

17:48-6nn

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2017 **CHAPTER:** 28

NJSA: 17:48-6nn (Requires health insurance coverage for treatment of substance use disorders; places certain restrictions on the prescription of opioid and certain other drugs; concerns continuing education related thereto)

BILL NO: S3 (Substituted for A3)

SPONSOR(S) Vitale and others

DATE INTRODUCED: 1-30-2017

COMMITTEE: **ASSEMBLY:** ---

SENATE: Health, Human Services and Senior Citizens

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** 2-15-2017

SENATE: 2-6-2017

DATE OF APPROVAL: 2-15-2017

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (First Reprint enacted) Yes

S3

SPONSOR'S STATEMENT: (Begins on page 40 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY:** No

SENATE: Yes

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, *may possibly* be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: Yes

A3

SPONSOR'S STATEMENT: (Begins on page 40 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY:** Yes

SENATE: No

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, *may possibly* be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: Yes

(continued)

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

To check for circulating copies, contact New Jersey State Government Publications at the State Library (609) 278-2640 ext.103 or <mailto:refdesk@njstatelib.org>

REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: Yes

"The Latest: Christie signs anti-opioid addiction bill," Associated Press State Wire: New Jersey, February 15, 2017
"Gov. Christie quickly signs anti-opioid legislation," Associated Press State Wire: New Jersey, February 15, 2017
"New Jersey to Limit Amount of Opioid Pills in Prescriptions," The Wall Street Journal, February 15, 2017
"Gov. Christie quickly signs anti-opioid legislation," New Jersey Herald, February 15, 2017
"Christie Signs Bill Addressing Opioid Epidemic," NJTV, February 15, 2017
"N.J. limits opioid prescriptions, requires insurers to cover drug treatment," The Philadelphia Inquirer, February 15, 2017
"Christie Signs Law to Combat Opioid Addiction," WBGO.org, February 15, 2017
"Christie signs new painkiller prescription limit into law," New Jersey 101.5, February 15, 2017
"Christie signs opioid bill," Courier-Post, February 15, 2017
"Christie signs opioid legislation into law," Burlington County Times, February 16, 2017
"Christie signs bill to limit painkiller Rx's," The Jersey Journal, February 16, 2017
"Christie signs drug legislation – insurance mandate has significant flaws, say critics," The Record, February 16, 2017
"Statehouse Christie signs bill limiting prescriptions," South Jersey Times, February 16, 2017
"Five-day limit on opioids is now law," The Star-Ledger, February 16, 2017
"Statehouse bill limiting painkiller prescriptions now law in N.J.," The Times, February 16, 2017
"Insurance reform and addiction: 5 things to know," app.com, February 16, 2017
"Christie signs drug rehab, opioid supply bill," New Jersey Herald, February 16, 2017
"Governor Gets His Addiction Law Just 5 Weeks After Outlined in State of State," NJ Spotlight, February 16, 2017
New Law Aims to Stem Opioid Addiction Crisis," NJTV, February 16, 2017

RWH/JA

§1 - C.17:48-6nn
§2 - C.17:48A-7kk
§3 - C.17:48E-35.38
§4 - C.17B:26-2.1hh
§5 - C.17B:27-46.1nn
§6 - C.17B:27A-7.21
§7 - C.17B:27A-19.25
§8 - C26:2J-4.39
§9 - C.52:14-17.29u
§10 - C.52:14-17.46.6f
§§11&13 -
C.24:21-15.2 &
24:21-15.3
§18 - C.45:6-10.2a
§19 - C.45:9-7.8
§20 - C.45:9-27.25a
§21 - C.45:11-26.3
§22 - C.45:14-54.1
§23 - T&E
§24 - Repealer
§25 - Note

P.L.2017, CHAPTER 28, *approved February 15, 2017*
Senate, No. 3 (*First Reprint*)

1 AN ACT concerning substance use disorders and revising and
2 supplementing various parts of the statutory law.

3

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

6

7 1. (New section) a. A hospital service corporation contract
8 that provides hospital or medical expense benefits and is delivered,
9 issued, executed or renewed in this State, or approved for issuance
10 or renewal in this State by the Commissioner of Banking and
11 Insurance, on or after the effective date of this act, shall provide
12 unlimited benefits for inpatient and outpatient treatment of
13 substance use disorder at in-network facilities. The services for the
14 treatment of substance use disorder shall be prescribed by a licensed
15 physician, licensed psychologist, or licensed psychiatrist and
16 provided by licensed health care professionals or licensed or
17 certified substance use disorder providers in licensed or otherwise
18 State-approved facilities, as required by the laws of the state in
19 which the services are rendered.

20 b. The benefits for the first 180 days per plan year of inpatient
21 and outpatient treatment of substance use disorder shall be provided

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.

Matter enclosed in superscript numerals has been adopted as follows:

¹Senate SHH committee amendments adopted January 30, 2017.

1 when determined medically necessary by the covered person's
2 physician, psychologist or psychiatrist without the imposition of
3 any prior authorization or other prospective utilization management
4 requirements. ¹The facility shall notify the hospital service
5 corporation of both the admission and the initial treatment plan
6 within 48 hours of the admission or initiation of treatment.¹ If there
7 is no in-network facility immediately available for a covered
8 person, a hospital service corporation shall provide necessary
9 exceptions to its network to ensure admission in a treatment facility
10 within 24 hours.

11 c. Providers of treatment for substance use disorder to persons
12 covered under a covered contract shall not require pre-payment of
13 medical expenses during this 180 days in excess of applicable co-
14 payment, deductible, or co-insurance under the contract.

15 d. The benefits for outpatient visits shall not be subject to
16 concurrent or retrospective review of medical necessity or any other
17 utilization management review.

18 e. (1) The benefits for the first 28 days of an inpatient stay
19 during each plan year shall be provided without any retrospective
20 review or concurrent review of medical necessity and medical
21 necessity shall be as determined by the covered person's physician.

22 (2) The benefits for days 29 and thereafter of inpatient care shall
23 be subject to concurrent review as defined in this section. A request
24 for approval of inpatient care beyond the first 28 days shall be
25 submitted for concurrent review before the expiration of the initial
26 28 day period. A request for approval of inpatient care beyond any
27 period that is approved under concurrent review shall be submitted
28 within the period that was previously approved. No hospital service
29 corporation shall initiate concurrent review more frequently than
30 ¹~~three-week~~ two-week¹ intervals. If a hospital service
31 corporation determines that continued inpatient care in a facility is
32 no longer medically necessary, the hospital service corporation
33 shall within 24 hours provide written notice to the covered person
34 and the covered person's physician of its decision and the right to
35 file an expedited internal appeal of the determination pursuant to an
36 expedited process pursuant to sections 11 through 13 of P.L.1997,
37 c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as
38 applicable. The hospital service corporation shall review and make
39 a determination with respect to the internal appeal within 24 hours
40 and communicate such determination to the covered person and the
41 covered person's physician. If the determination is to uphold the
42 denial, the covered person and the covered person's physician have
43 the right to file an expedited external appeal with the Independent
44 Health Care Appeals Program in the Department of Banking and
45 Insurance pursuant to sections 11 through 13 of P.L.1997, c.192
46 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as
47 applicable. An independent utilization review organization shall
48 make a determination within 24 hours. If the hospital service

1 corporation's determination is upheld and it is determined
2 continued inpatient care is not medically necessary, the hospital
3 service corporation shall remain responsible to provide benefits for
4 the inpatient care through the day following the date the
5 determination is made and the covered person shall only be
6 responsible for any applicable co-payment, deductible and co-
7 insurance for the stay through that date as applicable under the
8 contract. The covered person shall not be discharged or released
9 from the inpatient facility until all internal appeals and independent
10 utilization review organization appeals are exhausted. For any costs
11 incurred after the day following the date of determination until the
12 day of discharge, the covered person shall only be responsible for
13 any applicable cost-sharing, and any additional charges shall be
14 paid by the facility or provider.

