ASSEMBLY, No. 1258

STATE OF NEW JERSEY

219th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

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SYNOPSIS

Requires pharmacy benefits manager under contract with SHBP and SEHBP to report price paid to pharmacy and amount charged to SHBP and SEHBP.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.

(Sponsorship Updated As Of: 2/13/2020)

AN ACT concerning prescription drug benefits in the State Health Benefits Program and the School Employees' Health Benefits Program and amending P.L.1961, c.49.

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

1. Section 5 of P.L.1961, c.49 (C.52:14-17.29) is amended to read as follows:

5. (A) The contract or contracts purchased by the commission pursuant to subsection b. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall provide separate coverages or policies as follows:

(1) Basic benefits which shall include:

(a) Hospital benefits, including outpatient;

(b) Surgical benefits;

(c) Inpatient medical benefits;

(d) Obstetrical benefits; and

(e) Services rendered by an extended care facility or by a home health agency and for specified medical care visits by a physician during an eligible period of such services, without regard to whether the patient has been hospitalized, to the extent and subject to the conditions and limitations agreed to by the commission and the carrier or carriers.

Basic benefits shall be substantially equivalent to those available on a group remittance basis to employees of the State and their dependents under the subscription contracts of the New Jersey "Blue Cross" and "Blue Shield" Plans. Such basic benefits shall include benefits for:

(i) Additional days of inpatient medical service;

(ii) Surgery elsewhere than in a hospital;

(iii) X-ray, radioactive isotope therapy and pathology services;

(iv) Physical therapy services;

(v) Radium or radon therapy services;

and the extended basic benefits shall be subject to the same conditions and limitations, applicable to such benefits, as are set forth in "Extended Outpatient Hospital Benefits Rider," Form 1500, 71(9-66), and in "Extended Benefit Rider" (as amended), Form MS 7050J(9-66) issued by the New Jersey "Blue Cross" and "Blue Shield" Plans, respectively, and as the same may be amended or superseded, subject to filing by the Commissioner of Banking and Insurance; and

(2) Major medical expense benefits which shall provide benefit payments for reasonable and necessary eligible medical expenses for hospitalization, surgery, medical treatment and other related services and supplies to the extent they are not covered by basic

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 <u>thus</u> is new matter.

benefits. The commission may, by regulation, determine what types of services and supplies shall be included as "eligible medical services" under the major medical expense benefits coverage as well as those which shall be excluded from or limited under such coverage. Benefit payments for major medical expense benefits shall be equal to a percentage of the reasonable charges for eligible medical services incurred by a covered employee or an employee's covered dependent, during a calendar year as exceed a deductible for such calendar year of $100.00 subject to the maximums hereinafter provided and to the other terms and conditions authorized by this act. The percentage shall be 80% of the first $2,000.00 of charges for eligible medical services incurred subsequent to satisfaction of the deductible and 100% thereafter. There shall be a separate deductible for each calendar year for (a) each enrolled employee and (b) all enrolled dependents of such employee. Not more than $1,000,000.00 shall be paid for major medical expense benefits with respect to any one person for the entire period of such person's coverage under the plan, whether continuous or interrupted except that this maximum may be reapplied to a covered person in amounts not to exceed $2,000.00 a year. Maximums of $10,000.00 per calendar year and $20,000.00 for the entire period of the person's coverage under the plan shall apply to eligible expenses incurred because of mental illness or functional nervous disorders, and such may be reapplied to a covered person, except as provided in P.L.1999, c.441 (C.52:14-17.29d et al.). The same provisions shall apply for retired employees and their dependents. Under the conditions agreed upon by the commission and the carriers as set forth in the contract, the deductible for a calendar year may be satisfied in whole or in part by eligible charges incurred during the last three months of the prior calendar year.

Any service determined by regulation of the commission to be an "eligible medical service" under the major medical expense benefits coverage which is performed by a duly licensed practicing psychologist within the lawful scope of his practice shall be recognized for reimbursement under the same conditions as would apply were such service performed by a physician.

