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ASSEMBLY, No. 1255

STATE OF NEW JERSEY

220th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2022 SESSION

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SYNOPSIS

"Ensuring Transparency in Prior Authorization Act."

CURRENT VERSION OF TEXT

As reported by the Assembly Health Committee on May 26, 2022, with amendments.

(Sponsorship Updated As Of: 11/20/2023)

AN ACT concerning prior authorization of services covered by health benefits plans and supplementing Title 26 of the Revised Statutes.

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

1. This act shall be known and may be cited as the "Ensuring Transparency in Prior Authorization Act."

2. The Legislature finds and declares that:

a. the physician-patient relationship is paramount and should not be subject to third party intrusion;

b. prior authorization programs can place attempted cost savings ahead of optimal patient care;

c. prior authorization programs shall not be permitted to hinder patient care or intrude on the practice of medicine; and

d. prior authorization programs must include the use of written clinical criteria and reviews by appropriate physicians to ensure a fair process for patients.

3. As used in this act:

"Adverse determination" means a decision by a utilization review entity that the covered services furnished or proposed to be furnished to a subscriber are not medically necessary, or are experimental or investigational; and benefit coverage is therefore denied, reduced, or terminated. A decision to deny, reduce, or terminate services which are not covered for reasons other than their medical necessity or experimental or investigational nature is not an "adverse determination" for purposes of this act.

"Authorization" means a determination by a utilization review entity that a covered service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness and that payment will be made for that health care service.

"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 [1], and shall include the State Health Benefits Program and the School Employees' Health Benefits Program[1].

"Clinical criteria" means the written policies, written screening procedures, drug formularies or lists of covered drugs, determination rules, determination abstracts, clinical protocols,

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:
[1]Assembly AHE committee amendments adopted May 26, 2022.

practice guidelines, medical protocols and any other criteria or rationale used by the utilization review entity to determine the necessity and appropriateness of covered services.

"Covered person" means a person on whose behalf a carrier offering the health benefits plan is obligated to pay benefits or provide services pursuant to the plan.

"Covered service" means a health care service provided to a covered person under a health benefits plan for which the carrier is obligated to pay benefits or provide services, and shall include "health care service" and "emergency health care services."

"Emergency health care services" means those covered services that are provided in an emergency health care facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing a covered person's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

[1]<u>"Enrollee" means a covered person or subscriber.</u>[1]

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, health benefits plan shall not include the following plans, policies, or contracts: accident only, credit, disability, long-term care, TRICARE supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), or hospital confinement indemnity coverage.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health benefits plan. Health care provider includes, but is not limited to, a physician and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

"Health care service" means health care procedures, treatments or services: (1) provided by a health care facility licensed in New Jersey; or (2) provided by a doctor of medicine, a doctor of osteopathy, or within the scope of practice for which a health care professional is licensed in New Jersey. The term "health care service" also includes the provision of pharmaceutical products or services or durable medical equipment.

"Medically necessary health care services" means health care services that a prudent physician would provide to a covered person for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site and duration; and (3) not primarily for the economic benefit of the health benefits plan and purchaser of a plan or for the convenience of the covered person, treating physician, or other health care provider.

[1]"Medications for opioid use disorder" means the use of medications, commonly in combination with counseling and behavioral therapies, to provide a comprehensive approach to the treatment of opioid use disorder. Medications approved by the United States Food and Drug Administration used to treat opioid addiction include, but are not limited to, methadone, buprenorphine (alone or in combination with naloxone) and extended-release injectable naltrexone. Types of behavioral therapies include, but are not limited to, individual therapy, group counseling, family behavior therapy, motivational incentives and other modalities.[1]

"NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs SCRIPT Standard Version [1][2013101] 2017071[1], or the most recent standard adopted by the United States Department of Health and Human Services (HHS). Subsequently released versions of the NCPDP SCRIPT Standard may be used[1][, provided that the new version of the standard is backward compatible to the current version adopted by HHS][1].

"Prior authorization" means the process by which a utilization review entity determines the medical necessity of an otherwise covered service prior to the rendering of the service including, but not limited to, preadmission review, pretreatment review, utilization review, and case management. "Prior authorization" also includes a utilization review entity's requirement that a subscriber or health care provider notify the carrier or utilization review entity prior to providing a health care service.

"Step therapy protocol" means a protocol or program that establishes the specific sequence in which prescription drugs for a medical condition that are medically appropriate for a particular subscriber are authorized by a utilization review entity.

"Subscriber" means, in the case of a group contract, a person whose employment or other status, except family status, is the basis for eligibility for enrollment by the carrier or, in the case of an individual contract, the person in whose name the contract is issued. The term "subscriber" includes a subscriber's legally authorized representative.

