ASSEMBLY COMMITTEE SUBSTITUTE FOR

ASSEMBLY, No. 1858



STATE OF NEW JERSEY

218th LEGISLATURE

 ADOPTED DECEMBER 3, 2018

Sponsored by:

Assemblywoman PAMELA R. LAMPITT

District 6 (Burlington and Camden)

Assemblywoman VALERIE VAINIERI HUTTLE

District 37 (Bergen)

Assemblyman DANIEL R. BENSON

District 14 (Mercer and Middlesex)

Co-Sponsored by:

Assemblyman Chiaravalloti, Assemblywoman McKnight and Assemblyman Schaer

SYNOPSIS

Requires continued coverage of prescription drugs for certain medical conditions.

CURRENT VERSION OF TEXT

Substitute as adopted by the Assembly Financial Institutions and Insurance Committee.



**An Act** concerning prescription drug coverage for certain medical conditions and supplementing various parts of the statutory law.

**Be It Enacted** *by the Senate and General Assembly of the State of New Jersey:*

1. a. As used in this section:

“Complex or chronic medical condition” means a physical, behavioral, or developmental condition that does not have a known cure or that can be severely debilitating or fatal if left untreated or undertreated.

“Rare disease” means any disease or condition that affects less than 200,000 persons in the United States.

b. Every group or individual hospital service corporation contract delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State, on or after the effective date of this act, which provides for pharmacy services, prescription drugs, or for participation in a prescription drug plan shall continue to provide coverage for a drug for a covered person with a complex or chronic medical condition or a rare disease, if the drug was previously covered by the contract, while an appeal is at any stage of the appeals process in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, except as provided for in subsection d. of this section.

c. With respect to a drug for a covered person with a complex or chronic medical condition or a rare disease which meets the conditions of subsection b. of this section in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, while the appeal is in any stage of the appeals process, the provisions of a group or individual hospital service corporation contract shall not apply so as to:

(1) set forth limitations on maximum coverage of prescription drug benefits;

(2) subject the covered person to increased out-of-pocket costs; or

(3) move a drug for a covered person to a more restrictive tier, if the group or individual hospital service corporation contract uses a formulary with tiers.

d. A hospital service corporation may only deny coverage during the appeals process for a drug for a covered person with a complex or chronic medical condition or a rare disease if:

(1) the prescribing provider has discontinued prescription of the drug for the covered person;

(2) the United States Food and Drug Administration has issued a notice, guidance, warning, announcement, or any other statement about the drug which calls into question the clinical safety of the drug; or

(3) the manufacturer of the drug has notified the United States Food and Drug Administration of any manufacturing discontinuance or potential discontinuance as required by 21 U.S.C.s.356c.

2. a. As used in this section:

“Complex or chronic medical condition” means a physical, behavioral, or developmental condition that does not have a known cure or that can be severely debilitating or fatal if left untreated or undertreated.

“Rare disease” means any disease or condition that affects less than 200,000 persons in the United States.

b. Every group or individual medical service corporation contract delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State, on or after the effective date of this act, which provides for pharmacy services, prescription drugs, or for participation in a prescription drug plan shall continue to provide coverage for a drug for a covered person with a complex or chronic medical condition or a rare disease, if the drug was previously covered by the contract, while an appeal is at any stage of the appeals process in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, except as provided for in subsection d. of this section.

c. With respect to a drug for a covered person with a complex or chronic medical condition or a rare disease which meets the conditions of subsection b. of this section in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, while the appeal is in any stage of the appeals process, the provisions of a group or individual medical service corporation contract shall not apply so as to:

(1) set forth limitations on maximum coverage of prescription drug benefits;

(2) subject the covered person to increased out-of-pocket costs; or

(3) move a drug for a covered person to a more restrictive tier, if the group or individual medical service corporation contract uses a formulary with tiers.

d. A medical service corporation may only deny coverage during the appeals process for a drug for a covered person with a complex or chronic medical condition or a rare disease if:

(1) the prescribing provider has discontinued prescription of the drug for the covered person;

(2) the United States Food and Drug Administration has issued a notice, guidance, warning, announcement, or any other statement about the drug which calls into question the clinical safety of the drug; or

(3) the manufacturer of the drug has notified the United States Food and Drug Administration of any manufacturing discontinuance or potential discontinuance as required by 21 U.S.C.s.356c.

3. a. As used in this section:

“Complex or chronic medical condition” means a physical, behavioral, or developmental condition that does not have a known cure or that can be severely debilitating or fatal if left untreated or undertreated.