(B) The contract or contracts purchased by the commission pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall include coverage for services and benefits that are at a level that is equal to or exceeds the level of services and benefits set forth in this subsection, provided that such services and benefits shall include only those that are eligible medical services and not those deemed experimental, investigative or otherwise not eligible medical services. The determination of whether services or benefits are eligible medical services shall be made by the commission consistent with the best interests of the State and participating employers, employees, and dependents. The following list of

services is not intended to be exclusive or to require that any limits or exclusions be exceeded.

Covered services shall include:

(1) Physician services, including:

(a) Inpatient services, including:

(i) medical care including consultations;

(ii) surgical services and services related thereto; and

(iii) obstetrical services including normal delivery, cesarean section, and abortion.

(b) Outpatient/out-of-hospital services, including:

(i) office visits for covered services and care;

(ii) allergy testing and related diagnostic/therapy services;

(iii) dialysis center care;

(iv) maternity care;

(v) well child care;

(vi) child immunizations/lead screening;

(vii) routine adult physicals including pap, mammography, and prostate examinations; and

(viii) annual routine obstetrical/gynecological exam.

(2) Hospital services, both inpatient and outpatient, including:

(a) room and board;

(b) intensive care and other required levels of care;

(c) semi-private room;

(d) therapy and diagnostic services;

(e) surgical services or facilities and treatment related thereto;

(f) nursing care;

(g) necessary supplies, medicines, and equipment for care; and

(h) maternity care and related services.

(3) Other facility and services, including:

(a) approved treatment centers for medical emergency/accidental injury;

(b) approved surgical center;

(c) hospice;

(d) chemotherapy;

(e) diagnostic x-ray and lab tests;

(f) ambulance;

(g) durable medical equipment;

(h) prosthetic devices;

(i) foot orthotics;

(j) diabetic supplies and education; and

(k) oxygen and oxygen administration.

(4) All services for which coverage is required pursuant to P.L.1961, c.49 (C.52:14-17.25 et seq.), as amended and supplemented. Benefits under the contract or contracts purchased as authorized by the State Health Benefits Program shall include those for mental health services subject to limits and exclusions consistent with the provisions of the New Jersey State Health Benefits Program Act.

(C) The contract or contracts purchased by the commission pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall include the following provisions regarding reimbursements and payments:

(1) In the successor plan, the co-payment for doctor's office visits shall be $10 per visit with a maximum out-of-pocket of $400 per individual and $1,000 per family for in-network services for each calendar year. The out-of-network deductible shall be $100 per individual and $250 per family for each calendar year, and the participant shall receive reimbursement for out-of-network charges at the rate of 80% of reasonable and customary charges, provided that the out-of-pocket maximum shall not exceed $2,000 per individual and $5,000 per family for each calendar year.

(2) In the State managed care plan that is required to be included in a contract entered into pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-17.28), the co-payment for doctor's office visits shall be $15 per visit. The participant shall receive reimbursement for out-of-network charges at the rate of 70% of reasonable and customary charges. The in-network and out-of-network limits, exclusions, maximums, and deductibles shall be substantially equivalent to those in the NJ PLUS plan in effect on June 30, 2007, with adjustments to that plan pursuant to a binding collective negotiations agreement or pursuant to action by the commission, in its sole discretion, to apply such adjustments to State employees for whom there is no majority representative for collective negotiations purposes.

(3) "Reasonable and customary charges" means charges based upon the 90th percentile of the usual, customary, and reasonable (UCR) fee schedule determined by the Health Insurance Association of America or a similar nationally recognized database of prevailing health care charges.

(D) Benefits under the contract or contracts purchased as authorized by this act may be subject to such limitations, exclusions, or waiting periods as the commission finds to be necessary or desirable to avoid inequity, unnecessary utilization, duplication of services or benefits otherwise available, including coverage afforded under the laws of the United States, such as the federal Medicare program, or for other reasons.

Benefits under the contract or contracts purchased as authorized by this act shall include those for the treatment of alcoholism where such treatment is prescribed by a physician and shall also include treatment while confined in or as an outpatient of a licensed hospital or residential treatment program which meets minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation. No benefits shall be provided beyond those stipulated in the contracts held by the State Health Benefits Commission.