15 f. (1) The benefits for the first 28 days of intensive outpatient
16 or partial hospitalization services shall be provided without any
17 retrospective review of medical necessity and medical necessity
18 shall be as determined by the covered person's physician.

19 (2) The benefits for days 29 and thereafter of intensive
20 outpatient or partial hospitalization services shall be subject to a
21 retrospective review of the medical necessity of the services.

22 g. Benefits for inpatient and outpatient treatment of substance
23 use disorder after the first 180 days per plan year shall be subject to
24 the medical necessity determination of the hospital service
25 corporation and may be subject to prior authorization or,
26 retrospective review and other utilization management
27 requirements.

28 h. Medical necessity review shall utilize an evidence-based and
29 peer reviewed clinical review tool to be designated through
30 rulemaking by the Commissioner of Human Services in
31 consultation with the Department of Health.

32 i. The benefits for outpatient prescription drugs to treat
33 substance use disorder shall be provided when determined
34 medically necessary by the covered person's physician,
35 psychologist or psychiatrist without the imposition of any prior
36 authorization or other prospective utilization management
37 requirements.

38 j. The first 180 days per plan year of benefits shall be
39 computed based on inpatient days. One or more unused inpatient
40 days may be exchanged for two outpatient visits. All extended
41 outpatient services such as partial hospitalization and intensive
42 outpatient, shall be deemed inpatient days for the purpose of the
43 visit to day exchange provided in this subsection.

44 k. Except as stated above, the benefits and cost-sharing shall be
45 provided to the same extent as for any other medical condition
46 covered under the contract.

47 l. The benefits required by this section are to be provided to all
48 covered persons with a diagnosis of substance use disorder. The

1 presence of additional related or unrelated diagnoses shall not be a
2 basis to reduce or deny the benefits required by this section.

3 m. The provisions of this section shall apply to all hospital
4 service corporation contracts in which the hospital service
5 corporation has reserved the right to change the premium.

6 n. The Attorney General's Office shall be responsible for
7 overseeing any violations of law that may result from P.L. ,
8 c. (C.) (pending before the Legislature as this bill), including
9 fraud, abuse, waste, and mistreatment of covered persons. The
10 Attorney General's Office is authorized to adopt, pursuant to the
11 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
12 seq.), rules and regulations to implement any of the provisions of
13 P.L. , c. (C.) (pending before the Legislature as this bill).

14 o. The provisions of this section shall not apply to a hospital
15 service corporation contract which, pursuant to a contract between
16 the hospital service corporation and the Department of Human
17 Services, provides benefits to persons who are eligible for medical
18 assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family
19 Health Care Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.), or
20 any other program administered by the Division of Medical
21 Assistance and Health Services in the Department of Human
22 Services.

23 p. As used in this section:

24 "Concurrent review" means inpatient care is reviewed as it is
25 provided. Medically qualified reviewers monitor appropriateness of
26 the care, the setting, and patient progress, and as appropriate, the
27 discharge plans.

28 "Substance use disorder" is as defined by the American
29 Psychiatric Association in the Diagnostic and Statistical Manual of
30 Mental Disorders, Fifth Edition and any subsequent editions and
31 shall include substance use withdrawal.

32

33 2. (New section) a. A medical service corporation contract
34 that provides hospital or medical expense benefits and is delivered,
35 issued, executed or renewed in this State, or approved for issuance
36 or renewal in this State by the Commissioner of Banking and
37 Insurance, on or after the effective date of this act, shall provide
38 unlimited benefits for inpatient and outpatient treatment of
39 substance use disorder at in-network facilities. The services for the
40 treatment of substance use disorder shall be prescribed by a licensed
41 physician, licensed psychologist, or licensed psychiatrist and
42 provided by licensed health care professionals or licensed or
43 certified substance use disorder providers in licensed or otherwise
44 State-approved facilities, as required by the laws of the state in
45 which the services are rendered.

46 b. The benefits for the first 180 days per plan year of inpatient
47 and outpatient treatment of substance use disorder shall be provided
48 when determined medically necessary by the covered person's

1 physician, psychologist or psychiatrist without the imposition of
2 any prior authorization or other prospective utilization management
3 requirements. ¹The facility shall notify the medical service
4 corporation of both the admission and the initial treatment plan
5 within 48 hours of the admission or initiation of treatment.¹ If there
6 is no in-network facility immediately available for a covered
7 person, a medical service corporation shall provide necessary
8 exceptions to its network to ensure admission in a treatment facility
9 within 24 hours.

10 c. Providers of treatment for substance use disorder to persons
11 covered under a covered contract shall not require pre-payment of
12 medical expenses during this 180 days in excess of applicable co-
13 payment, deductible, or co-insurance under the contract.

14 d. The benefits for outpatient visits shall not be subject to
15 concurrent or retrospective review of medical necessity or any other
16 utilization management review.

17 e. (1) The benefits for the first 28 days of an inpatient stay
18 during each plan year shall be provided without any retrospective
19 review or concurrent review of medical necessity and medical
20 necessity shall be as determined by the covered person's physician.

21 (2) The benefits for days 29 and thereafter of inpatient care shall
22 be subject to concurrent review as defined in this section. A request
23 for approval of inpatient care beyond the first 28 days shall be
24 submitted for concurrent review before the expiration of the initial
25 28 day period. A request for approval of inpatient care beyond any
26 period that is approved under concurrent review shall be submitted
27 within the period that was previously approved. No medical service
28 corporation shall initiate concurrent review more frequently than
29 **['three-week']** two-week¹ intervals. If a medical service
30 corporation determines that continued inpatient **['confinement']**
31 care¹ in a facility is no longer medically necessary, the medical
32 service corporation shall within 24 hours provide written notice to
33 the covered person and the covered person's physician of its
34 decision and the right to file an expedited internal appeal of the
35 determination pursuant to an expedited process pursuant to sections
36 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13)
37 and N.J.A.C.11:24A-3.5, as applicable. The medical service
38 corporation shall review and make a determination with respect to
39 the internal appeal within 24 hours and communicate such
40 determination to the covered person and the covered person's
41 physician. If the determination is to uphold the denial, the covered
42 person and the covered person's physician have the right to file an
43 expedited external appeal with the Independent Health Care
44 Appeals Program in the Department of Banking and Insurance
45 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
46 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
47 independent utilization review organization shall make a

1 determination within 24 hours. If the medical service corporation's
2 determination is upheld and it is determined continued inpatient
3 care is not medically necessary, the medical service corporation
4 shall remain responsible to provide benefits for the inpatient care
5 through the day following the date the determination is made and
6 the covered person shall only be responsible for any applicable co-
7 payment, deductible and co-insurance for the stay through that date
8 as applicable under the contract. The covered person shall not be
9 discharged or released from the inpatient facility until all internal
10 appeals and independent utilization review organization appeals are
11 exhausted. For any costs incurred after the day following the date of
12 determination until the day of discharge, the covered person shall
13 only be responsible for any applicable cost-sharing, and any
14 additional charges shall be paid by the facility or provider.

