SENATE COMMERCE COMMITTEE

STATEMENT TO

SENATE, No. 1794

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 9, 2022

The Senate Commerce Committee reports favorably and with committee amendments Senate Bill No. 1794.

As amended, the bill places certain requirements regarding the use of prior authorization of health benefits on carriers and utilization review entities acting on behalf of carriers. The bill defines "carrier" to include insurance companies, health, hospital, and medical service corporations, health maintenance organizations, and the State Health Benefits Program and School Employees' Health Benefits Program. The bill also adds a definition of "enrollee" and "medications for opioid use disorder" and adds mental health services and behavioral health services to the definition of "urgent health care service."

The bill requires a utilization review entity to make certain disclosures regarding its prior authorization requirements and restrictions, on its website and in writing, including certain statistics concerning approvals and denials, as set forth in the bill. This includes data on whether prior authorization determinations were appealed, approved or denied on appeal, and the time between submission of prior authorization requests and the determination.

The bill also requires that a utilization review entity ensure that a physician make any adverse determination and specifies the qualifications the physician is to meet to make the determination. Additionally, questions over the medical necessity of a health care service are to be conveyed from the utilization review entity to the physician of the enrollee who is to receive the health care service and that physician is granted the opportunity to discuss the service with the physician who will determine its authorization for the review entity. The utilization review entity is to also ensure that a physician who is to review an appeal of an adverse determination meets certain requirements delineated in the bill.

The bill provides that if a utilization review entity requires prior authorization of a covered service, the utilization review entity shall make a prior authorization or adverse determination and notify the subscriber (also commonly known as a "policyholder") and the subscriber's health care provider of the prior authorization or adverse determination within one calendar day of obtaining all

necessary information to make the prior authorization or adverse determination. Necessary information is considered received if it is transmitted to the utilization review entity after being sent by electronic portal, e-mail, facsimile, telephone or other means of communication.

The bill provides that a utilization review entity is to render a prior authorization or adverse determination concerning an urgent health care service, and notify the subscriber and the subscriber's health care provider of that prior authorization or adverse determination, not later than 24 hours after receiving all information needed to complete the review of the requested service. The bill further adds that medications for opioid use disorder do not require prior authorization.

The bill requires a utilization review entity to adhere to certain practices with respect to authorization of emergency health care services, establishes a presumption that these services are medically necessary in some situations, and deems certain services to be approved under certain circumstances.

The bill also prohibits a utilization review entity from:

(1) Requiring a health care provider offering services to a covered person to participate in a step therapy protocol if the provider deems that the step therapy protocol is not in the covered person's best interests;

(2) Requiring that a health care provider first obtain a waiver, exception, or other override when deeming a step therapy protocol to not be in a covered person's best interests; or

(3) Sanctioning or otherwise penalizing a health care provider for recommending or issuing a prescription, performing or recommending a procedure, or performing a test that may conflict with the step therapy protocol of the carrier.

Additionally, the bill establishes requirements regarding the prior authorization of certain medications.

The bill further provides that a utilization review entity is not to revoke, limit, condition, or restrict a prior authorization if care is provided within 45 business days from the date the health care provider received the prior authorization. A prior authorization is to be valid for purposes of authorizing the health care provider to provide care for a period of one year from the date the health care provider receives the prior authorization. The bill also includes a provision authorizing a utilization review entity to honor a previous prior authorization for the initial 60 days of coverage under a new health plan of an enrollee, grant the entity the right to review the prior authorization during the initial 60 days, and prohibit any change in coverage or approval criteria for prior authorization from impacting an enrollee's access to the service authorized previously if the service was authorized before the effective date of the change for the remainder of the enrollee's plan year.

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

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

COMMITTEE AMENDMENTS

The committee amended the bill to:

(1) add the State Health Benefits Program and School Employees' Health Benefits Program to the definition of "carrier;"

(2) add definitions for "clinical laboratory," "enrollee," and "medications for opioid use disorder;"

(3) update the version of the NCPDP SCRIPT Standard to be used for prior authorization for medication coverage and remove the reference to the date in the provision that a carrier accept and reply to prior authorization requests on medication coverage through the NCPDP SCRIPT Standard;

(4) stipulate that the definition of "urgent health care service" includes mental health services and behavioral health services;

(5) require a utilization review entity to collect data on whether prior authorization determinations were appealed, approved or denied on appeal, and the time between submission of prior authorization requests and the determination;

(6) stipulate that a physician is to make adverse determinations and add criteria a physician is to meet to qualify for making adverse determinations;

(7) incorporate language requiring a utilization review entity to notify the physician of the enrollee if the entity is questioning the medical necessity of a health care service and requiring the physician of the enrollee to discuss medical necessity of a health care service with the physician who will determine the authorization of the health care service;

(8) establish criteria of the review of an adverse determination on appeal and of the physician who is to review an adverse determination on appeal;

(9) adjust the time a utilization review entity takes to determine if a covered service requiring prior authorization is approved or denied from two business days to one calendar day of receipt of all necessary information and clarify that necessary information is considered transmitted to the review entity if sent electronically, by facsimile, phone, or other means of communication;

(10) require a utilization review entity to render a decision on prior authorization for an urgent health care service and notify the

subscriber and the subscriber's health care provider of that decision within 24 hours of receiving all information needed to complete the review;

(11) add medication for opioid use disorder to the items that do not need prior authorization by a utilization review entity;

(12) specify that prior authorization granted for a health care service for the treatment of a chronic or long-term care condition is to remain valid for the length of the treatment and the review entity may not require the enrollee to obtain prior authorization again for the rendering of the health care service;

(13) create parameters within which to use a step therapy protocol;

(14) prohibit prior authorization of certain medications and of testing performed by clinical laboratories; and

(15) add language authorizing a utilization review entity to honor a previous prior authorization for the initial 60 days of coverage under a new health plan of an enrollee, grant the entity the right to review the prior authorization during the initial 60 days, and prohibit any change in coverage or approval criteria for prior authorization from impacting an enrollee's access to the service authorized previously if the service was authorized before the effective date of the change for the remainder of the enrollee's plan year.