“Rare disease” means any disease or condition that affects less than 200,000 persons in the United States.

b. Every group or individual health service corporation contract delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State, on or after the effective date of this act, which provides for pharmacy services, prescription drugs, or for participation in a prescription drug plan shall continue to provide coverage for a drug for a covered person with a complex or chronic medical condition or a rare disease, if the drug was previously covered by the contract, while an appeal is at any stage of the appeals process in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, except as provided for in subsection d. of this section.

c. With respect to a drug for a covered person with a complex or chronic medical condition or a rare disease which meets the conditions of subsection b. of this section in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, while the appeal is in any stage of the appeals process, the provisions of a group or individual health service corporation contract shall not apply so as to:

(1) set forth limitations on maximum coverage of prescription drug benefits;

(2) subject the covered person to increased out-of-pocket costs; or

(3) move a drug for a covered person to a more restrictive tier, if the group or individual health service corporation contract uses a formulary with tiers.

d. A health service corporation may only deny coverage during the appeals process for a drug for a covered person with a complex or chronic medical condition or a rare disease if:

(1) the prescribing provider has discontinued prescription of the drug for the covered person;

(2) the United States Food and Drug Administration has issued a notice, guidance, warning, announcement, or any other statement about the drug which calls into question the clinical safety of the drug; or

(3) the manufacturer of the drug has notified the United States Food and Drug Administration of any manufacturing discontinuance or potential discontinuance as required by 21 U.S.C.s.356c.

4. a. As used in this section:

“Complex or chronic medical condition” means a physical, behavioral, or developmental condition that does not have a known cure or that can be severely debilitating or fatal if left untreated or undertreated.

“Rare disease” means any disease or condition that affects less than 200,000 persons in the United States.

b. Every individual health insurance policy or contract delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State, on or after the effective date of this act, which provides for pharmacy services, prescription drugs, or for participation in a prescription drug plan shall continue to provide coverage for a drug for a covered person with a complex or chronic medical condition or a rare disease, if the drug was previously covered by the contract, while an appeal is at any stage of the appeals process in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, except as provided for in subsection d. of this section.

c. With respect to a drug for a covered person with a complex or chronic medical condition or a rare disease which meets the conditions of subsection b. of this section in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, while the appeal is in any stage of the appeals process, the provisions of an individual health insurance policy or contract shall not apply so as to:

(1) set forth limitations on maximum coverage of prescription drug benefits;

(2) subject the covered person to increased out-of-pocket costs; or

(3) move a drug for a covered person to a more restrictive tier, if the individual health insurance policy or contract uses a formulary with tiers.

d. An individual health insurance policy or contract may only deny coverage during the appeals process for a drug for a covered person with a complex or chronic medical condition or a rare disease if:

(1) the prescribing provider has discontinued prescription of the drug for the covered person;

(2) the United States Food and Drug Administration has issued a notice, guidance, warning, announcement, or any other statement about the drug which calls into question the clinical safety of the drug; or

(3) the manufacturer of the drug has notified the United States Food and Drug Administration of any manufacturing discontinuance or potential discontinuance as required by 21 U.S.C.s.356c.

5. a. As used in this section:

“Complex or chronic medical condition” means a physical, behavioral, or developmental condition that does not have a known cure or that can be severely debilitating or fatal if left untreated or undertreated.

“Rare disease” means any disease or condition that affects less than 200,000 persons in the United States.

b. Every group health insurance policy or contract delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State, on or after the effective date of this act, which provides for pharmacy services, prescription drugs, or for participation in a prescription drug plan shall continue to provide coverage for a drug for a covered person with a complex or chronic medical condition or a rare disease, if the drug was previously covered by the contract, while an appeal is at any stage of the appeals process in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, except as provided for in subsection d. of this section.

c. With respect to a drug for a covered person with a complex or chronic medical condition or a rare disease which meets the conditions of subsection b. of this section in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, while the appeal is in any stage of the appeals process, the provisions of a group health insurance policy or contract shall not apply so as to:

(1) set forth limitations on maximum coverage of prescription drug benefits;

(2) subject the covered person to increased out-of-pocket costs; or

(3) move a drug for a covered person to a more restrictive tier, if the group health insurance policy or contract uses a formulary with tiers.

d. A group health insurance policy or contract may only deny coverage during the appeals process for a drug for a covered person with a complex or chronic medical condition or a rare disease if:

(1) the prescribing provider has discontinued prescription of the drug for the covered person;

(2) the United States Food and Drug Administration has issued a notice, guidance, warning, announcement, or any other statement about the drug which calls into question the clinical safety of the drug; or

(3) the manufacturer of the drug has notified the United States Food and Drug Administration of any manufacturing discontinuance or potential discontinuance as required by 21 U.S.C.s.356c.

6. a. As used in this section:

“Complex or chronic medical condition” means a physical, behavioral, or developmental condition that does not have a known cure or that can be severely debilitating or fatal if left untreated or undertreated.