(E) The rates charged for any contract purchased under the authority of this act shall reasonably and equitably reflect the cost of the benefits provided based on principles which in the judgment of the commission are actuarially sound. The rates charged shall be determined by the carrier on accepted group rating principles with due regard to the experience, both past and contemplated, under the contract. The commission shall have the right to particularize subgroups for experience purposes and rates. No increase in rates shall be retroactive.

(F) The initial term of any contract purchased by the commission under the authority of this act shall be for such period to which the commission and the carrier may agree, but permission may be made for automatic renewal in the absence of notice of termination by the commission. Subsequent terms for which any contract may be renewed as herein provided shall each be limited to a period not to exceed one year.

(G) A contract purchased by the commission pursuant to subsection b. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall contain a provision that if basic benefits or major medical expense benefits of an employee or of an eligible dependent under the contract, after having been in effect for at least one month in the case of basic benefits or at least three months in the case of major medical expense benefits, is terminated, other than by voluntary cancellation of enrollment, there shall be a 31-day period following the effective date of termination during which such employee or dependent may exercise the option to convert, without evidence of good health, to converted coverage issued by the carriers on a direct payment basis. Such converted coverage shall include benefits of the type classified as "basic benefits" or "major medical expense benefits" in subsection (A) hereof and shall be equivalent to the benefits which had been provided when the person was covered as an employee. The provision shall further stipulate that the employee or dependent exercising the option to convert shall pay the full periodic charges for the converted coverage which shall be subject to such terms and conditions as are normally prescribed by the carrier for this type of coverage.

(H) The commission may purchase a contract or contracts to provide drug prescription and other health care benefits or authorize the purchase of a contract or contracts to provide drug prescription and other health care benefits as may be required to implement a duly executed collective negotiations agreement or as may be required to implement a determination by a public employer to provide such benefit or benefits to employees not included in collective negotiations units.

A pharmacy benefit manager shall disclose to the State Health Benefits Commission and the School Employees' Health Benefits Commission any differences between the amount paid by the manager to a pharmacy for each prescription drug dispensed and the

amount charged to the program for that prescription drug. The contract shall specify the detail, methodology, time and manner of such disclosures by the pharmacy benefits manager. Each commission may provide for exemptions from disclosure in cases when it is deemed not appropriate or pertinent under certain circumstances.

(I) The commission shall take action as necessary, in cooperation with the School Employees' Health Benefits Commission established pursuant to section 33 of P.L.2007, c.103 (C.52:14-17.46.3), to effectuate the purposes of the School Employees' Health Benefits Program Act as provided in sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-17.46.11) and to enable the School Employees' Health Benefits Commission to begin providing coverage to participants pursuant to the School Employees' Health Benefits Program Act as of July 1, 2008.

(J) Beginning January 1, 2012, the State Health Benefits Plan Design Committee shall provide to employees the option to select one of at least three levels of coverage each for family, individual, individual and spouse, and individual and dependent, or equivalent categories, for each plan offered by the program differentiated by out of pocket costs to employees including co-payments and deductibles. Notwithstanding any other provision of law to the contrary, the committee shall have the sole discretion to set the amounts for maximums, co-pays, deductibles, and other such participant costs for all plans in the program. The committee shall also provide for a high deductible health plan that conforms with Internal Revenue Code Section 223.

There shall be appropriated annually for each State fiscal year, through the annual appropriations act, such amounts as shall be necessary as funding by the State as an employer, or as otherwise required, with regard to employees or retirees who have enrolled in a high deductible health plan that conforms with Internal Revenue Code Section 223.

(cf: P.L.2011, c.78, s.47)

2. This act shall take effect immediately.

STATEMENT

This bill will requires a pharmacy benefit manager that has a contract with the State Health Benefits Commission and the School Employees’ Health Benefits Commission to disclose to the appropriate commission any differences between the amount paid by the manager to a pharmacy for each prescription drug dispensed and the amount charged to the program for that prescription drug.

The contract is to specify the detail, methodology, time and manner of such disclosures by the pharmacy benefits manager. Each commission may provide for exemptions from disclosure in cases when it is deemed not appropriate or pertinent under certain circumstances.