ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 1255

STATE OF NEW JERSEY

DATED: DECEMBER 11, 2023

The Assembly Financial Institutions and Insurance Committee reports favorably an Assembly Committee Substitute for Assembly Bill No. 1255.

The bill repeals the "Health Claims Authorization, Processing and Payment Act" and replaces it with the "Ensuring Transparency in Prior Authorization Act." Prior authorization is the process by which a payer determines the medical necessity of an otherwise covered service prior to its rendering and subsequent level of reimbursement for claims submitted. A payer is the term used in the bill to capture health insurance companies and other types of health insurers and benefits plans who require utilization management to be performed to authorize the approval of a health care service. Among the types of health benefits plans considered a payer is the State Health Benefits Program and School Employees' Health Benefits Program.

Under the bill, a payer is required to provide, in a clear and conspicuous manner, information on an Internet website regarding its use of utilization management and the processing and payment of claims in detail, using easily understandable language, for review by health care providers, individuals covered by a health insurer or benefits plan, and the general public. The information is to be posted no later than 30 calendar days before any provisions take effect. Changes made to this information are to be clearly noted on the website. For health care services, excluding the provision of pharmaceutical products, a payer is to provide contracted in-network health care providers with written notice with any new or amended requirements or restriction no less than 90 days before the item is implemented and is restricted from implementing certain changes until the changes have been posted on its website and included in a notification to the in-network providers.

The bill provides several parameters within which the prior authorization process is to operate, including the following: (1) a payer is to respond to a hospital or health care provider request for prior authorization upon submission of all necessary information; (2) a carrier is to respond to prior authorization requests for medication coverage submitted using the NCPDP SCRIPT Standard for ePA transactions, under the pharmacy benefit part of a health benefits plan,

within 72 hours after obtaining all necessary information; (3) prior authorization for treatment of a long term care or chronic condition is to remain valid for 180 days; (4) denial or limitation of a prior authorization request is to be made by a physician who, among other requirements, is of the same specialty as the physician who typically manages the medical condition or disease; and (5) a prior authorization for a service which includes a defined number of discrete services in a set timeframe is to be valid for a period of one year.

If prior authorization granted by a previous payer for treatment of a covered person was based on information provided in good faith by a health care provider, a new payer is to honor the prior authorization for at least the initial 60 days of coverage under a new health plan. A denial of a prior authorization is to be communicated (1) no later than 12 days if the request is submitted in paper, or eight days if submitted electronically, following the time the request was made, for a covered person who will receive inpatient hospital services; (2) 24 hours for a covered person currently receiving inpatient hospital services; and (3) no later than 72 hours in the case of a request for prior authorization for a covered person who is to receive health care services in an outpatient or other setting. These same time frames are applicable if a payer requests additional information from a provider or hospital. If a payer fails to respond to an authorization request within these time frames, a claim for services provided that is submitted by a hospital or health care provider to the payer cannot be denied on the basis of a failure to secure prior authorization for the service.

The bill also establishes an appeals process, which requires, among other items, review of a denial of prior authorization by a physician 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, or be knowledgeable of, and have experience providing, the health care services under review. Moreover, the bill establishes the conditions in which a payer cannot deny a request for prior authorization.

With regards to medically necessary emergency and urgent care health care services, a payer is to allow the passage of a minimum of 24 hours before the payer is notified regarding a covered person's emergency admission or provision of emergency health care services. Coverage is to be approved by a payer for emergency health care services necessary to screen and stabilize a covered person.

The bill delineates penalties applicable to payers for noncompliance with certain provisions of the bill. The Department of Banking and Insurance is authorized as the enforcing agency of the bill's provisions.

The bill requires payers to make readily available statistics on prior authorization approvals and denials on the Internet website of the payer. Part of the statistics to be made available include the time between submission of prior authorization requests and

determinations; the average median time that elapsed between a request for clinical records by a payer to a health care provider and receipt of adequate records by the payer; and the number of appeals generated for cases denied in which there was inadequate or no prior clinical information.

Lastly, the bill makes technical updates to current law to reference the “Ensuring Transparency in Prior Authorization Act.”