

[First Reprint]

ASSEMBLY, No. 1255

STATE OF NEW JERSEY

220th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2022 SESSION

Sponsored by:

Assemblyman STERLEY S. STANLEY

District 18 (Middlesex)

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District 7 (Burlington)

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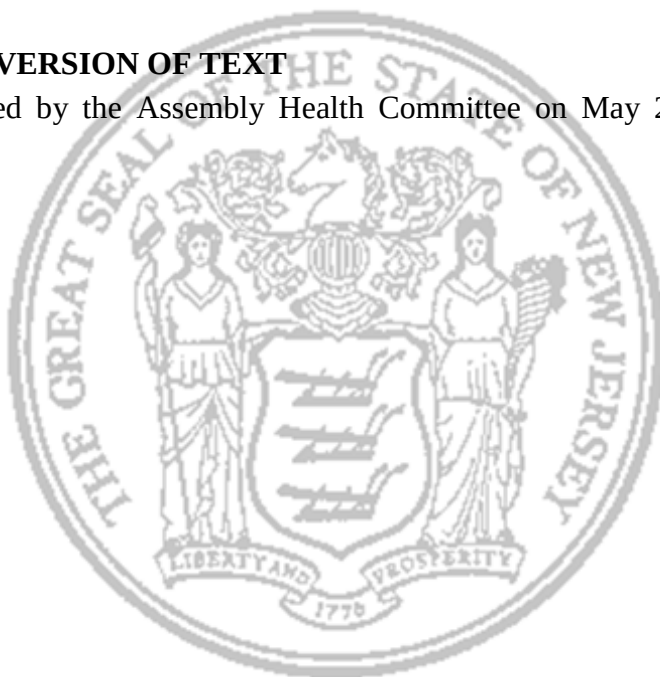
Assemblywoman Jimenez, Assemblyman DeAngelo, Assemblywomen Reynolds-Jackson, Murphy and Dunn

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: 2/23/2023)

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

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

7
8 1. This act shall be known and may be cited as the “Ensuring
9 Transparency in Prior Authorization Act.”

10
11 2. The Legislature finds and declares that:

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

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

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

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

21
22 3. As used in this act:

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

31 “Authorization” means a determination by a utilization review
32 entity that a covered service has been reviewed and, based on the
33 information provided, satisfies the utilization review entity’s
34 requirements for medical necessity and appropriateness and that
35 payment will be made for that health care service.

36 “Carrier” means an insurance company, health service
37 corporation, hospital service corporation, medical service
38 corporation, or health maintenance organization authorized to issue
39 health benefits plans in this State ¹, and shall include the State
40 Health Benefits Program and the School Employees’ Health
41 Benefits Program¹.

42 “Clinical criteria” means the written policies, written screening
43 procedures, drug formularies or lists of covered drugs,
44 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:

¹Assembly AHE committee amendments adopted May 26, 2022.

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

4 “Covered person” means a person on whose behalf a carrier
5 offering the health benefits plan is obligated to pay benefits or
6 provide services pursuant to the plan.

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

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

21 ¹“Enrollee” means a covered person or subscriber.¹

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

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

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

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

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

21 “NCPDP SCRIPT Standard” means the National Council for
22 Prescription Drug Programs SCRIPT Standard Version ¹**‘[2013101]**
23 **2017071**¹, or the most recent standard adopted by the United States
24 Department of Health and Human Services (HHS). Subsequently
25 released versions of the NCPDP SCRIPT Standard may be used ¹**‘,**
26 provided that the new version of the standard is backward
27 compatible to the current version adopted by HHS ¹**’**.

28 “Prior authorization” means the process by which a utilization
29 review entity determines the medical necessity of an otherwise
30 covered service prior to the rendering of the service including, but
31 not limited to, preadmission review, pretreatment review, utilization
32 review, and case management. “Prior authorization” also includes a
33 utilization review entity’s requirement that a subscriber or health
34 care provider notify the carrier or utilization review entity prior to
35 providing a health care service.

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

40 “Subscriber” means, in the case of a group contract, a person
41 whose employment or other status, except family status, is the basis
42 for eligibility for enrollment by the carrier or, in the case of an
43 individual contract, the person in whose name the contract is issued.
44 The term “subscriber” includes a subscriber’s legally authorized
45 representative.

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

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

21
22 4. a. A utilization review entity shall make any current prior
23 authorization requirements and restrictions, including written
24 clinical criteria, readily accessible on its Internet website to
25 subscribers, health care providers, and the general public.
26 Requirements shall be described in detail but also in easily
27 understandable language.

