Oppose A.3717/S.728
Increases Health Care Costs and Undermines Competition

A.3717 would prohibit a PBM from retroactively reducing payments on a claim, even when the reduction results from not meeting performance and other quality measures. This legislation will insulate pharmacies from competition and increase costs for payers, and may conflict with other state laws on payer recoupment of funds from providers.

A.3717 Interferes With Mutually Agreed Upon Contracts

PBMs contracting with pharmacies in the commercial market should not be prohibited from using the same market based incentives that are being used to drive innovation in other market segments including Medicare. Pharmacies should not be excluded from this movement toward rewarding quality and value based on:

- Generic Dispensing Rate
- Patient Adherence Rate
- Prescription Refill Rate
- Dispensing Volume
- Increases in efficiency and value
- Opioid Dispensing Oversight

These benchmarks are not immediately measurable and assessments must necessarily be delivered after a claim has been processed. A.3717 would directly conflict with these privately agreed upon contracts and eliminates the means for payers to recoup funds from providers who do not meet these value-based benchmarks.

A.3717 Will Increase Costs for Payers and Consumers

- This legislation will eliminate a PBMs ability to enforce performance based service that reduces beneficiary premiums and drug costs for payers.
- Value-based benchmarks incent pharmacies to operate efficiently by encouraging generic and cost-effective dispensing, lowering costs for plan sponsors and improving medication adherence, leading to better health outcomes for patients.
- Medicare Part D utilizes similar value-based benchmarks seen in the private marketplace and have realized significant savings. Since its inception in the Part D program, these benchmarks have saved Part D beneficiaries 21.5%, or $12.4 billion on their premiums.[1]
- This legislation also prevents payers from justly recouping funds from providers, especially if errors are found outside of the contracting process.

[1] Centers for Medicare and Medicaid Services. Medicare Part D – Direct and Indirect Remuneration (DIR). January 19, 2017. Retrieved May 28, 2017 from https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2017-fact-sheet-items/2017-01-19- 2.html.

A.3717 Insulates Pharmacies From Market Competition

- The Legislative Statement makes a direct reference to Medicare Part D implying that this legislation might seek to regulate a federal program; however, the Medicare Part D program is not the purview of state government.
- **This legislation creates a new definition of a "clean claim" that is significantly different than the current definition codified under state law.** (N.J.A.C. 11:22-1.2) The vagueness in the new definition could create a loophole for pharmacies to be paid for uncovered services, fraudulent claims, etc. Why should a pharmacy claim be afforded the legislative protection of a "guaranteed payment?"
- This legislation prohibits PBMs from retroactively reducing payment on clean claims submitted by pharmacies that may arise from failing to meet certain payment or performance standards including the use of aggregated effective rates for reimbursement of generic drugs. In so doing, this bill is nothing more than a shield for the pharmacy lobby to insulate themselves from competition. This bill would have a cost to taxpayers and increase beneficiary premiums.

A.3717 Would Open Plan Sponsors to Fraud, Waste and Abuse

- This legislation would create an opportunity for fraud. The only exception in the bill to guaranteed payment is if, on "routine audits" agreed to by the pharmacy in its contract with the plan, the claim is determined not to be a "clean claim". This is problematic for many reasons:
    - PBMs must be able to conduct audits beyond "routine" audits. PBM's need to be able to do "unscheduled" audits especially where there is a suspicion of fraud, waste, or abuse (FWA). Under the bill, deficient claims detected in these cases could not be subject to reduction. This should be a major concern to those seeking to reduce the opportunities for FWA.
    - PBMs are required to conduct audit under certain provisions in their downstream contracts, but under this proposal it seems these audits are not considered "routine" and therefore any payments based on fraudulent or compromised claims could not be reversed.

A.3717 is a Step Backward to Outdated Payment Methods

- Performance based contracting encourages a wide range of creative, evolving reimbursement arrangements that cannot be reasonably determined at POS. Performance based contracting for hospitals, doctors and now pharmacies encourages innovation, care coordination, quality and related incentives, and moves away from the antiquated fee-for service models to payments based on quality and value. This new approach to reimbursement is cornerstone of commitment to institute health care delivery reform. Indeed, the future of delivery high quality pharmacy care will rely less on incentives promoting volume-based and more outcome-based" care.