, liquidation, conservation of prepaid prescription service organization.

21. Any rehabilitation, liquidation or conservation of a prepaid prescription service organization shall be subject to the provisions of N.J.S.17B:32-1 et seq. and shall be conducted under the supervision of the commissioner; except that the commissioner shall have the authority to regulate any prepaid prescription service organization doing business in this State as a domestic insurer. The commissioner may apply for an order directing him to rehabilitate, liquidate, reorganize or conserve an organization upon any one or more applicable grounds as stated for insurers in N.J.S.17B:32-1 et seq. or any other provision of Title 17B of the New

Jersey Statutes or when in his opinion the organization fails to satisfy the requirements for the issuance of a certificate of authority relating to solvency or the requirements for solvency protection as set forth in this act.

C.17:48F-22 Order of rehabilitation.

22. If an order of rehabilitation issued pursuant to this act directs or provides for the continued operation of the prepaid prescription service organization, including the receipt of payments from, and the provision of prescription services to enrollees, the order may authorize the rehabilitator to make the payments necessary for continued operation, including those expenses necessary for the conduct of the rehabilitation.

C.17:48F-23 Providers enjoined from billing enrollees, beneficiaries under order of rehabilitation.

23. In the event that an order of rehabilitation or liquidation is granted, the order may enjoin providers from billing enrollees and their beneficiaries for health care services provided. In the course of a rehabilitation proceeding, the court may allow reformation of enrollee and provider contracts, or other restructuring of outstanding liabilities, or transfer of the business to another prepaid prescription service organization. A primary goal of the restructuring or transfer shall be the provision of uninterrupted services to enrollees of the organization. In the course of a rehabilitation proceeding, a plan for settling the claims of general creditors shall not be deemed to be inequitable or to constitute preferential treatment if the amount of reimbursement for an outstanding claim depends, in part, on the estimated increase or decrease in future or prior claims of the creditor.

C.17:48F-24 Inapplicability of C.17B:32A-1 et seq.

24. A prepaid prescription service organization shall not be subject to the "New Jersey Life and Health Insurance Guaranty Association Act," P.L.1991, c.208 (C.17B:32A-1 et seq.), and the New Jersey Life and Health Insurance Guaranty Association established pursuant to that act shall not provide protection to any individuals entitled to receive prescription services from a prepaid prescription service organization.

C.17:48F-25 Application, examination fees.

25. A prepaid prescription service organization subject to the provisions of this act shall pay to the commissioner such application fees and examination fees for applying for a certificate of authority as established by regulation by the commissioner.

C.17:48F-26 Violations; penalties.

26. a. The commissioner may, upon notice and hearing, levy an administrative penalty in an amount not less than $1,000 nor more than $30,000 for each violation, per contract or enrollee. Penalties imposed by the commissioner pursuant to this section may be in lieu of, or in addition to, suspension or revocation of a certificate of authority pursuant to this act. A penalty may be recovered in a summary proceeding pursuant to "the penalty enforcement law," N.J.S.2A:58-1 et seq.

b. If the commissioner believes that any violation of this act has occurred or is threatened, the commissioner may give notice to the prepaid prescription service organization, its representatives, or any other persons who appear to be involved in the alleged violation. The commissioner may arrange a conference with the alleged violators or their authorized representatives to ascertain the facts relating to the alleged violation. In the event that it appears that a violation has occurred or is threatened, the commissioner may implement the necessary measures to correct or prevent the violation. Appeals under this section shall be conducted pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

C.17:48F-27 Cease and desist order; injunctive relief.

27. a. The commissioner may issue an order directing a prepaid prescription service organization to cease and desist from engaging in any act or practice which is in violation of the

provisions of this act. The order shall be subject to review pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

b. In the event of noncompliance with a cease and desist order issued pursuant to subsection a. of this section, or if the commissioner elects not to issue a cease and desist order in the case of a violation of any provision of this act, the commissioner may institute a proceeding to obtain injunctive relief, in accordance with the applicable procedures provided in the Rules of Court.

C.17:48F-28 Confidentiality of data, information.

28. Any data or information relating to the diagnosis, treatment or health of an enrollee or prospective enrollee obtained by a prepaid prescription service organization from the contract holder, enrollee, prospective enrollee or any provider shall be confidential and shall not be disclosed to any person except:

a. To the extent that it may be necessary to carry out the purposes of this act;

b. Upon the express consent of the enrollee or prospective enrollee;

c. Pursuant to statute or court order for the production of evidence or the discovery thereof; or

d. In the event of a claim or litigation between an enrollee or a prospective enrollee and the organization wherein such data or information is relevant. An organization shall be entitled to claim any statutory privilege against disclosure which the provider who furnished the information to the organization is entitled to claim.

C.17:48F-29 Rules, regulations.

29. The commissioner shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate the purposes of this act.

30. This act shall take effect 180 days after enactment, but the commissioner may take such anticipatory administrative action in advance of the effective date as shall be necessary for the implementation of the act.

Approved January 19, 1998.