“Rare disease” means any disease or condition that affects less than 200,000 persons in the United States.

b. Every certificate of authority to establish and operate a health maintenance organization delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State, on or after the effective date of this act, which provides for pharmacy services, prescription drugs, or for participation in a prescription drug plan shall continue to provide coverage for a drug for a covered person with a complex or chronic medical condition or a rare disease, if the drug was previously covered by the contract, while an appeal is at any stage of the appeals process in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, except as provided for in subsection d. of this section.

c. With respect to a drug for a covered person with a complex or chronic medical condition or a rare disease which meets the conditions of subsection b. of this section in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, while the appeal is in any stage of the appeals process, the provisions of an enrollee agreement shall not apply so as to:

(1) set forth limitations on maximum coverage of prescription drug benefits;

(2) subject the covered person to increased out-of-pocket costs; or

(3) move a drug for a covered person to a more restrictive tier, if the health maintenance organization uses a formulary with tiers.

d. A health maintenance organization may only deny coverage during the appeals process for a drug for a covered person with a complex or chronic medical condition or a rare disease if:

(1) the prescribing provider has discontinued prescription of the drug for the covered person;

(2) the United States Food and Drug Administration has issued a notice, guidance, warning, announcement, or any other statement about the drug which calls into question the clinical safety of the drug; or

(3) the manufacturer of the drug has notified the United States Food and Drug Administration of any manufacturing discontinuance or potential discontinuance as required by 21 U.S.C.s.356c.

7. a. As used in this section:

“Complex or chronic medical condition” means a physical, behavioral, or developmental condition that does not have a known cure or that can be severely debilitating or fatal if left untreated or undertreated.

“Rare disease” means any disease or condition that affects less than 200,000 persons in the United States.

b. Every individual health benefits plan delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State, on or after the effective date of this act, which provides for pharmacy services, prescription drugs, or for participation in a prescription drug plan shall continue to provide coverage for a drug for a covered person with a complex or chronic medical condition or a rare disease, if the drug was previously covered by the contract, while an appeal is at any stage of the appeals process in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, except as provided for in subsection d. of this section.

c. With respect to a drug for a covered person with a complex or chronic medical condition or a rare disease which meets the conditions of subsection b. of this section in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, while the appeal is in any stage of the appeals process, the provisions of an individual health benefits plan shall not apply so as to:

(1) set forth limitations on maximum coverage of prescription drug benefits;

(2) subject the covered person to increased out-of-pocket costs; or

(3) move a drug for a covered person to a more restrictive tier, if the individual health benefits plan uses a formulary with tiers.

d. An individual health benefits plan may only deny coverage during the appeals process for a drug for a covered person with a complex or chronic medical condition or a rare disease if:

(1) the prescribing provider has discontinued prescription of the drug for the covered person;

(2) the United States Food and Drug Administration has issued a notice, guidance, warning, announcement, or any other statement about the drug which calls into question the clinical safety of the drug; or

(3) the manufacturer of the drug has notified the United States Food and Drug Administration of any manufacturing discontinuance or potential discontinuance as required by 21 U.S.C.s.356c.

8. a. As used in this section:

“Complex or chronic medical condition” means a physical, behavioral, or developmental condition that does not have a known cure or that can be severely debilitating or fatal if left untreated or undertreated.

“Rare disease” means any disease or condition that affects less than 200,000 persons in the United States.

b. Every small employer health benefits plan delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State, on or after the effective date of this act, which provides for pharmacy services, prescription drugs, or for participation in a prescription drug plan shall continue to provide coverage for a drug for a covered person with a complex or chronic medical condition or a rare disease, if the drug was previously covered by the contract, while an appeal is at any stage of the appeals process in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, except as provided for in subsection d. of this section.

c. With respect to a drug for a covered person with a complex or chronic medical condition or a rare disease which meets the conditions of subsection b. of this section in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, while the appeal is in any stage of the appeals process, the provisions of a small employer health benefits plan shall not apply so as to:

(1) set forth limitations on maximum coverage of prescription drug benefits;

(2) subject the covered person to increased out-of-pocket costs; or

(3) move a drug for a covered person to a more restrictive tier, if the small employer health benefits plan uses a formulary with tiers.

d. A small employer health benefits plan may only deny coverage during the appeals process for a drug for a covered person with a complex or chronic medical condition or a rare disease if:

(1) the prescribing provider has discontinued prescription of the drug for the covered person;

(2) the United States Food and Drug Administration has issued a notice, guidance, warning, announcement, or any other statement about the drug which calls into question the clinical safety of the drug; or

(3) the manufacturer of the drug has notified the United States Food and Drug Administration of any manufacturing discontinuance or potential discontinuance as required by 21 U.S.C.s.356c.

9. a. As used in this section:

“Complex or chronic medical condition” means a physical, behavioral, or developmental condition that does not have a known cure or that can be severely debilitating or fatal if left untreated or undertreated.

