ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, No. 1255

with committee amendments

STATE OF NEW JERSEY

DATED: DECEMBER 18, 2023

The Assembly Appropriations Committee reports favorably and with committee amendments the Assembly Committee Substitute for Assembly Bill No. 1255.

As amended, 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. 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.

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, including prescription drug formularies, 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 impacted in-network health care providers with written notice with any new or materially adverse 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 24 hours for urgent requests and 72 hours for non-urgent requests after obtaining all necessary information; (3) except where a shorter time frame is necessary to monitor patient safety or treatment effectiveness and with notice to the treating provider, prior authorization for treatment of a long term care or chronic condition or for when a service includes a defined number of discrete services in a set time frame is to remain valid for 180 days; and (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.

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 nine days if submitted electronically, following the time the request was made, for a covered person who will receive inpatient or outpatient hospital services; (2) 24 hours for a covered person currently receiving inpatient hospital services; and (3) no later than 72 hours for a claim involving urgent care, unless information received by a hospital or health care provider fails to provide sufficient information. 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 requirements of a physician who is to approve or make an adverse determination of a prior authorization request and of a physician who is to review an appeal of an adverse determination decision. Moreover, the bill establishes the conditions in which a payer cannot deny a request for prior authorization.

With regards to medically necessary emergency health care services, a payer is to approve coverage for screening and stabilizing a covered person without prior authorization. Admission on an in-patient basis may be subject to concurrent review.

Included are penalties applicable to payers for noncompliance with a deadline delineated in 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 available, in readily accessible format as determined by the department, 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.

The health benefits programs of the State Health Benefits Commission and the School Employees' Health Benefits Commission are to comply with specific provisions of the bill, provided that nothing in the bill is to limit the authority of, or process followed by, the third-party medical claims reviewer of the commissions or the requirements imposed on carriers with which the commissions' contract pursuant to current law.

Lastly, the bill makes technical updates to current law.

COMMITTEE AMENDMENTS:

The committee amended the bill to:

1) update certain definitions, including the removal of the State Health Benefits Program and School Employees Health Benefits Program from the definition of "carrier" and adding to "health benefits plan" Medicare Advantage and Medicare Supplement;

2) require prescription drug formularies to be publicly available on a payer's website;

3) clarify that information will be made available by payers to impacted contracted out-of-network providers through written notice of new or materially adverse amended requirement or restriction and will not be implemented until 90 days has passed since written notice was sent to the impacted providers;

4) account for when shorter time frames are necessary to monitor patient safety for long-term care or in the case of when a discrete service has a set time frame;

5) alter time frames for in-patient, out-patient, emergency health care services, and urgent care;

6) establish requirements for physicians who approve or adversely determine a prior authorization request and who hear appeals of adverse determinations;

7) assign penalties and other enforcement responsibilities for violations and non-compliance to the Department of Banking and Insurance;

8) require health benefits programs of the State Health Benefits Commission and School Employees' Health Benefits Commission to comply with certain provisions of the bill; and

9) make technical updates.

FISCAL IMPACT:

Fiscal information for this bill is currently unavailable.