New Jersey

New Jersey - AB 2010

Sponsor:

Actions: 01/11/2022 Introduced; referred to the Assembly Health Committee

Summary:

Bill Links 1/11/2022 Version

New Jersey - AB 2544

Sponsor: Assemblymember Carol Murphy (D)

Actions: 02/14/2022 Introduced; Referred to Assembly Financial Institutions and Insurance Committee

Summary: Summary of 2/14/2022 Version

This measure creates a new state code concerning health benefits coverage for buprenorphine and buprenorphine/naloxone.

This measure applies to health, hospital and medical service corporations, commercial individual and group health insurers; health maintenance organizations, health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs, the State Health Benefits Program, and the School Employees' Health Benefits Program.

This measure requires health insurers to provide health benefits coverage for any expenses incurred by a covered person for the prescription and purchase of buprenorphine or buprenorphine/naloxone for the treatment of pain. Coverage is not subject to step therapy or fail-first protocols.

This measure will take effect on the 90th day following enactment.

Bill Links

New Jersey - AB 417

Sponsor: Assemblymember Ralph Caputo (D)

Actions: 01/11/2022 Introduced; Referred to Assembly Health Committee

Summary: Summary for 2/2/2022 Version

This measure requires emergency medical service providers to apply for certificates of need before the construction or expansion of their facilities; provides additional application requirements.

This measure states that construction or expansion of any health care facility is prohibited without application and receipt of a certificate of need. Certificates of need are required to lawfully operate as an emergency medical services provider. Certificates issued to these providers are valid for three calendar years before they need to reapply for another certificate of need. In addition to other application requirements, emergency service providers must provide a list of services and the cost of each of those services as well as a plan to provide patients an itemized receipt listing the cost of each service.

“Emergency medical services provider” means any association, organization, company, department, agency, service, program, unit, or other entity that provides pre-hospital emergency medical care to patients in this State, including, but not limited to, a basic life support ambulance service, a mobile intensive care unit, an air medical service, or a non-volunteer first aid, rescue, and ambulance squad.

This measure takes effect immediately.

Bill Links 2/2/2022 Version

New Jersey - SB 308

Sponsor: Senator Joseph Vitale (D)

Actions: 01/11/2022 Introduced; Referred to Senate Commerce Committee

Summary: Summary of 1/11/2022 Version

The measure establishes guidelines for health insurance carriers regarding step therapy protocols.

The measure applies to health insurance carriers, utilization review organizations, and all health insurance policies and contracts delivered, issued, executed, or renewed on or after January 1, 2021.

The measure mandates clinical review criteria utilized to establish a step therapy protocol must be based on guidelines that recommend that the prescription drugs be taken in the specific sequence required by the step therapy protocol, developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups, based on high-quality studies, research, and medical practice, created by an explicit and transparent process, and continually updated through a review of new evidence, research, and newly developed treatments.

The measure mandates the health insurance carrier, upon written request, to provide specific written clinical review criteria relating to a particular condition or disease, including clinical review criteria relating to a step therapy protocol exception determination. The carrier must also make available the clinical review criteria and other clinical information on its internet website and to a health care professional on behalf of an insured person upon written request.

The measure mandates when the coverage of a prescription drug is restricted for use by a carrier or a utilization review organization, the carrier or organization must provide the covered person and prescribing practitioner a clear, readily accessible, and convenient process to request a step therapy exception. The carrier or organization may utilize its existing medical exemptions process to meet the requirement. The carrier or organization must disclose all rules and criteria related to the protocol upon request to all prescribing practitioners.

The measure states a step therapy exemption may be granted if the required prescription drug is contraindicated or is likely to cause an adverse reaction or physical or mental harm to the patient, the required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen, the patient has tried the required prescription drug or another prescription drug in the same pharmacologic class or with the same mechanism of action and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event, the required prescription drug is not in the best interest of the patient, based on medical necessity, or the patient is stable on a prescription drug selected by their health care provider for the medical condition under consideration.

The measure mandates when a step therapy exemption is granted for the carrier or organization to authorize coverage for the prescription drug prescribed by the patient's treating health care provider. The measure clarifies any step therapy exemption may be eligible for an appeal by a covered person. The carrier or organization must grant or deny a step therapy exception appeal or request within 72 hours. In cases where exigent circumstances exist, the carrier or utilization review organization shall respond within 24 hours of receipt.

The measure mandates the carrier or organization to annually report to the commissioner, the number of step therapy exception requests received, by reason for the exception, the type of health care providers or the medical specialties of the health care providers submitting step therapy exception requests, the number of step therapy exception requests that were denied, by reason for the exception, and the reasons for the denials, the number of step therapy exception requests that were approved, by reason for the exception, the number of step therapy exception requests that were initially denied and then appealed, by reason for the exception, the number of step therapy exception that was initially denied and then subsequently reversed by internal appeals or external reviews, by reason for the exception, and the medical conditions for which patients are granted exceptions due to the likelihood that switching from the prescription drug will likely cause an adverse reaction by or physical or mental harm to the insured.

The measure mandates the commissioner to adopt applicable rules and regulations to carry out the measure.

The measure will take effect on the 60th day after enactment.

Bill Links 1/11/2022 Version