"Urgent health care service" means a health care service with respect to which the application of the time periods for making a nonexpedited prior authorization, in the opinion of a physician with knowledge of the covered person's medical condition: (1) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or (2) could subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review. [1]"Urgent health care service" shall include, but not be limited to, mental health services and behavioral health services that otherwise comply with this definition.[1]

"Utilization review entity" means an individual or entity that performs prior authorization for one or more of the following entities: (1) an employer with employees in New Jersey who are covered under a health benefits plan; (2) a carrier; and (3) any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a health care provider in New Jersey under a policy, plan, or contract. A carrier shall be a utilization review entity if it performs prior authorization.

4. a. A utilization review entity shall make any current prior authorization requirements and restrictions, including written clinical criteria, readily accessible on its Internet website to subscribers, health care providers, and the general public. Requirements shall be described in detail but also in easily understandable language.

b. If a utilization review entity intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review entity shall ensure that the new or amended requirement is not implemented unless the utilization review entity's Internet website has been updated to reflect the new or amended requirement or restriction.

c. If a utilization review entity intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review entity shall provide contracted in-network health care providers with written notice of the new or amended requirement or amendment no less than 60 days before the requirement or restriction is implemented.

d. A utilization review entity that uses prior authorization shall make statistics available regarding prior authorization approvals and denials on its Internet website in a readily accessible format. Entities shall include categories for:

(1) physician specialty;

(2) medication or diagnostic tests and procedures;

(3) indication offered; [1]**[**and**]**[1]

(4) reason for denial[1];

(5) whether prior authorization determinations were:

(a) appealed; or

(b) approved or denied on appeal; and

(6) the time between submission of prior authorization requests and the determination[1].

[1]5. A utilization review entity shall ensure that all adverse determinations are made by a physician. The physician shall:

a. possess a current and valid non-restricted license to practice medicine and surgery in the State of New Jersey;

b. be of the same specialty as the physician who typically manages the medical condition or disease, or provides the health care service involved in the request;

c. have experience treating patients with the medical condition or disease for which the health care services are being requested; and

d. make the adverse determination under the clinical direction of a medical director of the utilization review entity who is responsible for the provision of health care services provided to enrollees of the State of New Jersey. All medical directors of a utilization review entity shall be physicians licensed in the State of New Jersey.[1]

[1]6. a. If a utilization review entity is questioning the medical necessity of a health care service, the entity shall notify the physician of the enrollee.

b. Prior to issuing an adverse determination, the physician of the enrollee shall have the opportunity to discuss the medical necessity of the health care service by phone with the physician who will be responsible for determining authorization of the health care service under review.[1]

[1]7. A utilization review entity shall ensure that all appeals are reviewed by a physician. The physician shall:

a. possess a current and valid non-restricted license to practice medicine and surgery in the State of New Jersey;

b. be currently in active practice in the same or similar specialty as the physician who typically manages the medical condition or disease for at least five consecutive years;

c. be knowledgeable of, and have experience providing, the health care services under review;

d. not be employed by or under contract with a utilization review entity other than to participate in one or more of the utilization review entity's health care provider networks or to perform reviews on appeal, or otherwise have any financial interest in the outcome of the appeal;

e. not have been directly involved in making adverse determinations; and

f. consider all known clinical aspects of the health care service under review, including, but not limited to, a review of all pertinent medical records provided to the utilization review entity by the health care provider of the enrollee, any relevant records provided to the utilization review entity by a health care facility, and any medical literature provided to the utilization review entity by the health care provider of the enrollee.[1]

[1][[]5.[]] 8.[1] Notwithstanding the provisions of any other law to the contrary:

a. If a utilization review entity requires prior authorization of a covered service, the utilization review entity shall make a prior authorization or adverse determination and notify the subscriber and the subscriber's health care provider of the prior authorization or adverse determination within [1][[]two business days[]] one calendar day[1] of obtaining all necessary information to make the prior authorization or adverse determination. For purposes of this section, "necessary information"[1]:

(1)[1] includes the results of any face-to-face clinical evaluation or second opinion that may be required[1]; and

(2) shall be considered transmitted to the utilization review entity upon being sent by electronic portal, e-mail, facsimile, telephone or other means of communication[1].

b. A utilization review entity shall render a prior authorization or adverse determination concerning an urgent health care service, and notify the subscriber and the subscriber's health care provider of that prior authorization or adverse determination, not later than [1][[]one business day[]] 24 hours[1] after receiving all information needed to complete the review of the requested service.

c. (1) A utilization review entity shall not require prior authorization for pre-hospital transportation [1][[]or for[]] the[1] provision of emergency health care services [1], or medications for opioid use disorder when prescribed incident to an emergency[1].