“Rare disease” means any disease or condition that affects less than 200,000 persons in the United States.

b. Every prepaid prescription service organization contract delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State, on or after the effective date of this act, shall continue to provide coverage for a drug for a covered person with a complex or chronic medical condition or a rare disease, if the drug was previously covered by the contract, while an appeal is at any stage of the appeals process in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, except as provided for in subsection d. of this section.

c. With respect to a drug for a covered person with a complex or chronic medical condition or a rare disease which meets the conditions of subsection b. of this section in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, while the appeal is in any stage of the appeals process, the provisions of a prepaid prescription service organization contract shall not apply so as to:

(1) set forth limitations on maximum coverage of prescription drug benefits;

(2) subject the covered person to increased out-of-pocket costs; or

(3) move a drug for a covered person to a more restrictive tier, if the prepaid prescription service organization contract uses a formulary with tiers.

d. A prepaid prescription service organization may only deny coverage during the appeals process for a drug for a covered person with a complex or chronic medical condition or a rare disease if:

(1) the prescribing provider has discontinued prescription of the drug for the covered person;

(2) the United States Food and Drug Administration has issued a notice, guidance, warning, announcement, or any other statement about the drug which calls into question the clinical safety of the drug; or

(3) the manufacturer of the drug has notified the United States Food and Drug Administration of any manufacturing discontinuance or potential discontinuance as required by 21 U.S.C.s.356c.

10. a. As used in this section:

“Complex or chronic medical condition” means a physical, behavioral, or developmental condition that does not have a known cure or that can be severely debilitating or fatal if left untreated or undertreated.

“Rare disease” means any disease or condition that affects less than 200,000 persons in the United States.

b. The State Health Benefits Commission shall ensure that every contract purchased by the State Health Benefits Program, on or after the effective date of this act, which provides for pharmacy services, prescription drugs, or for participation in a prescription drug plan shall continue to provide coverage for a drug for a covered person with a complex or chronic medical condition or a rare disease, if the drug was previously covered by the contract, while an appeal is at any stage of the appeals process in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, except as provided for in subsection d. of this section.

c. With respect to a drug for a covered person with a complex or chronic medical condition or a rare disease which meets the conditions of subsection b. of this section in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, while the appeal is in any stage of the appeals process, the provisions of the State Health Benefits Program contract shall not apply so as to:

(1) set forth limitations on maximum coverage of prescription drug benefits;

(2) subject the covered person to increased out-of-pocket costs; or

(3) move a drug for a covered person to a more restrictive tier, if the State Health Benefits Program contract uses a formulary with tiers.

d. The State Health Benefits Commission may only deny coverage during the appeals process for a drug for a covered person with a complex or chronic medical condition or a rare disease if:

(1) the prescribing provider has discontinued prescription of the drug for the covered person;

(2) the United States Food and Drug Administration has issued a notice, guidance, warning, announcement, or any other statement about the drug which calls into question the clinical safety of the drug; or

(3) the manufacturer of the drug has notified the United States Food and Drug Administration of any manufacturing discontinuance or potential discontinuance as required by 21 U.S.C.s.356c.

11. a. As used in this section:

“Complex or chronic medical condition” means a physical, behavioral, or developmental condition that does not have a known cure or that can be severely debilitating or fatal if left untreated or undertreated.

“Rare disease” means any disease or condition that affects less than 200,000 persons in the United States.

b. The School Employees’ Health Benefits Commission shall ensure that every contract purchased by the School Employees’ Health Benefits Program on or after the effective date of this act, which provides for pharmacy services, prescription drugs, or for participation in a prescription drug plan shall continue to provide coverage for a drug for a covered person with a complex or chronic medical condition or a rare disease, if the drug was previously covered by the contract, while an appeal is at any stage of the appeals process in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, except as provided for in subsection d. of this section.

c. With respect to a drug for a covered person with a complex or chronic medical condition or a rare disease which meets the conditions of subsection b. of this section in situations in which a covered person appeals a denial of coverage for the drug based on medical necessity, while the appeal is in any stage of the appeals process, the provisions of the School Employees’ Health Benefits contract shall not apply so as to:

(1) set forth limitations on maximum coverage of prescription drug benefits;

(2) subject the covered person to increased out-of-pocket costs; or

(3) move a drug for a covered person to a more restrictive tier, if the School Employees’ Health Benefits contract uses a formulary with tiers.

d. The School Employees’ Health Benefits Commission may only deny coverage during the appeals process for a drug for a covered person with a complex or chronic medical condition or a rare disease if:

(1) the prescribing provider has discontinued prescription of the drug for the covered person;

(2) the United States Food and Drug Administration has issued a notice, guidance, warning, announcement, or any other statement about the drug which calls into question the clinical safety of the drug; or

(3) the manufacturer of the drug has notified the United States Food and Drug Administration of any manufacturing discontinuance or potential discontinuance as required by 21 U.S.C.s.356c.