

SENATE, No. 1210

STATE OF NEW JERSEY 219th LEGISLATURE

INTRODUCED FEBRUARY 3, 2020

Sponsored by:

Senator JOSEPH P. CRYAN

District 20 (Union)

Senator TROY SINGLETON

District 7 (Burlington)

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

As introduced.



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

4
5 **BE IT ENACTED** *by the Senate and General Assembly of the State*
6 *of New Jersey:*

7
8 1. Section 5 of P.L.1961, c.49 (C.52:14-17.29) is amended to
9 read as follows:

10 5. (A) The contract or contracts purchased by the commission
11 pursuant to subsection b. of section 4 of P.L.1961, c.49 (C.52:14-
12 17.28) shall provide separate coverages or policies as follows:

13 (1) Basic benefits which shall include:

14 (a) Hospital benefits, including outpatient;

15 (b) Surgical benefits;

16 (c) Inpatient medical benefits;

17 (d) Obstetrical benefits; and

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

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

29 (i) Additional days of inpatient medical service;

30 (ii) Surgery elsewhere than in a hospital;

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

32 (iv) Physical therapy services;

33 (v) Radium or radon therapy services;

34 and the extended basic benefits shall be subject to the same
35 conditions and limitations, applicable to such benefits, as are set
36 forth in "Extended Outpatient Hospital Benefits Rider," Form 1500,
37 71(9-66), and in "Extended Benefit Rider" (as amended), Form MS
38 7050J(9-66) issued by the New Jersey "Blue Cross" and "Blue
39 Shield" Plans, respectively, and as the same may be amended or
40 superseded, subject to filing by the Commissioner of Banking and
41 Insurance; and

42 (2) Major medical expense benefits which shall provide benefit
43 payments for reasonable and necessary eligible medical expenses
44 for hospitalization, surgery, medical treatment and other related
45 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 thus is new matter.

1 benefits. The commission may, by regulation, determine what types
2 of services and supplies shall be included as "eligible medical
3 services" under the major medical expense benefits coverage as
4 well as those which shall be excluded from or limited under such
5 coverage. Benefit payments for major medical expense benefits
6 shall be equal to a percentage of the reasonable charges for eligible
7 medical services incurred by a covered employee or an employee's
8 covered dependent, during a calendar year as exceed a deductible
9 for such calendar year of \$100.00 subject to the maximums
10 hereinafter provided and to the other terms and conditions
11 authorized by this act. The percentage shall be 80% of the first
12 \$2,000.00 of charges for eligible medical services incurred
13 subsequent to satisfaction of the deductible and 100% thereafter.
14 There shall be a separate deductible for each calendar year for (a)
15 each enrolled employee and (b) all enrolled dependents of such
16 employee. Not more than \$1,000,000.00 shall be paid for major
17 medical expense benefits with respect to any one person for the
18 entire period of such person's coverage under the plan, whether
19 continuous or interrupted except that this maximum may be
20 reapplied to a covered person in amounts not to exceed \$2,000.00 a
21 year. Maximums of \$10,000.00 per calendar year and \$20,000.00
22 for the entire period of the person's coverage under the plan shall
23 apply to eligible expenses incurred because of mental illness or
24 functional nervous disorders, and such may be reapplied to a
25 covered person, except as provided in P.L.1999, c.441 (C.52:14-
26 17.29d et al.). The same provisions shall apply for retired
27 employees and their dependents. Under the conditions agreed upon
28 by the commission and the carriers as set forth in the contract, the
29 deductible for a calendar year may be satisfied in whole or in part
30 by eligible charges incurred during the last three months of the prior
31 calendar year.

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

38 (B) The contract or contracts purchased by the commission
39 pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-
40 17.28) shall include coverage for services and benefits that are at a
41 level that is equal to or exceeds the level of services and benefits set
42 forth in this subsection, provided that such services and benefits
43 shall include only those that are eligible medical services and not
44 those deemed experimental, investigative or otherwise not eligible
45 medical services. The determination of whether services or benefits
46 are eligible medical services shall be made by the commission
47 consistent with the best interests of the State and participating

1 employers, employees, and dependents. The following list of
2 services is not intended to be exclusive or to require that any limits
3 or exclusions be exceeded.

4 Covered services shall include:

5 (1) Physician services, including:

6 (a) Inpatient services, including:

7 (i) medical care including consultations;

8 (ii) surgical services and services related thereto; and

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

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

12 (i) office visits for covered services and care;

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

14 (iii) dialysis center care;

15 (iv) maternity care;

16 (v) well child care;

17 (vi) child immunizations/lead screening;

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

20 (viii) annual routine obstetrical/gynecological exam.

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

22 (a) room and board;

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

24 (c) semi-private room;

25 (d) therapy and diagnostic services;

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

27 (f) nursing care;

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

29 (h) maternity care and related services.

30 (3) Other facility and services, including:

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

33 (b) approved surgical center;

34 (c) hospice;

35 (d) chemotherapy;

36 (e) diagnostic x-ray and lab tests;

37 (f) ambulance;

38 (g) durable medical equipment;

39 (h) prosthetic devices;

40 (i) foot orthotics;

41 (j) diabetic supplies and education; and

42 (k) oxygen and oxygen administration.

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

1 consistent with the provisions of the New Jersey State Health
2 Benefits Program Act.

3 (C) The contract or contracts purchased by the commission
4 pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-
5 17.28) shall include the following provisions regarding
6 reimbursements and payments:

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

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

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

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

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

1 provided beyond those stipulated in the contracts held by the State
2 Health Benefits Commission.

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

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

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

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

47 A pharmacy benefit manager shall disclose to the State Health
48 Benefits Commission and the School Employees' Health Benefits

1 Commission any differences between the amount paid by the
2 manager to a pharmacy for each prescription drug dispensed and the
3 amount charged to the program for that prescription drug. The
4 contract shall specify the detail, methodology, time and manner of
5 such disclosures by the pharmacy benefits manager. Each
6 commission may provide for exemptions from disclosure in cases
7 when it is deemed not appropriate or pertinent under certain
8 circumstances.

9 (I) The commission shall take action as necessary, in
10 cooperation with the School Employees' Health Benefits
11 Commission established pursuant to section 33 of P.L.2007, c.103
12 (C.52:14-17.46.3), to effectuate the purposes of the School
13 Employees' Health Benefits Program Act as provided in sections 31
14 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-
15 17.46.11) and to enable the School Employees' Health Benefits
16 Commission to begin providing coverage to participants pursuant to
17 the School Employees' Health Benefits Program Act as of July 1,
18 2008.

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

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

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

38
39 2. This act shall take effect immediately.
40
41

42 STATEMENT

43
44 This bill will requires a pharmacy benefit manager that has a
45 contract with the State Health Benefits Commission and the School
46 Employees' Health Benefits Commission to disclose to the
47 appropriate commission any differences between the amount paid

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