SYNOPSIS

Prohibits pharmacy benefits managers from making certain retroactive reductions in claims payments to pharmacies; requires pharmacy benefits managers to disclose certain product information to pharmacies.

CURRENT VERSION OF TEXT

As amended by the General Assembly on June 27, 2019.

(Sponsorship Updated As Of: 6/28/2019)
AN ACT concerning pharmacy benefits managers ↑and amending↑ 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. (New section) a. After the date of receipt of a clean claim for payment made by a pharmacy, a pharmacy benefits manager shall not retroactively reduce payment on the claim, either directly or indirectly, through aggregated effective rate ↑, direct or indirect↑ remuneration, quality assurance program,↑ or otherwise, except if the claim is found not to be a clean claim during the course of a routine audit performed pursuant to an agreement between the pharmacy benefits manager and the pharmacy. ↑Nothing in this section shall be construed to prohibit any retroactive increase in payment to a pharmacy pursuant to a written agreement between the pharmacy benefits manager and the pharmacy.↓ When a pharmacy adjudicates a claim at the point of sale, the reimbursement amount provided to the pharmacy by the pharmacy benefits manager shall constitute a final reimbursement amount.↑ 2↑Nothing in this section shall be construed to prohibit any retroactive increase in payment to a pharmacy pursuant to a ↑written agreement↑ contract between the pharmacy benefits manager, and the pharmacy services administration organization, or a pharmacy.↓

b. For the purpose of this section, “clean claim” means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or ↑particular↑ other↑ circumstance requiring special treatment, including, but not limited to, those listed in subsection d. of this section, that prevents timely payment from being made on the claim.

c. A pharmacy benefits manager shall not recoup funds from a pharmacy in connection with claims for which the pharmacy has already been paid unless the recoupment is:

(1) otherwise permitted or required by law;

(2) the result of an audit, performed pursuant to a contract between the pharmacy benefits manager and the pharmacy; or

(3) the result of an audit, performed pursuant to a contract between the pharmacy benefits manager and the designated pharmacy services administrative organization.

d. The provisions of this section shall not apply to an investigative audit of pharmacy records when:

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:

↑Assembly AFI committee amendments adopted September 13, 2018.

↑Senate SCM committee amendments adopted June 17, 2019.

↑Senate floor amendments adopted June 20, 2019.

↑Assembly floor amendments adopted June 27, 2019.
(1) fraud, waste, abuse or other intentional misconduct is indicated by physical review or review of claims data or statements; or
(2) other investigative methods indicate a pharmacy is or has been engaged in criminal wrongdoing, fraud or other intentional or willful misrepresentation.

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

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

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 and brand effective rate, generic effective rate, and professional fee including, if applicable, the brand effective rate, generic effective rate, dispensing fee effective rate, maximum allowable cost or any other pricing formula, or other pricing methodology utilized by the pharmacy benefits manager as a benchmark for pharmacy reimbursement of the pharmacy benefits manager;

   (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, professional fee, and dispensing fee effective rate, or any other pricing formulas and any other pricing methodology utilized by the pharmacy benefits manager as a benchmark for pharmacy reimbursement and any successive pricing formulas in a timely manner; and

   b. 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.
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.
(cf: P.L.2015, c.179, s.2)

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

4. All contracts between a pharmacy benefits manager and a
[contracted] pharmacy services administrative organization, or its
contracted pharmacies, and all contracts directly between a pharmacy
benefits manager and pharmacy shall include a process to appeal,
investigate, and resolve disputes regarding brand and multiple
source generic drug pricing, including, if applicable, brand
effective rate, generic effective rate, professional fees, State
Health Benefits Program plans dispensing fee effective rate, and
any other pricing methodology utilized by the pharmacy benefits
manager as a benchmark formula for pharmacy reimbursement.
The contract provision establishing the process shall include the
following:

a. The right to appeal shall be limited to 14 calendar days
following the initial claim;

