SENATE, No. 1047

STATE OF NEW JERSEY

221st LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2024 SESSION

Sponsored by:
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District 14 (Mercer and Middlesex)
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SYNOPSIS

Regulates certain practices of pharmacy benefits managers and health insurance carriers.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

AN ACT concerning pharmacy benefits managers and health insurance carriers 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. The Legislature finds and declares that:

a. The practice of steering by a pharmacy benefits manager represents a conflict of interest;

b. These practices have resulted in harm, including increasing drug prices, overcharging covered persons and carriers, restricting or underpaying covered persons' choice of pharmacies and fragmenting and creating barriers to care, particularly in rural New Jersey and for patients battling life-threatening illnesses and chronic diseases; and

c. Imposing a surcharge on pharmacy benefits managers that engage in steering in this State may encourage carriers to use pharmacy benefits managers committed to refraining from steering practices.

2. As used in this act:

"Commissioner" means the Commissioner of Banking and Insurance.

"Credentialing" means the process of assessing and validating the qualifications of a health care provider including, but not limited to, an evaluation of licensure status, education, training, experience, competence and professional judgement.

"Department" means the Department of Banking and Insurance.

"Health care provider" means an individual, which, acting within the scope of its licensure or certification, provides health care services, and includes, but is not limited to: a physician, dentist, nurse, pharmacist or other health care professional and whose professional practice is regulated pursuant to Title 45 of the Revised Statutes. "Health care provider" shall also mean a hospital or other health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.)

"Medicaid" means the program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"National average drug acquisition cost" means the monthly survey of retail pharmacies conducted by the federal Centers for Medicare and Medicaid Services to determine average acquisition cost for Medicaid covered outpatient drugs.

"Steering" means a practice employed by a pharmacy benefit manager or health carrier that channels a prescription to an affiliated pharmacy, or pharmacy in which a pharmacy benefits manager or carrier has an ownership interest, and includes but is not limited to retail, mail-order, or specialty pharmacies.

3. A pharmacy benefits manager shall:

a. not require a covered person to use a mail-order pharmaceutical distributor, including a mail-order pharmacy;

b. offer a health benefits plan the option of charging such health plan the same price for a prescription drug as it pays a pharmacy for the prescription drug; provided, however, that a pharmacy benefits manager shall charge a health benefits plan, the same price for a prescription drug as it pays a pharmacy for the prescription drug;

c. report in the aggregate to a health benefits plan the difference between the amount a pharmacy benefits manager reimbursed a pharmacy and the amount a pharmacy benefits manager charged a health benefits plan; and

d. when calculating a covered person's contribution to any out-of-pocket maximum, deductible, or copayment responsibility, include any amount paid by the covered person or paid on his or her behalf through a third-party payment, financial assistance, discount, or product voucher for a prescription drug that does not have a generic equivalent or that has a generic equivalent but was obtained through prior authorization, a step therapy protocol, or the carrier's exceptions and appeals process. Nothing in this subsection shall be construed to require that a pharmacy benefits manager accept a third-party payment, financial assistance, discount, or product voucher submitted on behalf of a covered person.

4. A pharmacy benefits manager shall be proscribed from:

a. prohibiting a pharmacist or pharmacy from providing a covered person information on the amount of the covered person's cost sharing for the covered person's prescription drug and the clinical efficacy of a more affordable alternative drug if one is available;

b. charging or collecting from a covered person a copayment that exceeds the total submitted charges by the network pharmacy for which the pharmacy is paid;

c. transferring or sharing records relative to prescription information containing patient-identifiable and prescriber-identifiable data to an affiliated pharmacy for any commercial purpose; provided, however, that nothing shall be construed to prohibit the exchange of prescription information between a pharmacy benefits manager and an affiliated pharmacy for the limited purposes of pharmacy reimbursement, formulary compliance, pharmacy care, or utilization review;

d. knowingly making a misrepresentation to a covered person, pharmacist or pharmacy;

e. charging a pharmacy a fee in connection with network enrollment;

f. removing a drug from a formulary or denying coverage of a drug for the purpose of incentivizing a covered person to seek coverage from a different health plan; and

g. withholding coverage or requiring prior authorization for a lower cost, therapeutically equivalent drug available to a covered person or failing to reduce a covered person's cost sharing amount when a covered person selects a lower cost, therapeutically equivalent drug.

