SENATE, No. 2301

STATE OF NEW JERSEY

216th LEGISLATURE

INTRODUCED JULY 10, 2014

Sponsored by:
Senator LINDA R. GREENSTEIN
District 14 (Mercer and Middlesex)
Senator BRIAN P. STACK
District 33 (Hudson)

Co-Sponsored by:
Senators Connors, Oroho, Thompson, Allen, Beach and A.R.Bucco

SYNOPSIS

Regulates pharmacy benefits managers and requires certain disclosures concerning multiple source generic drug pricing.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 12/8/2015)

AN ACT concerning pharmacy benefits managers and supplementing Title 17B of the New Jersey Statutes.

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

1. As used in this act:

"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.

"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.

"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, including, but not limited to, a carrier, self-insured employer, or union. 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, Medicare supplement coverage; CHAMPUS supplement coverage, coverage for Medicare services pursuant to a contract with the United States government, coverage arising out of a worker's compensation or similar law, 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.

“Pharmacy” means any place in the State 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 administers prescription drug benefits on behalf of a purchaser.

"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.

"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.

2. Beginning on the first day of each calendar year, a pharmacy benefits manager shall, with respect to contracts between a pharmacy benefits manager and a pharmacy:

a. (1) include in the contract the basis of the methodology and sources utilized to determine multiple source generic drug pricing, including, if applicable, the maximum allowable cost or any successive benchmark pricing formula, of the pharmacy benefits manager;

(2) update that pricing information each day; and

(3) establish a reasonable process for the prompt notification of those pricing updates to network pharmacies; and

b. Maintain a procedure to eliminate drugs from the list of drugs subject to multiple source generic drug pricing or modify maximum allowable cost rates in a timely fashion.

3. In order to place a particular prescription drug on a multiple source generic list, the pharmacy benefits manager shall, at a minimum, ensure that:

a. The drug has at least three nationally available, therapeutically equivalent multiple source generic drugs with a significant cost difference;

b. The drug is listed as therapeutically and pharmaceutically equivalent or “A” 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

c. 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.

4. The pharmacy benefits manager shall disclose to the purchaser in the contract:

a. the basis of the methodology and sources utilized to establish multiple source generic pricing. Applicable lists shall be updated and provided to the purchaser whenever there is a change; and

b. if a pharmacy benefits manager utilizes a multiple source generic list for drugs dispensed at retail, but does not utilize a similar list for drugs dispensed by mail. This practice shall be disclosed to the purchaser in writing either in the contract or no later than 21 business days from the implementation of the practice; and

c. whether or not the pharmacy benefits manager is using the identical multiple source generic drug list with respect to billing the purchaser as it does when reimbursing all network pharmacies. If multiple source generic drug lists are used, the pharmacy benefits manager shall disclose any difference between the amount paid to any pharmacy and the amount charged to the purchaser.

5. All contracts between a pharmacy benefits manager and a pharmacy shall include a process to appeal, investigate, and resolve disputes regarding multiple source generic drug pricing. The contract provision establishing the process shall include the following:

a. The right to appeal shall be limited to 60 days following the initial claim;

b. The appeal shall be investigated and resolved by the pharmacy benefits manager through an internal process within seven days of receipt of the appeal by the pharmacy benefits manager;

c. A telephone number at which a pharmacy may contact the pharmacy benefits manager and speak with an individual who is responsible for processing appeals; and

d. (1) If the appeal is denied, the pharmacy benefits manager shall provide the reason for the denial and identify the national drug code of a drug that may be purchased by contracted pharmacies at a price at or below the maximum allowable cost, or for a benchmark price as shall be determined by the pharmacy benefits manager;

(2) If the appeal is upheld, the pharmacy benefits manager shall make an adjustment retroactive to the date of adjudication. The pharmacy benefits manager shall make the adjustment effective for all similarly situated pharmacies in this State that are within the network.

6. All contracts between a pharmacy benefits manager and a pharmacy shall provide a contractual commitment to the pharmacy to deliver a generic effective rate. A generic effective rate shall be either:

a. a particular aggregate average reimbursement rate for generics; or

b. a maximum average wholesale price discount on multiple source generics as a whole.

For the purposes of this discount amount, a pharmacy benefits manager shall utilize an average wholesale price published by a nationally available compendium. The generic effective rate shall be calculated using the actual amount paid to the pharmacy, including pharmacy benefits manager reimbursement plus patient co-pay, excluding the dispensing fee, and shall not be calculated solely according to the amount allowed by the plan and shall include all generics dispensed, regardless of whether they are

subject to any pharmacy benefits manager-determined multiple source generic drug pricing.

7. 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.

8. This act shall take effect on the 90th day next following enactment and shall apply to all contracts or agreements for pharmacy benefits management services that are executed or renewed on or after the effective date.

STATEMENT

This bill requires pharmacy benefits managers (PBMs) to disclose certain information about multiple source generic drug pricing to plan sponsors and pharmacies and to deliver a particular aggregate average reimbursement rate for generics.

With respect to pharmacies, the bill requires pharmacy benefits managers to disclose the methodology and sources utilized to determine multiple source generic drug pricing. That pricing information is required to be updated daily and the PBM must have a process for the prompt notification of those pricing updates to network pharmacies. The bill also requires PBMs to maintain a procedure to eliminate products from the list of drugs subject to multiple source generic drug pricing or modify maximum allowable cost rates in a timely fashion.

Further, the bill stipulates that all contracts between a PBM and a pharmacy shall include a process to appeal, investigate, and resolve disputes regarding multiple source generic drug pricing. The contract provision establishing the process shall include the following:

(1) The right to appeal shall be limited to 60 days following the initial claim;

(2) The appeal shall be investigated and resolved within seven days;

(3) A telephone number at which a pharmacy may contact the pharmacy benefits manager and speak with an individual who is responsible for processing appeals;

(4) If the appeal is denied, the pharmacy benefits manager shall provide the reason for the denial and identify the national drug code of a drug that may be purchased by contracted pharmacies at a price at or below the maximum allowable cost, or benchmark price as determined by the pharmacy benefits manager;

(5) If the appeal is upheld, the pharmacy benefits manager shall make an adjustment retroactive to the date of adjudication. The pharmacy benefits manager shall make the adjustment effective for all similarly situated pharmacies in this State that are within the network.

The bill also requires that, in order for a PBM to place a particular prescription drug on a multiple source generic list, the PBM must ensure that:

(1) The drug has at least three or more nationally available, therapeutically equivalent multiple source generic drugs with a significant cost difference;

(2) The products must be listed as therapeutically and pharmaceutically equivalent or "A" 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

(3) The drug must be available for purchase without limitations by all pharmacies in the State from national or regional wholesalers and not obsolete or temporarily unavailable.

With respect to the plan sponsor, the PBM is required to disclose the basis of the methodology and sources utilized to establish multiple source generic pricing. Applicable lists shall be updated to the plan sponsor whenever there is a change. The PBM must also disclose to the plan sponsor:

(1) if the PBM utilizes a multiple source generic list for drugs dispensed at retail, but does not utilize a similar list for drugs dispensed by mail;

(2) whether or not it is using the identical multiple source generic drug list with respect to billing the plan sponsor as it does when reimbursing all network pharmacies;

(3) if multiple source generic drug lists are used, the PBM must disclose any difference between the amount paid to any pharmacy and the amount charged to the plan sponsor.

Finally, the bill requires a PBM to provide a contractual commitment to deliver a particular aggregate average reimbursement rate for generics or a maximum average wholesale price discount on multiple source generics as a whole, otherwise referred to as a "generic effective rate."