15 f. (1) The benefits for the first 28 days of intensive outpatient
16 or partial hospitalization services shall be provided without any
17 retrospective review of medical necessity and medical necessity
18 shall be as determined by the covered person's physician.

19 (2) The benefits for days 29 and thereafter of intensive
20 outpatient or partial hospitalization services shall be subject to a
21 retrospective review of the medical necessity of the services.

22 g. Benefits for inpatient and outpatient treatment of substance
23 use disorder after the first 180 days per plan year shall be subject to
24 the medical necessity determination of the medical service
25 corporation and may be subject to prior authorization or,
26 retrospective review and other utilization management
27 requirements.

28 h. Medical necessity review shall utilize an evidence-based and
29 peer reviewed clinical review tool to be designated through
30 rulemaking by the Commissioner of Human Services in
31 consultation with the Department of Health.

32 i. The benefits for medication-assisted treatments for
33 substance use disorder shall be provided when determined
34 medically necessary by the covered person's physician,
35 psychologist or psychiatrist without the imposition of any prior
36 authorization or other prospective utilization management
37 requirements.

38 j. The first 180 days per plan year of benefits shall be
39 computed based on inpatient days. One or more unused inpatient
40 days may be exchanged for two outpatient visits. All extended
41 outpatient services such as partial hospitalization and intensive
42 outpatient, shall be deemed inpatient days for the purpose of the
43 visit to day exchange provided in this subsection.

44 k. Except as stated above, the benefits and cost-sharing shall be
45 provided to the same extent as for any other medical condition
46 covered under the contract.

47 l. The benefits required by this section are to be provided to all
48 covered persons with a diagnosis of substance use disorder. The

1 presence of additional related or unrelated diagnoses shall not be a
2 basis to reduce or deny the benefits required by this section.

3 m. The provisions of this section shall apply to all medical
4 service corporation contracts in which the medical service
5 corporation has reserved the right to change the premium.

6 n. The Attorney General's office shall be responsible for
7 overseeing any violations of law that may result from P.L. ,
8 c. (C.) (pending before the Legislature as this bill), including
9 fraud, abuse, waste, and mistreatment of covered persons. The
10 Attorney General's office is authorized to adopt, pursuant to the
11 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
12 eq.), rules and regulations to implement any of the provisions of
13 P.L. , c. (C.) (pending before the Legislature as this bill).

14 o. The provisions of this section shall not apply to a medical
15 service corporation contract which, pursuant to a contract between
16 the medical service corporation and the Department of Human
17 Services, provides benefits to persons who are eligible for medical
18 assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family
19 Health Care Coverage Act," P.L.2005, c.156 (C.30:2J-8 et seq.), or
20 any other program administered by the Division of Medical
21 Assistance and Health Services in the Department of Human
22 Services.

23 p. As used in this section:

24 "Concurrent review" means inpatient care is reviewed as it is
25 provided. Medically qualified reviewers monitor appropriateness of
26 the care, the setting, and patient progress, and as appropriate, the
27 discharge plans.

28 "Substance use disorder" is as defined by the American
29 Psychiatric Association in the Diagnostic and Statistical Manual of
30 Mental Disorders, Fifth Edition and any subsequent editions and
31 shall include substance use withdrawal.

32

33 3. (New section) a. A health service corporation contract that
34 provides hospital or medical expense benefits and is delivered,
35 issued, executed or renewed in this State, or approved for issuance
36 or renewal in this State by the Commissioner of Banking and
37 Insurance, on or after the effective date of this act shall provide
38 unlimited benefits for inpatient and outpatient treatment of
39 substance use disorder at in-network facilities. The services for the
40 treatment of substance use disorder shall be prescribed by a licensed
41 physician, licensed psychologist, or licensed psychiatrist and
42 provided by licensed health care professionals or licensed or
43 certified substance use disorder providers in licensed or otherwise
44 State-approved facilities, as required by the laws of the state in
45 which the services are rendered.

46 b. The benefits for the first 180 days per plan year of inpatient
47 and outpatient treatment of substance use disorder shall be provided
48 when determined medically necessary by the covered person's

1 physician, psychologist or psychiatrist without the imposition of
2 any prior authorization or other prospective utilization management
3 requirements. ¹The facility shall notify the health service
4 corporation of both the admission and the initial treatment plan
5 within 48 hours of the admission or initiation of treatment.¹ If there
6 is no in-network facility immediately available for a covered
7 person, a health service corporation shall provide necessary
8 exceptions to its network to ensure admission in a treatment facility
9 within 24 hours.

10 c. Providers of treatment for substance use disorder to persons
11 covered under a covered contract shall not require pre-payment of
12 medical expenses during this 180 days in excess of applicable co-
13 payment, deductible, or co-insurance under the contract.

14 d. The benefits for outpatient visits shall not be subject to
15 concurrent or retrospective review of medical necessity or any other
16 utilization management review.

17 e. (1) The benefits for the first 28 days of an inpatient stay
18 during each plan year shall be provided without any retrospective
19 review or concurrent review of medical necessity and medical
20 necessity shall be as determined by the covered person's physician.

21 (2) The benefits for days 29 and thereafter of inpatient care shall
22 be subject to concurrent review as defined in this section. A request
23 for approval of inpatient care beyond the first 28 days shall be
24 submitted for concurrent review before the expiration of the initial
25 28 day period. A request for approval of inpatient care beyond any
26 period that is approved under concurrent review shall be submitted
27 within the period that was previously approved. No health service
28 corporation shall initiate concurrent review more frequently than
29 ¹~~three-week~~ two-week¹ intervals. If a health service corporation
30 determines that continued inpatient care in a facility is no longer
31 medically necessary, the health service corporation shall within 24
32 hours provide written notice to the covered person and the covered
33 person's physician of its decision and the right to file an expedited
34 internal appeal of the determination pursuant to an expedited
35 process pursuant to sections 11 through 13 of P.L.1997, c.192
36 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as
37 applicable. The health service corporation shall review and make a
38 determination with respect to the internal appeal within 24 hours
39 and communicate such determination to the covered person and the
40 covered person's physician. If the determination is to uphold the
41 denial, the covered person and the covered person's physician have
42 the right to file an expedited external appeal with the Independent
43 Health Care Appeals Program in the Department of Banking and
44 Insurance pursuant to sections 11 through 13 of P.L.1997, c.192
45 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as
46 applicable. An independent utilization review organization shall
47 make a determination within 24 hours. If the health service
48 corporation's determination is upheld and it is determined

1 continued inpatient care is not medically necessary, the health
2 service corporation shall remain responsible to provide benefits for
3 the inpatient care through the day following the date the
4 determination is made and the covered person shall only be
5 responsible for any applicable co-payment, deductible and co-
6 insurance for the stay through that date as applicable under the
7 policy. The covered person shall not be discharged or released
8 from the inpatient facility until all internal appeals and independent
9 utilization review organization appeals are exhausted. For any costs
10 incurred after the day following the date of determination until the
11 day of discharge, the covered person shall only be responsible for
12 any applicable cost-sharing, and any additional charges shall be
13 paid by the facility or provider.

14 f. (1) The benefits for the first 28 days of intensive outpatient
15 or partial hospitalization services shall be provided without any
16 retrospective review of medical necessity and medical necessity
17 shall be as determined by the covered person's physician.

18 (2) The benefits for days 29 and thereafter of intensive
19 outpatient or partial hospitalization services shall be subject to a
20 retrospective review of the medical necessity of the services.