5. a. A pharmacy benefits manager that engages in the practice of steering or imposing point-of-sale fees or retroactive fees shall be subject to a surcharge payable to the State of 10 percent on the aggregate dollar amount it reimbursed pharmacies in the previous calendar year for prescription drugs.

b Any person operating a health benefits plan and licensed under this title whose contracted pharmacy benefits manager engages in the practice of steering in connection with its health benefits plans shall be subject to a surcharge payable to the State of 10 percent on the aggregate dollar amount its pharmacy benefits manager reimbursed pharmacies on its behalf in the previous calendar year for prescription drugs.

c. On March 1 of each year, a pharmacy benefits manager or any other person operating a health benefits plan that utilizes a contracted pharmacy benefits manager shall provide a letter to the commissioner attesting as to whether or not, in the previous calendar year, it engaged in the practice of steering. The pharmacy benefits manager shall also submit to the commissioner, in a form and manner specified by the commissioner, data detailing all prescription drug claims it administered for covered persons on behalf of each health plan client and any other data the commissioner deems necessary to evaluate whether a pharmacy benefits manager is engaged in the practice of steering. Such data shall be confidential and not be subject to P.L.1963, c.73 (C.47:1A-1 et seq.); provided, however, that the commissioner shall prepare an aggregate report reflecting the total number of prescriptions administered by the reporting pharmacy benefits manager on behalf of all health plans in the State along with the total sum due to the State. The department shall have access to all confidential data collected by the Commissioner for audit purposes.

d. On April 1 of each year, a pharmacy benefits manager or other person operating a health benefits plan and licensed under this title shall pay into the general fund of the State treasury the surcharge owed, if any, as contained in the report submitted pursuant to subsection c. of this section.

e. Nothing in this section shall be construed to authorize the practice of steering where otherwise prohibited by law.

6. A carrier or pharmacy benefits manager shall not require satisfaction of pharmacy accreditation standards or recertification requirements in order to participate in a network which is inconsistent with, more stringent than, or in addition to, the federal and State requirements for a pharmacy in this State.

7. a. A carrier or pharmacy benefits manager shall issue a report every four months, which shall be provided to the commissioner and published, for no less than 24 months, by the pharmacy benefits manager on a website available to the public, of all drugs appearing on the national average drug acquisition cost list reimbursed 10 percent above or below the national average drug acquisition cost, as well as all drugs reimbursed 10 percent or above the national average drug acquisition cost.

b. For each drug in the report, a carrier or pharmacy benefits manager shall include:

(1) the month the drug was dispensed;

(2) the quantity of the drug dispensed;

(3) the amount the pharmacy was reimbursed per unit or dosage;

(4) whether the dispensing pharmacy was an affiliate of the pharmacy benefits manager;

(5) whether the drug was dispensed pursuant to a State or local government health benefits plan; and

(6) the average national average drug acquisition cost for the month the drug was dispensed.

8. a. No pharmacy benefits manager shall engage in the practice of medicine, except as otherwise provided in subsection b. of this section.

b. Any physician employed by or contracted with a pharmacy benefits manager that is advising on or making determinations specific to a covered person in connection with a prior authorization or step therapy appeal or determination review shall:

(1) have actively seen patients within the past five years; and

(2) have practiced in the same specialty area for which they are providing advisement within the past five years;

c. For contracts and amendments entered into with a pharmacy benefits manager on and after the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), the department may require the use of a physician licensed to practice medicine and surgery in the State of New Jersey for prior authorization or step therapy appeal or determination reviews.

9. This act shall take effect on the 180th day next following enactment.

STATEMENT

This bill regulates certain practices of pharmacy benefits managers and health insurance carriers.

Under the bill, a pharmacy benefits manager will be prohibited from the practice of steering, which, for the purpose of this bill, means a practice employed by a pharmacy benefit manager or health carrier that channels a prescription to an affiliated pharmacy, or pharmacy in which a pharmacy benefit manager or carrier has an ownership interest, and includes but is not limited to retail, mail-order, or specialty pharmacies.

