

ASSEMBLY, No. 1972

STATE OF NEW JERSEY 219th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

Sponsored by:

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District 18 (Middlesex)

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District 7 (Burlington)

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SYNOPSIS

“Ensuring Transparency in Prior Authorization Act.”

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



(Sponsorship Updated As Of: 1/27/2021)

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.

40 “Clinical criteria” means the written policies, written screening
41 procedures, drug formularies or lists of covered drugs,
42 determination rules, determination abstracts, clinical protocols,
43 practice guidelines, medical protocols and any other criteria or
44 rationale used by the utilization review entity to determine the
45 necessity and appropriateness of covered services.

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

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

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

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

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

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

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

1 of the covered person, treating physician, or other health care
2 provider.

3 “NCPDP SCRIPT Standard” means the National Council for
4 Prescription Drug Programs SCRIPT Standard Version 2013101, or
5 the most recent standard adopted by the United States Department
6 of Health and Human Services (HHS). Subsequently released
7 versions of the NCPDP SCRIPT Standard may be used, provided
8 that the new version of the standard is backward compatible to the
9 current version adopted by HHS.

10 “Prior authorization” means the process by which a utilization
11 review entity determines the medical necessity of an otherwise
12 covered service prior to the rendering of the service including, but
13 not limited to, preadmission review, pretreatment review, utilization
14 review, and case management. “Prior authorization” also includes a
15 utilization review entity’s requirement that a subscriber or health
16 care provider notify the carrier or utilization review entity prior to
17 providing a health care service.

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

22 “Subscriber” means, in the case of a group contract, a person
23 whose employment or other status, except family status, is the basis
24 for eligibility for enrollment by the carrier or, in the case of an
25 individual contract, the person in whose name the contract is issued.
26 The term “subscriber” includes a subscriber’s legally authorized
27 representative.

28 “Urgent health care service” means a health care service with
29 respect to which the application of the time periods for making a
30 nonexpedited prior authorization, in the opinion of a physician with
31 knowledge of the covered person’s medical condition: (1) could
32 seriously jeopardize the life or health of the covered person or the
33 ability of the covered person to regain maximum function; or (2)
34 could subject the covered person to severe pain that cannot be
35 adequately managed without the care or treatment that is the subject
36 of the utilization review.

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

46
47 4. a. A utilization review entity shall make any current prior
48 authorization requirements and restrictions, including written
49 clinical criteria, readily accessible on its Internet website to

1 subscribers, health care providers, and the general public.
2 Requirements shall be described in detail but also in easily
3 understandable language.

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

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

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

- 20 (1) physician specialty;
21 (2) medication or diagnostic tests and procedures;
22 (3) indication offered; and
23 (4) reason for denial.
24

25 5. Notwithstanding the provisions of any other law to the
26 contrary:

27 a. If a utilization review entity requires prior authorization of a
28 covered service, the utilization review entity shall make a prior
29 authorization or adverse determination and notify the subscriber and
30 the subscriber's health care provider of the prior authorization or
31 adverse determination within two business days of obtaining all
32 necessary information to make the prior authorization or adverse
33 determination. For purposes of this section, "necessary information"
34 includes the results of any face-to-face clinical evaluation or second
35 opinion that may be required.

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

42 c. (1) A utilization review entity shall not require prior
43 authorization for pre-hospital transportation or for provision of
44 emergency health care services.

45 (2) A utilization review entity shall allow a subscriber and the
46 subscriber's health care provider a minimum of 24 hours following
47 an emergency admission or provision of emergency health care
48 services for the subscriber or health care provider to notify the
49 utilization review entity of the admission or provision of covered

1 services. If the admission or covered service occurs on a holiday or
2 weekend, a utilization review entity shall not require notification
3 until the next business day after the admission or provision of the
4 service.

5 (3) A utilization review entity shall approve coverage for
6 emergency health care services necessary to screen and stabilize a
7 covered person. If a health care provider certifies in writing to a
8 utilization review entity within 72 hours of a covered person's
9 admission that the covered person's condition requires emergency
10 health care services, that certification shall create a presumption
11 that the emergency health care services are medically necessary and
12 that presumption may be rebutted only if the utilization review
13 entity establishes, with clear and convincing evidence, that the
14 emergency health care services are not medically necessary.