21 g. Benefits for inpatient and outpatient treatment of substance
22 use disorder after the first 180 days per plan year shall be subject to
23 the medical necessity determination of the health service
24 corporation and may be subject to prior authorization or,
25 retrospective review and other utilization management
26 requirements.

27 h. Medical necessity review shall utilize an evidence-based and
28 peer reviewed clinical review tool to be designated through
29 rulemaking by the Commissioner of Human Services in
30 consultation with the Department of Health.

31 i. The benefits for outpatient prescription drugs to treat
32 substance use disorder shall be provided when determined
33 medically necessary by the covered person's physician,
34 psychologist or psychiatrist without the imposition of any prior
35 authorization or other prospective utilization management
36 requirements.

37 j. The first 180 days per plan year of benefits shall be
38 computed based on inpatient days. One or more unused inpatient
39 days may be exchanged for two outpatient visits. All extended
40 outpatient services such as partial hospitalization and intensive
41 outpatient, shall be deemed inpatient days for the purpose of the
42 visit to day exchange provided in this subsection.

43 k. Except as stated above, the benefits and cost-sharing shall be
44 provided to the same extent as for any other medical condition
45 covered under the contract.

46 l. The benefits required by this section are to be provided to all
47 covered persons with a diagnosis of substance use disorder. The

1 presence of additional related or unrelated diagnoses shall not be a
2 basis to reduce or deny the benefits required by this section.

3 m. The provisions of this section shall apply to all health
4 service corporation contracts in which the health service
5 corporation has reserved the right to change the premium.

6 n. The Attorney General's Office shall be responsible for
7 overseeing any violations of law that may result from P.L. ,
8 c. (C.) (pending before the Legislature as this bill), including
9 fraud, abuse, waste, and mistreatment of covered persons. The
10 Attorney General's office is authorized to adopt, pursuant to the
11 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
12 seq.), rules and regulations to implement any of the provisions of
13 P.L. , c. (C.) (pending before the Legislature as this bill).

14 o. The provisions of this section shall not apply to a health
15 service corporation contract which, pursuant to a contract between
16 the health service corporation and the Department of Human
17 Services, provides benefits to persons who are eligible for medical
18 assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family
19 Health Care Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.) or
20 any other program administered by the Division of Medical
21 Assistance and Health Services in the Department of Human
22 Services.

23 p. As used in this section:

24 "Concurrent review" means inpatient care is reviewed as it is
25 provided. Medically qualified reviewers monitor appropriateness of
26 the care, the setting, and patient progress, and as appropriate, the
27 discharge plans.

28 "Substance use disorder" is as defined by the American
29 Psychiatric Association in the Diagnostic and Statistical Manual of
30 Mental Disorders, Fifth Edition and any subsequent editions and
31 shall include substance use withdrawal.

32

33 4. (New section) a. An individual health insurance policy that
34 provides hospital or medical expense benefits and is delivered,
35 issued, executed or renewed in this State, or approved for issuance
36 or renewal in this State by the Commissioner of Banking and
37 Insurance, on or after the effective date of this act, shall provide
38 unlimited benefits for inpatient and outpatient treatment of
39 substance use disorder at in-network facilities. The services for the
40 treatment of substance use disorder shall be prescribed by a licensed
41 physician, licensed psychologist, or licensed psychiatrist and
42 provided by licensed health care professionals or licensed or
43 certified substance use disorder providers in licensed or otherwise
44 State-approved facilities, as required by the laws of the state in
45 which the services are rendered.

46 b. The benefits for the first 180 days per plan year of inpatient
47 and outpatient treatment of substance use disorder shall be provided
48 when determined medically necessary by the covered person's

1 physician, psychologist or psychiatrist without the imposition of
2 any prior authorization or other prospective utilization management
3 requirements. ¹The facility shall notify the insurer of both the
4 admission and the initial treatment plan within 48 hours of the
5 admission or initiation of treatment.¹ If there is no in-network
6 facility immediately available for a covered person, an insurer shall
7 provide necessary exceptions to their network to ensure admission
8 in a treatment facility within 24 hours.

9 c. Providers of treatment for substance use disorder to persons
10 covered under a covered policy shall not require pre-payment of
11 medical expenses during this 180 days in excess of applicable co-
12 payment, deductible, or co-insurance under the policy.

13 d. The benefits for outpatient visits shall not be subject to
14 concurrent or retrospective review of medical necessity or any other
15 utilization management review.

16 e. (1) The benefits for the first 28 days of an inpatient stay
17 during each plan year shall be provided without any retrospective
18 review or concurrent review of medical necessity and medical
19 necessity shall be as determined by the covered person's physician.

20 (2) The benefits for days 29 and thereafter of inpatient care shall
21 be subject to concurrent review as defined in this section. A request
22 for approval of inpatient care beyond the first 28 days shall be
23 submitted for concurrent review before the expiration of the initial
24 28 day period. A request for approval of inpatient care beyond any
25 period that is approved under concurrent review shall be submitted
26 within the period that was previously approved. No insurer shall
27 initiate concurrent review more frequently than ¹~~three-week~~ two-
28 week¹ intervals. If an insurer determines that continued inpatient
29 care in a facility is no longer medically necessary, the insurer shall
30 within 24 hours provide written notice to the covered person and the
31 covered person's physician of its decision and the right to file an
32 expedited internal appeal of the determination pursuant to an
33 expedited process pursuant to sections 11 through 13 of P.L.1997,
34 c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as
35 applicable. The insurer shall review and make a determination with
36 respect to the internal appeal within 24 hours and communicate
37 such determination to the covered person and the covered person's
38 physician. If the determination is to uphold the denial, the covered
39 person and the covered person's physician have the right to file an
40 expedited external appeal with the Independent Health Care
41 Appeals Program in the Department of Banking and Insurance
42 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
43 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
44 independent utilization review organization shall make a
45 determination within 24 hours. If the insurer's determination is
46 upheld and it is determined continued inpatient care is not
47 medically necessary, the insurer shall remain responsible to provide
48 benefits for the inpatient care through the day following the date the

1 determination is made and the covered person shall only be
2 responsible for any applicable co-payment, deductible and co-
3 insurance for the stay through that date as applicable under the
4 policy. The covered person shall not be discharged or released
5 from the inpatient facility until all internal appeals and independent
6 utilization review organization appeals are exhausted. For any costs
7 incurred after the day following the date of determination until the
8 day of discharge, the covered person shall only be responsible for
9 any applicable cost-sharing, and any additional charges shall be
10 paid by the facility or provider.

11 f. (1) The benefits for the first 28 days of intensive outpatient
12 or partial hospitalization services shall be provided without any
13 retrospective review of medical necessity and medical necessity
14 shall be as determined by the covered person's physician.

15 (2) The benefits for days 29 and thereafter of intensive
16 outpatient or partial hospitalization services shall be subject to a
17 retrospective review of the medical necessity of the services.

18 g. Benefits for inpatient and outpatient treatment of substance
19 use disorder after the first 180 days per plan year shall be subject to
20 the medical necessity determination of the insurer and may be
21 subject to prior authorization or, retrospective review and other
22 utilization management requirements.

23 h. Medical necessity review shall utilize an evidence-based and
24 peer reviewed clinical review tool to be designated through
25 rulemaking by the Commissioner of Human Services in
26 consultation with the Department of Health.

27 i. The benefits for outpatient prescription drugs to treat
28 substance use disorder shall be provided when determined
29 medically necessary by the covered person's physician,
30 psychologist or psychiatrist without the imposition of any prior
31 authorization or other prospective utilization management
32 requirements.