(2) A utilization review entity shall allow a subscriber and the subscriber's health care provider a minimum of 24 hours following an emergency admission or provision of emergency health care services for the subscriber or health care provider to notify the utilization review entity of the admission or provision of covered services. If the admission or covered service occurs on a holiday or weekend, a utilization review entity shall not require notification until the next business day after the admission or provision of the service.

(3) A utilization review entity shall approve coverage for emergency health care services necessary to screen and stabilize a covered person. If a health care provider certifies in writing to a

utilization review entity within 72 hours of a covered person's admission that the covered person's condition requires emergency health care services, that certification shall create a presumption that the emergency health care services are medically necessary and that presumption may be rebutted only if the utilization review entity establishes, with clear and convincing evidence, that the emergency health care services are not medically necessary.

(4) A utilization review entity shall not determine medical necessity or appropriateness of emergency health care services based on whether or not those services are provided by participating or nonparticipating providers. A utilization review entity shall ensure that restrictions on coverage of emergency health care services provided by nonparticipating providers shall not be greater than restrictions that apply when those services are provided by participating providers.

(5) If a subscriber receives an emergency health care service that requires immediate post-evaluation or post-stabilization services, a utilization review entity shall make an authorization determination within 60 minutes of receiving a request. If the authorization determination is not made within 60 minutes, those services shall be deemed approved.

[1](6) If a utilization review entity requires prior authorization for a health care service for the treatment of a chronic or long-term care condition, the prior authorization shall remain valid for the length of the treatment and the utilization review entity shall not require the enrollee to obtain a prior authorization again for the health care service.[1]

9. [1][~~No later than January 1, 2019, a~~] A[1] carrier shall accept and respond to prior authorization requests for medication coverage, under the pharmacy benefit part of a health benefits plan, made through a secure electronic transmission using the NCPDP SCRIPT Standard ePA (electronic prior authorization) transactions. Facsimile, propriety payer portals, and electronic forms shall not be considered secure electronic transmission.

[1][~~6.~~] 10.[1] A utilization review entity shall not:

a. require a health care provider offering services to a covered person to participate in a step therapy protocol if the provider deems that the step therapy protocol is not in the covered person's best interests;

b. require that a health care provider first obtain a waiver, exception, or other override when deeming a step therapy protocol to not be in a covered person's best interests;

c. sanction or otherwise penalize a health care provider for recommending or issuing a prescription, performing or

recommending a procedure, or performing a test that may conflict with the step therapy protocol of the carrier[1];

d. require prior authorization for:

(1) generic medications that are not controlled substances;

(2) dosage changes of medications previously prescribed and authorized; or

(3) generic or brand name drugs after six months of adherence; or

e. deny medications on the grounds of therapeutic duplication.[1]

[1][7.] 11.[1] A utilization review entity shall not revoke, limit, condition or restrict a prior authorization if care is provided within 45 business days from the date the health care provider received the prior authorization. Any language in a contract or a policy or any other attempt to disclaim payment for services that have been authorized within that 45 day period shall be null and void.

[1][8.] 12.[1] A prior authorization shall be valid for purposes of authorizing the health care provider to provide care for a period of one year from the date the health care provider receives the prior authorization.

[1]13. a. On receipt of information documenting a prior authorization from the enrollee or the health care provider of the enrollee, a utilization review entity shall honor a prior authorization granted to an enrollee by a previous utilization review entity for at least the initial 60 days of coverage under a new health plan of the enrollee.

b. During the initial 60 days described in subsection a. of this section, a utilization review entity may perform its own review to grant a prior authorization.

c. If there is a change in coverage or approval criteria for a previously authorized health care service, the change in coverage or approval criteria shall not affect an enrollee who received prior authorization before the effective date of the change for the remainder of the enrollee's plan year.

d. A utilization review entity shall continue to honor a prior authorization it has granted to an enrollee when the enrollee changes products under the same carrier.[1]

[1][10.] 14.[1] Any failure by a utilization review entity to comply with a deadline or other requirement under the provisions of this act shall result in any health care services subject to review being automatically deemed authorized.

[1][11.] 15.[1] The Commissioner of Banking and Insurance shall promulgate rules and regulations, pursuant to the "Administrative

Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), including any penalties or enforcement provisions, that the commissioner deems necessary to effectuate the purposes of this act.

[1][**[**12.**]** 16.[1] This act shall take effect on the 90th day next following enactment.