

ASSEMBLY, No. 2474

STATE OF NEW JERSEY 219th LEGISLATURE

INTRODUCED FEBRUARY 3, 2020

Sponsored by:

Assemblyman HERB CONAWAY, JR.

District 7 (Burlington)

Assemblywoman VALERIE VAINIERI HUTTLE

District 37 (Bergen)

SYNOPSIS

Deletes prior authorization requirements by certain insurers for accessing certain health care services.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 2/13/2020)

1 AN ACT concerning prior authorization requirements by certain
2 carriers for accessing certain health care services and amending
3 P.L.1997, c.192.

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

7
8 1. Section 6 of P.L.1997, c.192 (C.26:2S-6) is amended to read
9 as follows:

10 6. a. A carrier which offers a managed care plan or uses a
11 utilization management system in any of its health benefits plans
12 shall designate a licensed physician to serve as medical director.
13 The medical director, or his designee, shall be designated to serve
14 as the medical director for medical services provided to covered
15 persons in the State and shall be licensed to practice medicine in
16 New Jersey.

17 The medical director shall be responsible for treatment policies,
18 protocols, quality assurance activities and utilization management
19 decisions of the carrier. The treatment policies, protocols, quality
20 assurance program and utilization management decisions of the
21 carrier shall be based on generally accepted standards of health care
22 practice. The quality assurance and utilization management
23 programs shall be in accordance with standards adopted by
24 regulation of the department pursuant to this act.

25 b. The medical director shall ensure that:

26 (1) Any utilization management decision to deny, reduce or
27 terminate a health care benefit or to deny payment for a health care
28 service, because that service is not medically necessary, shall be
29 made by a physician. In the case of a health care service prescribed
30 or provided by a dentist, the decision shall be made by a dentist;

31 (2) A utilization management decision shall not retrospectively
32 deny coverage for health care services provided to a covered person
33 when prior approval has been obtained from the carrier for those
34 services, unless the approval was based upon fraudulent information
35 submitted by the covered person or the participating provider;

36 (3) In the case of a managed care plan, a procedure is
37 implemented whereby participating physicians and dentists have an
38 opportunity to review and comment on all medical and surgical and
39 dental protocols, respectively, of the carrier;

40 (4) The utilization management program is available on a 24-
41 hour basis to respond to authorization requests for emergency and
42 urgent services and is available, at a minimum, during normal
43 working hours for inquiries and authorization requests for
44 nonurgent health care services; **[and]**

45 (5) In the case of a managed care plan, a covered person is
46 permitted to: choose or change a primary care physician from

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.

1 among participating providers in the provider network, and, when
2 appropriate, choose a specialist from among participating network
3 providers following an authorized referral, if required by the carrier,
4 and subject to the ability of the specialist to accept new patients;
5 and
6 (6) No prior authorization is required by the carrier in order for
7 a covered person to access the following health care services:
8 physical and occupational therapy services; prescription drugs and
9 biologics; radiological examinations; durable medical equipment;
10 and surgical services that address a single organ or organ system.
11 (cf: P.L.1997, c.192, s.6)

12
13 2. This act shall take effect on the first day of the fourth month
14 next following the date of enactment and shall apply to all contracts
15 and policies issued or renewed on or after the effective date.

16
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18 STATEMENT

19
20 This bill amends the "Health Care Quality Act," P.L.1997, c.192
21 (C.26:2S-1 et seq.), to prohibit certain health insurance carriers
22 from requiring prior authorization for accessing certain health care
23 services.

24 The bill requires the medical director of a carrier which offers a
25 managed care plan or uses a utilization management system in any
26 of its health benefits plans to ensure that no prior authorization is
27 required by the carrier in order for a covered person to access the
28 following health care services: physical and occupational therapy
29 services; prescription drugs and biologics; radiological
30 examinations; durable medical equipment; and surgical services that
31 address a single organ or organ system.