33 j. The first 180 days per plan year of benefits shall be
34 computed based on inpatient days. One or more unused inpatient
35 days may be exchanged for two outpatient visits. All extended
36 outpatient services such as partial hospitalization and intensive
37 outpatient, shall be deemed inpatient days for the purpose of the
38 visit to day exchange provided in this subsection.

39 k. Except as stated above, the benefits and cost-sharing shall be
40 provided to the same extent as for any other medical condition
41 covered under the policy.

42 l. The benefits required by this section are to be provided to all
43 covered persons with a diagnosis of substance use disorder. The
44 presence of additional related or unrelated diagnoses shall not be a
45 basis to reduce or deny the benefits required by this section.

46 m. The provisions of this section shall apply to those policies in
47 which the insurer has reserved the right to change the premium.

1 n. The Attorney General's Office shall be responsible for
2 overseeing any violations of law that may result from P.L. ,
3 c. (C.) (pending before the Legislature as this bill), including
4 fraud, abuse, waste, and mistreatment of covered persons. The
5 Attorney General's Office is authorized to adopt, pursuant to the
6 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
7 seq.), rules and regulations to implement any of the provisions of
8 P.L. , c. (C.) (pending before the Legislature as this bill).

9 o. The provisions of this section shall not apply to an
10 individual health insurance policy which, pursuant to a contract
11 between the insurer and the Department of Human Services,
12 provides benefits to persons who are eligible for medical assistance
13 under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family Health Care
14 Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.), or any other
15 program administered by the Division of Medical Assistance and
16 Health Services in the Department of Human Services.

17 p. As used in this section:

18 "Concurrent review" means inpatient care is reviewed as it is
19 provided. Medically qualified reviewers monitor appropriateness of
20 the care, the setting, and patient progress, and as appropriate, the
21 discharge plans.

22 "Substance use disorder" is as defined by the American
23 Psychiatric Association in the Diagnostic and Statistical Manual of
24 Mental Disorders, Fifth Edition and any subsequent editions and
25 shall include substance use withdrawal.

26

27 5. (New section) a. A group health insurance policy that
28 provides hospital or medical expense benefits and is delivered,
29 issued, executed or renewed in this State, or approved for issuance
30 or renewal in this State by the Commissioner of Banking and
31 Insurance, on or after the effective date of this act, shall provide
32 unlimited benefits for inpatient and outpatient treatment of
33 substance use disorder at in-network facilities. The services for the
34 treatment of substance use disorder shall be prescribed by a licensed
35 physician, licensed psychologist, or licensed psychiatrist and
36 provided by licensed health care professionals or licensed or
37 certified substance use disorder providers in licensed or otherwise
38 State-approved facilities, as required by the laws of the state in
39 which the services are rendered.

40 b. The benefits for the first 180 days per plan year of inpatient
41 and outpatient treatment of substance use disorder shall be provided
42 when determined medically necessary by the covered person's
43 physician, psychologist or psychiatrist without the imposition of
44 any prior authorization or other prospective utilization management
45 requirements. ¹The facility shall notify the insurer of both the
46 admission and the initial treatment plan within 48 hours of the
47 admission or initiation of treatment.¹ If there is no in-network
48 facility immediately available for a covered person, an insurer shall

1 provide necessary exceptions to its network to ensure admission in
2 a treatment facility within 24 hours.

3 c. Providers of treatment for substance use disorder to persons
4 covered under a covered insurance policy shall not require pre-
5 payment of medical expenses during this 180 days in excess of
6 applicable co-payment, deductible, or co-insurance under the
7 policy.

8 d. The benefits for outpatient visits shall not be subject to
9 concurrent or retrospective review of medical necessity or any other
10 utilization management review.

11 e. (1) The benefits for the first 28 days of an inpatient stay
12 during each plan year shall be provided without any retrospective
13 review or concurrent review of medical necessity and medical
14 necessity shall be as determined by the covered person's physician.

15 (2) The benefits for days 29 and thereafter of inpatient care shall
16 be subject to concurrent review as defined in this section. A request
17 for approval of inpatient care beyond the first 28 days shall be
18 submitted for concurrent review before the expiration of the initial
19 28 day period. A request for approval of inpatient care beyond any
20 period that is approved under concurrent review shall be submitted
21 within the period that was previously approved. No insurer shall
22 initiate concurrent review more frequently than ¹~~three-week~~ two-
23 week¹ intervals. If an insurer determines that continued inpatient
24 care in a facility is no longer medically necessary, the insurer shall
25 within 24 hours provide written notice to the covered person and the
26 covered person's physician of its decision and the right to file an
27 expedited internal appeal of the determination pursuant to an
28 expedited process pursuant to sections 11 through 13 of P.L.1997,
29 c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as
30 applicable. The insurer shall review and make a determination with
31 respect to the internal appeal within 24 hours and communicate
32 such determination to the covered person and the covered person's
33 physician. If the determination is to uphold the denial, the covered
34 person and the covered person's physician have the right to file an
35 expedited external appeal with the Independent Health Care
36 Appeals Program in the Department of Banking and Insurance
37 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
38 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
39 independent utilization review organization shall make a
40 determination within 24 hours. If the insurer's determination is
41 upheld and it is determined continued inpatient care is not
42 medically necessary, the insurer shall remain responsible to provide
43 benefits for the inpatient care through the day following the date the
44 determination is made and the covered person shall only be
45 responsible for any applicable co-payment, deductible and co-
46 insurance for the stay through that date as applicable under the
47 policy. The covered person shall not be discharged or released
48 from the inpatient facility until all internal appeals and independent

1 utilization review organization appeals are exhausted. For any costs
2 incurred after the day following the date of determination until the
3 day of discharge, the covered person shall only be responsible for
4 any applicable cost-sharing, and any additional charges shall be
5 paid by the facility or provider.

6 f. (1) The benefits for the first 28 days of intensive outpatient
7 or partial hospitalization services shall be provided without any
8 retrospective review of medical necessity and medical necessity
9 shall be as determined by the covered person's physician.

10 (2) The benefits for days 29 and thereafter of intensive
11 outpatient or partial hospitalization services shall be subject to a
12 retrospective review of the medical necessity of the services.

13 g. Benefits for inpatient and outpatient treatment of substance
14 use disorder after the first 180 days per plan year shall be subject to
15 the medical necessity determination of the insurer and may be
16 subject to prior authorization or, retrospective review and other
17 utilization management requirements.

18 h. Medical necessity review shall utilize an evidence-based and
19 peer reviewed clinical review tool to be designated through
20 rulemaking by the Commissioner of Human Services in
21 consultation with the Department of Health.

22 i. The benefits for outpatient prescription drugs to treat
23 substance use disorder shall be provided when determined
24 medically necessary by the covered person's physician,
25 psychologist or psychiatrist without the imposition of any prior
26 authorization or other prospective utilization management
27 requirements.

28 j. The first 180 days per plan year of benefits shall be
29 computed based on inpatient days. One or more unused inpatient
30 days may be exchanged for two outpatient visits. All extended
31 outpatient services such as partial hospitalization and intensive
32 outpatient, shall be deemed inpatient days for the purpose of the
33 visit to day exchange provided in this subsection.

34 k. Except as stated above, the benefits and cost-sharing shall be
35 provided to the same extent as for any other medical condition
36 covered under the policy.

37 l. The benefits required by this section are to be provided to all
38 covered persons with a diagnosis of substance use disorder. The
39 presence of additional related or unrelated diagnoses shall not be a
40 basis to reduce or deny the benefits required by this section.