On March 1 of each year, a pharmacy benefits manager or carrier that utilizes a contracted pharmacy benefits manager will be required to provide a letter to the commissioner attesting as to whether or not, in the previous calendar year, it engaged in the practice of steering. The pharmacy benefits manager will also submit to the commissioner, in a form and manner specified by the commissioner, data detailing all prescription drug claims it administered for covered persons on behalf of each health plan client and any other data the commissioner deems necessary to evaluate whether a pharmacy benefits manager is engaged in the practice of steering. This data will be confidential and not be subject to the "Open Public Records Act;" provided, however, that the commissioner prepare an aggregate report reflecting the total number of prescriptions administered by the reporting pharmacy benefits manager on behalf of all health plans in the State along with the total sum due to the State. The department will have access to all confidential data collected by the Commissioner for audit purposes.

Under the bill, a pharmacy benefits manager that engages in the practice of steering or imposing point-of-sale fees or retroactive fees will be subject to a surcharge payable to the State of 10 percent on the aggregate dollar amount it reimbursed pharmacies in the previous calendar year for prescription drugs. Any other person operating a health plan and licensed under this title whose contracted pharmacy benefits manager engages in the practice of steering in connection with its health plans will be subject to a surcharge payable to the State of 10 percent on the aggregate dollar amount its pharmacy benefits manager reimbursed pharmacies on its behalf in the previous calendar year for prescription drugs.

The bill also provides that a pharmacy benefits manager will be proscribed from, among other provisions:

(1) prohibiting a pharmacist or pharmacy from providing a covered person information on the amount of the covered person's cost sharing for the covered person's prescription drug and the clinical efficacy of a more affordable alternative drug if one is available;

(2) charging or collecting from a covered person a copayment that exceeds the total submitted charges by the network pharmacy for which the pharmacy is paid; or

(3) transferring or sharing records relative to prescription information containing patient-identifiable and prescriber-identifiable data to an affiliated pharmacy for any commercial purpose; provided, however, that nothing shall be construed to prohibit the exchange of prescription information between a pharmacy benefits manager and an affiliated pharmacy for the limited purposes of pharmacy reimbursement, formulary compliance, pharmacy care, or utilization review.

The bill further provides that a health insurance carrier or pharmacy benefits manager will:

(1) be prohibited from requiring pharmacy accreditation standards or recertification requirements to participate in a network which is inconsistent with, more stringent than, or in addition to, the federal and State requirements for a pharmacy in this State; and

(2) suspend denials based on health care provider credentialing requirements. Any credentialing determination shall be issued within 45 days after receipt by the health insurance carrier of a universal physician application credentialing application or a complete New Jersey physician recredentialing application.

The bill additionally provides that a health insurance carrier or pharmacy benefits manager will produce a report every four months, which will be provided to the commissioner and published by the pharmacy benefits manager on a website available to the public for no less than 24 months, of all drugs appearing on the national average drug acquisition cost list reimbursed 10 percent above or below the national average drug acquisition cost, as well as all drugs reimbursed 10 percent or above the national average drug acquisition cost.

Under the bill, a pharmacy benefits manager will not be allowed to engage in the practice of medicine, unless a physician employed or contracted by a pharmacy benefits manager is advising on or making determinations specific to a covered person in connection with a prior authorization or step therapy appeal or determination review and is able to meet certain requirements. Finally, the bill provides that a pharmacy benefits manager will, among other related provisions:

(1) not require covered persons to use a mail-order pharmaceutical distributor, including a mail-order pharmacy; or

(2) offer a health insurance carrier the ability to receive 100 percent of all rebates it receives from pharmaceutical manufacturers. In addition, a pharmacy benefits manager shall report annually to each client, which shall include but not be limited to insurers, payors, health plans, and the department the aggregate amount of all rebates and other payments that a pharmacy benefits manager received from a pharmaceutical manufacturer in

connection with claims, if administered on behalf of the client and the aggregate amount of such rebates a pharmacy benefits manager received from a pharmaceutical manufacturer did not pass through to the client health plan.