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

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

29

30 6. A utilization review entity shall not:

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

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

38 c. sanction or otherwise penalize a health care provider for
39 recommending or issuing a prescription, performing or
40 recommending a procedure, or performing a test that may conflict
41 with the step therapy protocol of the carrier.

42

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

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

5
6 9. No later than January 1, 2019, a carrier shall accept and
7 respond to prior authorization requests for medication coverage,
8 under the pharmacy benefit part of a health benefits plan, made
9 through a secure electronic transmission using the NCPDP SCRIPT
10 Standard ePA (electronic prior authorization) transactions.
11 Facsimile, propriety payer portals, and electronic forms shall not be
12 considered secure electronic transmission.

13
14 10. Any failure by a utilization review entity to comply with a
15 deadline or other requirement under the provisions of this act shall
16 result in any health care services subject to review being
17 automatically deemed authorized.

18
19 11. The Commissioner of Banking and Insurance shall
20 promulgate rules and regulations, pursuant to the “Administrative
21 Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.), including
22 any penalties or enforcement provisions, that the commissioner
23 deems necessary to effectuate the purposes of this act.

24
25 12. This act shall take effect on the 90th day next following
26 enactment.

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STATEMENT

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31 This bill places certain requirements regarding the use of prior
32 authorization of health benefits on carriers and utilization review
33 entities acting on behalf of carriers.

34 The bill requires a utilization review entity to make certain
35 disclosures regarding its prior authorization requirements and
36 restrictions, on its website and in writing, including certain statistics
37 concerning approvals and denials, as set forth in the bill.

38 The bill provides that if a utilization review entity requires prior
39 authorization of a covered service, the utilization review entity shall
40 make a prior authorization or adverse determination and notify the
41 subscriber (also commonly known as a “policyholder”) and the
42 subscriber’s health care provider of the prior authorization or
43 adverse determination within two business days of obtaining all
44 necessary information to make the prior authorization or adverse
45 determination.

46 The bill provides that a utilization review entity shall render a
47 prior authorization or adverse determination concerning an urgent
48 health care service, and notify the subscriber and the subscriber’s
49 health care provider of that prior authorization or adverse

1 determination, not later than one business day after receiving all
2 information needed to complete the review of the requested service.
3 The bill requires a utilization review entity to adhere to certain
4 practices with respect to authorization of emergency health care
5 services, establishes a presumption that these services are medically
6 necessary in some situations, and deems certain services to be
7 approved under certain circumstances.

8 The bill also prohibits a utilization review entity from:

- 9 • Requiring a health care provider offering services to a
10 covered person to participate in a step therapy protocol if the
11 provider deems that the step therapy protocol is not in the
12 covered person's best interests;
- 13 • Requiring that a health care provider first obtain a waiver,
14 exception, or other override when deeming a step therapy
15 protocol to not be in a covered person's best interests; or
- 16 • Sanctioning or otherwise penalizing a health care provider
17 for recommending or issuing a prescription, performing or
18 recommending a procedure, or performing a test that may
19 conflict with the step therapy protocol of the carrier.

20 The bill further provides that a utilization review entity shall not
21 revoke, limit, condition or restrict a prior authorization if care is
22 provided within 45 business days from the date the health care
23 provider received the prior authorization. A prior authorization shall
24 be valid for purposes of authorizing the health care provider to
25 provide care for a period of one year from the date the health care
26 provider receives the prior authorization.

27 The bill provides that no later than January 1, 2019, a carrier
28 shall accept and respond to a prior authorization request for
29 medication coverage, under the pharmacy benefit part of a health
30 benefits plan, made through a secure electronic transmission using
31 the NCPDP SCRIPT Standard ePA (electronic prior authorization)
32 transactions. Facsimile, propriety payer portals, and electronic
33 forms shall not be considered secure electronic transmission.

34 Any failure by a utilization review entity to comply with a
35 deadline or other requirement under the provisions of the bill shall
36 result in any health care services subject to review being
37 automatically deemed authorized.

38 Finally, the Commissioner of Banking and Insurance shall
39 promulgate rules and regulations, pursuant to the "Administrative
40 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), including
41 any penalties or enforcement provisions, that the commissioner
42 deems necessary to effectuate the purposes of the bill.