41 m. The provisions of this section shall apply to those policies in
42 which the insurer has reserved the right to change the premium.

43 n. The Attorney General's Office shall be responsible for
44 overseeing any violations of law that may result from P.L. ,
45 c. (C.) (pending before the Legislature as this bill), including
46 fraud, abuse, waste, and mistreatment of covered persons. The
47 Attorney General's Office is authorized to adopt, pursuant to the
48 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et

1 seq.), rules and regulations to implement any of the provisions of
2 P.L. , c. (C.) (pending before the Legislature as this bill).

3 o. The provisions of this section shall not apply to a group
4 health insurance policy which, pursuant to a contract between the
5 insurer and the Department of Human Services, provides benefits to
6 persons who are eligible for medical assistance under P.L.1968,
7 c.413 (C.30:4D-1 et seq.), the “Family Health Care Coverage Act,”
8 P.L.2005, c.156 (C.30:4J-8 et seq.), or any other program
9 administered by the Division of Medical Assistance and Health
10 Services in the Department of Human Services.

11 p. As used in this section:

12 “Concurrent review” means inpatient care is reviewed as it is
13 provided. Medically qualified reviewers monitor appropriateness of
14 the care, the setting, and patient progress, and as appropriate, the
15 discharge plans.

16 “Substance use disorder” is as defined by the American
17 Psychiatric Association in the Diagnostic and Statistical Manual of
18 Mental Disorders, Fifth Edition and any subsequent editions and
19 shall include substance use withdrawal.

20

21 6. (New section) a. An individual health benefits plan that
22 provides hospital or medical expense benefits and is delivered,
23 issued, executed or renewed in this State, or approved for issuance
24 or renewal in this State by the Commissioner of Banking and
25 Insurance, on or after the effective date of this act, shall provide
26 unlimited benefits for inpatient and outpatient treatment of
27 substance use disorder at in-network facilities. The services for the
28 treatment of substance use disorder shall be prescribed by a licensed
29 physician, licensed psychologist, or licensed psychiatrist and
30 provided by licensed health care professionals or licensed or
31 certified substance use disorder providers in licensed or otherwise
32 State-approved facilities, as required by the laws of the state in
33 which the services are rendered.

34 b. The benefits for the first 180 days per plan year of inpatient
35 and outpatient treatment of substance use disorder shall be provided
36 when determined medically necessary by the covered person’s
37 physician, psychologist or psychiatrist without the imposition of
38 any prior authorization or other prospective utilization management
39 requirements. ¹The facility shall notify the carrier of both the
40 admission and the initial treatment plan within 48 hours of the
41 admission or initiation of treatment.¹ If there is no in-network
42 facility immediately available for a covered person, a carrier shall
43 provide necessary exceptions to their network to ensure admission
44 in a treatment facility within 24 hours.

45 c. Providers of treatment for substance use disorder to persons
46 covered under a covered health benefits plan shall not require pre-
47 payment of medical expenses during this 180 days in excess of
48 applicable co-payment, deductible, or co-insurance under the plan.

1 d. The benefits for outpatient visits shall not be subject to
2 concurrent or retrospective review of medical necessity or any other
3 utilization management review.

4 e. (1) The benefits for the first 28 days of an inpatient stay
5 during each plan year shall be provided without any retrospective
6 review or concurrent review of medical necessity and medical
7 necessity shall be as determined by the covered person's physician.

8 (2) The benefits for days 29 and thereafter of inpatient care shall
9 be subject to concurrent review as defined in this section. A request
10 for approval of inpatient care beyond the first 28 days shall be
11 submitted for concurrent review before the expiration of the initial
12 28 day period. A request for approval of inpatient care beyond any
13 period that is approved under concurrent review shall be submitted
14 within the period that was previously approved. No carrier shall
15 initiate concurrent review more frequently than ¹~~three-week~~ two-
16 week¹ intervals. If a carrier determines that continued inpatient
17 care in a facility is no longer medically necessary, the carrier shall
18 within 24 hours provide written notice to the covered person and the
19 covered person's physician of its decision and the right to file an
20 expedited internal appeal of the determination pursuant to an
21 expedited process pursuant to sections 11 through 13 of P.L.1997,
22 c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as
23 applicable. The carrier shall review and make a determination with
24 respect to the internal appeal within 24 hours and communicate
25 such determination to the covered person and the covered person's
26 physician. If the determination is to uphold the denial, the covered
27 person and the covered person's physician have the right to file an
28 expedited external appeal with the Independent Health Care
29 Appeals Program in the Department of Banking and Insurance
30 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
31 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
32 independent utilization review organization shall make a
33 determination within 24 hours. If the carrier's determination is
34 upheld and it is determined continued inpatient care is not
35 medically necessary, the carrier shall remain responsible to provide
36 benefits for the inpatient care through the day following the date the
37 determination is made and the covered person shall only be
38 responsible for any applicable co-payment, deductible and co-
39 insurance for the stay through that date as applicable under the
40 policy. The covered person shall not be discharged or released
41 from the inpatient facility until all internal appeals and independent
42 utilization review organization appeals are exhausted. For any costs
43 incurred after the day following the date of determination until the
44 day of discharge, the covered person shall only be responsible for
45 any applicable cost-sharing, and any additional charges shall be
46 paid by the facility or provider.

47 f. (1) The benefits for the first 28 days of intensive outpatient
48 or partial hospitalization services shall be provided without any

1 retrospective review of medical necessity and medical necessity
2 shall be as determined by the covered person's physician.

3 (2) The benefits for days 29 and thereafter of intensive
4 outpatient or partial hospitalization services shall be subject to a
5 retrospective review of the medical necessity of the services.

6 g. Benefits for inpatient and outpatient treatment of substance
7 use disorder after the first 180 days per plan year shall be subject to
8 the medical necessity determination of the ¹~~insurer~~ carrier¹ and
9 may be subject to prior authorization or, retrospective review and
10 other utilization management requirements.

11 h. Medical necessity review shall utilize an evidence-based and
12 peer reviewed clinical review tool to be designated through
13 rulemaking by the Commissioner of Human Services in
14 consultation with the Department of Health.

15 i. The benefits for outpatient prescription drugs to treat
16 substance use disorder shall be provided when determined
17 medically necessary by the covered person's physician,
18 psychologist or psychiatrist without the imposition of any prior
19 authorization or other prospective utilization management
20 requirements.

21 j. The first 180 days per plan year of benefits shall be
22 computed based on inpatient days. One or more unused inpatient
23 days may be exchanged for two outpatient visits. All extended
24 outpatient services such as partial hospitalization and intensive
25 outpatient, shall be deemed inpatient days for the purpose of the
26 visit to day exchange provided in this subsection.

27 k. Except as stated above, the benefits and cost-sharing shall be
28 provided to the same extent as for any other medical condition
29 covered under the health benefits plan.

30 l. The benefits required by this section are to be provided to all
31 covered persons with a diagnosis of substance use disorder. The
32 presence of additional related or unrelated diagnoses shall not be a
33 basis to reduce or deny the benefits required by this section.

34 m. The provisions of this section shall apply to all individual
35 health benefits plans in which the carrier has reserved the right to
36 change the premium.

37 n. The Attorney General's Office shall be responsible for
38 overseeing any violations of law that may result from P.L. ,

39 c. (C.) (pending before the Legislature as this bill), including
40 fraud, abuse, waste, and mistreatment of covered persons. The
41 Attorney General's Office is authorized to adopt, pursuant to the
42 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
43 seq.), rules and regulations to implement any of the provisions of
44 P.L. , c. (C.) (pending before the Legislature as this bill).