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

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

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

- 44 (1) physician specialty;
45 (2) medication or diagnostic tests and procedures;
46 (3) indication offered; ¹**[and]**¹
47 (4) reason for denial¹;

1 (5) whether prior authorization determinations were:
2 (a) appealed; or
3 (b) approved or denied on appeal; and
4 (6) the time between submission of prior authorization requests
5 and the determination¹.

7 ¹5. A utilization review entity shall ensure that all adverse
8 determinations are made by a physician. The physician shall:

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

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

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

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

24 ¹6. a. If a utilization review entity is questioning the medical
25 necessity of a health care service, the entity shall notify the
26 physician of the enrollee.

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

33 ¹7. A utilization review entity shall ensure that all appeals are
34 reviewed by a physician. The physician shall:

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

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

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

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

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

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

10
11 ¹**[5.] 8.**¹ Notwithstanding the provisions of any other law to
12 the contrary:

13 a. If a utilization review entity requires prior authorization of a
14 covered service, the utilization review entity shall make a prior
15 authorization or adverse determination and notify the subscriber and
16 the subscriber's health care provider of the prior authorization or
17 adverse determination within ¹**[two business days]** one calendar
18 day¹ of obtaining all necessary information to make the prior
19 authorization or adverse determination. For purposes of this section,
20 "necessary information"¹;

21 (1)¹ includes the results of any face-to-face clinical evaluation
22 or second opinion that may be required¹; and

23 (2) shall be considered transmitted to the utilization review
24 entity upon being sent by electronic portal, e-mail, facsimile,
25 telephone or other means of communication¹.

26 b. A utilization review entity shall render a prior authorization
27 or adverse determination concerning an urgent health care service,
28 and notify the subscriber and the subscriber's health care provider
29 of that prior authorization or adverse determination, not later than
30 ¹**[one business day]** 24 hours¹ after receiving all information
31 needed to complete the review of the requested service.

32 c. (1) A utilization review entity shall not require prior
33 authorization for pre-hospital transportation ¹**[or for]** the¹ provision
34 of emergency health care services ¹, or medications for opioid use
35 disorder when prescribed incident to an emergency¹.

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

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

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

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

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

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

28
29 9. ¹**[No later than January 1, 2019, a]** A¹ carrier shall accept
30 and respond to prior authorization requests for medication coverage,
31 under the pharmacy benefit part of a health benefits plan, made
32 through a secure electronic transmission using the NCPDP SCRIPT
33 Standard ePA (electronic prior authorization) transactions.
34 Facsimile, propriety payer portals, and electronic forms shall not be
35 considered secure electronic transmission.

36
37 ¹**[6.] 10.**¹ A utilization review entity shall not:

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

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

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

1 recommending a procedure, or performing a test that may conflict
2 with the step therapy protocol of the carrier¹;

3 d. require prior authorization for:

4 (1) generic medications that are not controlled substances;

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

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

8 or

9 e. deny medications on the grounds of therapeutic duplication.¹
10

11 ¹**[7.] 11.**¹ A utilization review entity shall not revoke, limit,
12 condition or restrict a prior authorization if care is provided within
13 45 business days from the date the health care provider received the
14 prior authorization. Any language in a contract or a policy or any
15 other attempt to disclaim payment for services that have been
16 authorized within that 45 day period shall be null and void.
17

18 ¹**[8.] 12.**¹ A prior authorization shall be valid for purposes of
19 authorizing the health care provider to provide care for a period of
20 one year from the date the health care provider receives the prior
21 authorization.
22

23 ¹13. a. On receipt of information documenting a prior
24 authorization from the enrollee or the health care provider of the
25 enrollee, a utilization review entity shall honor a prior authorization
26 granted to an enrollee by a previous utilization review entity for at
27 least the initial 60 days of coverage under a new health plan of the
28 enrollee.

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

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

37 d. A utilization review entity shall continue to honor a prior
38 authorization it has granted to an enrollee when the enrollee
39 changes products under the same carrier.¹
40

41 ¹**[10.] 14.**¹ Any failure by a utilization review entity to comply
42 with a deadline or other requirement under the provisions of this act
43 shall result in any health care services subject to review being
44 automatically deemed authorized.
45

46 ¹**[11.] 15.**¹ The Commissioner of Banking and Insurance shall
47 promulgate rules and regulations, pursuant to the "Administrative

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

4

5 ¹~~12.~~ 16.¹ This act shall take effect on the 90th day next
6 following enactment.