b. The appeal shall be investigated and resolved by the
pharmacy benefits manager through an internal process within 14
calendar days of receipt of the appeal by the pharmacy benefits
manager;

c. A telephone number at which a pharmacy services
administrative organization, or a pharmacy may contact the
pharmacy benefits manager and speak with an individual who is
involved in the appeals process; and

d. (1) If the appeal is denied, the pharmacy benefits manager
shall provide the reason for the denial [and]

to the pharmacy services administrative organization and its contra-
ted pharmacies and the pharmacy services administrative
organization shall inform its contracted pharmacies of the
availability, location and pricing of the appealed drug in the State;

(b) provide the reason for the denial directly to a pharmacy, if it
contracts directly with a pharmacy benefits manager;

(c) identify the national drug code of a drug product that is
available for purchase by [contracted pharmacies] the specific
contracted pharmacy appealing the claim in this State from
wholesalers registered pursuant to P.L.1961, c.52 (C.24:6B-1 et
seq.) [and the outlet in the State of New Jersey where pharmacies
may acquire the product] at a price which is available to the
specific contracted pharmacy appealing the claim and which is
equal to or less than the maximum allowable cost or the brand
effective rate, generic effective rate \(^2\) and professional fee \(^2\) or other
pricing \(^2\) for the appealed drug as determined by the pharmacy
benefits manager; \(^2\) and

(d) provide the name of wholesalers registered under P.L.1961,
c.52 (C.24:6B-1 et seq.) from which the appealing pharmacy can
obtain the brand or multiple source generic drug at or below the
brand effective rate, generic effective rate, dispensing fee effective
rate, maximum allowable cost or any other pricing formula for
pharmacy reimbursement; \(^2\)

(2) If the appeal is approved, the pharmacy benefits manager
shall make the price correction, permit the reporting pharmacy to
reverse and rebill the appealed claim, and make the price correction
effective for all similarly situated pharmacies from the date of the
approved appeal.

e. A pharmacy \(^2\) benefits manager shall not terminate a
pharmacy \(^2\) licensed in the State of New Jersey \(^2\) [shall be permitted
to make product deliveries] solely on the basis that the pharmacy
offers and provides store direct delivery \(^2\) and mail prescriptions to
patients without contractual restrictions by a pharmacy benefits
manager \(^2\) an insured as an ancillary service \(^2\).

(cf: P.L.2015, c.179, s.4)

4. (New section) A pharmacy benefits manager or third-party
payer shall not require pharmacy accreditation standards or
recertification requirements to participate in a network which are
inconsistent with, more stringent than, or in addition to, the federal and
State requirements for \(^4\) [licensure as] \(^4\) a pharmacy in this State. \(^4\)

5. (New section) The Commissioner of Banking and Insurance
may review and approve the compensation program of a pharmacy
benefits manager with a health benefits plan to ensure that the
reimbursement for pharmacist services paid to a pharmacist or
pharmacy is fair and reasonable to provide an adequate pharmacy
benefits manager network for a health benefits plan. \(^1\)

6. (New section) 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 \(^2\) [and shall apply to plans offered through the State
Health Benefits Program] \(^3\) \(_3\) except for any agreement by a
pharmacy benefits manager to administer prescription drug benefits
on behalf of the State Health Benefits Plan, the School Employees
Health Benefits Plan, 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. \(^3\) \(_3\)
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. a penalty, after warning notice and;

b. an opportunity to cure the violation within 14 days following the issuance of the notice;

c. a hearing, for each day during which the violation continues, before the commissioner within 70 days following the issuance of the notice; and

d. if the violation has not been cured pursuant to subsection b. of this section, a penalty of not less than $5,000 or more than $10,000 for each violation.

This act shall take effect immediately on the 90th day next following enactment, except that section 7 of P.L. (pending before the Legislature as this bill) shall take effect following the promulgation of regulations by the Department of Banking and Insurance implementing that section.