45 o. The provisions of this section shall not apply to an
46 individual health benefits plan which, pursuant to a contract
47 between the carrier and the Department of Human Services,
48 provides benefits to persons who are eligible for medical assistance

1 under P.L.1968, c.413 (C.30:4D-1 et seq.), the “Family Health Care
2 Coverage Act,” P.L.2005, c.156 (C.30:4J-8 et seq.), or any other
3 program administered by the Division of Medical Assistance and
4 Health Services in the Department of Human Services.

5 p. As used in this section:

6 “Concurrent review” means inpatient care is reviewed as it is
7 provided. Medically qualified reviewers monitor appropriateness of
8 the care, the setting, and patient progress, and as appropriate, the
9 discharge plans.

10 “Substance use disorder” is as defined by the American
11 Psychiatric Association in the Diagnostic and Statistical Manual of
12 Mental Disorders, Fifth Edition and any subsequent editions and
13 shall include substance use withdrawal.

14
15 7. (New section) a. A small employer health benefits plan that
16 provides hospital or medical expense benefits and is delivered,
17 issued, executed or renewed in this State, or approved for issuance
18 or renewal in this State by the Commissioner of Banking and
19 Insurance, on or after the effective date of this act, shall provide
20 unlimited benefits for inpatient and outpatient treatment of
21 substance use disorder at in-network facilities. The services for the
22 treatment of substance use disorder shall be prescribed by a licensed
23 physician, licensed psychologist, or licensed psychiatrist and
24 provided by licensed health care professionals or licensed or
25 certified substance use disorder providers in licensed or otherwise
26 State-approved facilities, as required by the laws of the state in
27 which the services are rendered.

28 b. The benefits for the first 180 days per plan year of inpatient
29 and outpatient treatment of substance use disorder shall be provided
30 when determined medically necessary by the covered person’s
31 physician, psychologist or psychiatrist without the imposition of
32 any prior authorization or other prospective utilization management
33 requirements. ¹The facility shall notify the carrier of both the
34 admission and the initial treatment plan within 48 hours of the
35 admission or initiation of treatment.¹ If there is no in-network
36 facility immediately available for a covered person, a carrier shall
37 provide necessary exceptions to their network to ensure admission
38 in a treatment facility within 24 hours.

39 c. Providers of treatment for substance use disorder to persons
40 covered under a covered health benefits plan shall not require pre-
41 payment of medical expenses during this 180 days in excess of
42 applicable co-payment, deductible, or co-insurance under the plan.

43 d. The benefits for outpatient visits shall not be subject to
44 concurrent or retrospective review of medical necessity or any other
45 utilization management review.

46 e. (1) The benefits for the first 28 days of an inpatient stay
47 during each plan year shall be provided without any retrospective

1 review or concurrent review of medical necessity and medical
2 necessity shall be as determined by the covered person's physician.

3 (2) The benefits for days 29 and thereafter of inpatient care shall
4 be subject to concurrent review as defined in this section. A request
5 for approval of inpatient care beyond the first 28 days shall be
6 submitted for concurrent review before the expiration of the initial
7 28 day period. A request for approval of inpatient care beyond any
8 period that is approved under concurrent review shall be submitted
9 within the period that was previously approved. No carrier shall
10 initiate concurrent review more frequently than ¹~~three-week~~ two-
11 week¹ intervals. If a carrier determines that continued inpatient
12 care in a facility is no longer medically necessary, the carrier shall
13 within 24 hours provide written notice to the covered person and the
14 covered person's physician of its decision and the right to file an
15 expedited internal appeal of the determination pursuant to an
16 expedited process pursuant to sections 11 through 13 of P.L.1997,
17 c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as
18 applicable. The carrier shall review and make a determination with
19 respect to the internal appeal within 24 hours and communicate
20 such determination to the covered person and the covered person's
21 physician. If the determination is to uphold the denial, the covered
22 person and the covered person's physician have the right to file an
23 expedited external appeal with the Independent Health Care
24 Appeals Program in the Department of Banking and Insurance
25 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
26 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
27 independent utilization review organization shall make a
28 determination within 24 hours. If the carrier's determination is
29 upheld and it is determined continued inpatient care is not
30 medically necessary, the carrier shall remain responsible to provide
31 benefits for the inpatient care through the day following the date the
32 determination is made and the covered person shall only be
33 responsible for any applicable co-payment, deductible and co-
34 insurance for the stay through that date as applicable under the
35 policy. The covered person shall not be discharged or released
36 from the inpatient facility until all internal appeals and independent
37 utilization review organization appeals are exhausted. For any costs
38 incurred after the day following the date of determination until the
39 day of discharge, the covered person shall only be responsible for
40 any applicable cost-sharing, and any additional charges shall be
41 paid by the facility or provider.

42 f. (1) The benefits for the first 28 days of intensive outpatient
43 or partial hospitalization services shall be provided without any
44 retrospective review of medical necessity and medical necessity
45 shall be as determined by the covered person's physician.

46 (2) The benefits for days 29 and thereafter of intensive
47 outpatient or partial hospitalization services shall be subject to a
48 retrospective review of the medical necessity of the services.

- 1 g. Benefits for inpatient and outpatient treatment of substance
2 use disorder after the first 180 days per plan year shall be subject to
3 the medical necessity determination of the carrier and may be
4 subject to prior authorization or, retrospective review and other
5 utilization management requirements.
- 6 h. Medical necessity review shall utilize an evidence-based and
7 peer reviewed clinical review tool to be designated through
8 rulemaking by the Commissioner of Human Services in
9 consultation with the Department of Health.
- 10 i. The benefits for outpatient prescription drugs to treat
11 substance use disorder shall be provided when determined
12 medically necessary by the covered person's physician,
13 psychologist or psychiatrist without the imposition of any prior
14 authorization or other prospective utilization management
15 requirements.
- 16 j. The first 180 days per plan year of benefits shall be
17 computed based on inpatient days. One or more unused inpatient
18 days may be exchanged for two outpatient visits. All extended
19 outpatient services such as partial hospitalization and intensive
20 outpatient, shall be deemed inpatient days for the purpose of the
21 visit to day exchange provided in this subsection.
- 22 k. Except as stated above, the benefits and cost-sharing shall be
23 provided to the same extent as for any other medical condition
24 covered under the health benefits plan.
- 25 l. The benefits required by this section are to be provided to all
26 covered persons with a diagnosis of substance use disorder. The
27 presence of additional related or unrelated diagnoses shall not be a
28 basis to reduce or deny the benefits required by this section.
- 29 m. The provisions of this section shall apply to all small
30 employer health benefits plans in which the carrier has reserved the
31 right to change the premium.
- 32 n. The Attorney General's Office shall be responsible for
33 overseeing any violations of law that may result from P.L. ,
34 c. (C.) (pending before the Legislature as this bill), including
35 fraud, abuse, waste, and mistreatment of covered persons. The
36 Attorney General's Office is authorized to adopt, pursuant to the
37 Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
38 seq.), rules and regulations to implement any of the provisions of
39 P.L. , c. (C.) (pending before the Legislature as this bill).
- 40 o. As used in this section:
- 41 "Concurrent review" means inpatient care is reviewed as it is
42 provided. Medically qualified reviewers monitor appropriateness of
43 the care, the setting, and patient progress, and as appropriate, the
44 discharge plans.
- 45 "Substance use disorder" is as defined by the American
46 Psychiatric Association in the Diagnostic and Statistical Manual of
47 Mental Disorders, Fifth Edition and any subsequent editions and
48 shall include substance abuse withdrawal.

1 8. (New section) a. A health maintenance organization
2 contract that provides hospital or medical expense benefits and is
3 delivered, issued, executed or renewed in this State, or approved for
4 issuance or renewal in this State by the Commissioner of Banking
5 and Insurance, on or after the effective date of this act, shall provide
6 unlimited benefits for inpatient and outpatient treatment of
7 substance use disorder at in-network facilities. The services for the
8 treatment of substance use disorder shall be prescribed by a licensed
9 physician, licensed psychologist, or licensed psychiatrist and
10 provided by licensed health care professionals or licensed or
11 certified substance use disorder providers in licensed or otherwise
12 State-approved facilities, as required by the laws of the state in
13 which the services are rendered.

14 b. The benefits for the first 180 days per plan year of inpatient
15 and outpatient treatment of substance use disorder shall be provided
16 when determined medically necessary by the covered person's
17 physician, psychologist or psychiatrist without the imposition of
18 any prior authorization or other prospective utilization management
19 requirements. ¹The facility shall notify the health maintenance
20 organization of both the admission and the initial treatment plan
21 within 48 hours of the admission or initiation of treatment.¹ If there
22 is no in-network facility immediately available for a covered
23 person, a health maintenance organization shall provide necessary
24 exceptions to their network to ensure admission in a treatment
25 facility within 24 hours.

26 c. Providers of treatment for substance use disorder to persons
27 covered under a covered contract shall not require pre-payment of
28 medical expenses during this 180 days in excess of applicable co-
29 payment, deductible, or co-insurance under the policy.

30 d. The benefits for outpatient visits shall not be subject to
31 concurrent or retrospective review of medical necessity or any other
32 utilization management review.

33 e. (1) The benefits for the first 28 days of an inpatient stay
34 during each plan year shall be provided without any retrospective
35 review or concurrent review of medical necessity and medical
36 necessity shall be as determined by the covered person's physician.

37 (2) The benefits for days 29 and thereafter of inpatient care shall
38 be subject to concurrent review as defined in this section. A request
39 for approval of inpatient care beyond the first 28 days shall be
40 submitted for concurrent review before the expiration of the initial
41 28 day period. A request for approval of inpatient care beyond any
42 period that is approved under concurrent review shall be submitted
43 within the period that was previously approved. No health
44 maintenance organization shall initiate concurrent review more
45 frequently than ¹~~three-week~~ two-week¹ intervals. If a health
46 maintenance organization determines that continued inpatient
47 ¹~~care~~ care¹ in a facility is no longer medically necessary,

1 the health ¹~~insurance~~ maintenance¹ organization shall within 24
2 hours provide written notice to the covered person and the covered
3 person's physician of its decision and the right to file an expedited
4 internal appeal of the determination pursuant to an expedited
5 process pursuant to sections 11 through 13 of P.L.1997, c.192
6 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as
7 applicable. The health maintenance organization shall review and
8 make a determination with respect to the internal appeal within 24
9 hours and communicate such determination to the covered person
10 and the covered person's physician. If the determination is to
11 uphold the denial, the covered person and the covered person's
12 physician have the right to file an expedited external appeal with
13 the Independent Health Care Appeals Program in the Department of
14 Banking and Insurance pursuant to sections 11 through 13 of
15 P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and
16 N.J.A.C.11:24A-3.6, as applicable. An independent utilization
17 review organization shall make a determination within 24 hours. If
18 the health maintenance organization's determination is upheld and
19 it is determined continued inpatient care is not medically necessary,
20 the carrier shall remain responsible to provide benefits for the
21 inpatient care through the day following the date the determination
22 is made and the covered person shall only be responsible for any
23 applicable co-payment, deductible and co-insurance for the stay
24 through that date as applicable under the policy. The covered
25 person shall not be discharged or released from the inpatient facility
26 until all internal appeals and independent utilization review
27 organization appeals are exhausted. For any costs incurred after the
28 day following the date of determination until the day of discharge,
29 the covered person shall only be responsible for any applicable
30 cost-sharing, and any additional charges shall be paid by the facility
31 or provider.

32 f. (1) The benefits for the first 28 days of intensive outpatient
33 or partial hospitalization services shall be provided without any
34 retrospective review of medical necessity and medical necessity
35 shall be as determined by the covered person's physician.

36 (2) The benefits for days 29 and thereafter of intensive
37 outpatient or partial hospitalization services shall be subject to a
38 retrospective review of the medical necessity of the services.

39 g. Benefits for inpatient and outpatient treatment of substance
40 use disorder after the first 180 days per plan year shall be subject to
41 the medical necessity determination of the health maintenance
42 organization and may be subject to prior authorization or,
43 retrospective review and other utilization management
44 requirements.

45 h. Medical necessity review shall utilize an evidence-based and
46 peer reviewed clinical review tool to be designated through
47 rulemaking by the Commissioner of Human Services in
48 consultation with the Department of Health.

1 i. The benefits for outpatient prescription drugs to treat
2 substance use disorder shall be provided when determined
3 medically necessary by the covered person's physician,
4 psychologist or psychiatrist without the imposition of any prior
5 authorization or other prospective utilization management
6 requirements.

7 j. The first 180 days per plan year of benefits shall be
8 computed based on inpatient days. One or more unused inpatient
9 days may be exchanged for two outpatient visits. All extended
10 outpatient services such as partial hospitalization and intensive
11 outpatient, shall be deemed inpatient days for the purpose of the
12 visit to day exchange provided in this subsection.

13 k. Except as stated above, the benefits and cost-sharing shall be
14 provided to the same extent as for any other medical condition
15 covered under the contract.

16 l. The benefits required by this section are to be provided to all
17 covered persons with a diagnosis of substance use disorder. The
18 presence of additional related or unrelated diagnoses shall not be a
19 basis to reduce or deny the benefits required by this section.

20 m. The provisions of this section shall apply to those contracts
21 in which the health maintenance organization has reserved the right
22 to change the premium.

23 n. The Attorney General's Office shall be responsible for
24 overseeing any violations of law that may result from P.L. ,
25 c. (C.) (pending before the Legislature as this bill), including
26 fraud, abuse, waste, and mistreatment of covered persons. The
27 Attorney General's Office is authorized to adopt, pursuant to the
28 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
29 seq.), rules and regulations to implement any of the provisions of
30 P.L. , c. (C.) (pending before the Legislature as this bill).

31 o. The provisions of this section shall not apply to a health
32 maintenance organization contract which, pursuant to a contract
33 between the health maintenance organization and the Department of
34 Human Services, provides benefits to persons who are eligible for
35 medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the
36 "Family Health Care Coverage Act," P.L.2005, c.156 (C.30:4J-8 et
37 seq.), or any other program administered by the Division of Medical
38 Assistance and Health Services in the Department of Human
39 Services.

40 p. As used in this section:

41 "Concurrent review" means inpatient care is reviewed as it is
42 provided. Medically qualified reviewers monitor appropriateness of
43 the care, the setting, and patient progress, and as appropriate, the
44 discharge plans.

45 "Substance use disorder" is as defined by the American
46 Psychiatric Association in the Diagnostic and Statistical Manual of
47 Mental Disorders, Fifth Edition and any subsequent editions and
48 shall include substance use withdrawal.

1 9. (New section) a. The State Health Benefits Commission
2 shall ensure that every contract purchased by the commission on or
3 after the effective date of this act provides unlimited benefits for
4 inpatient and outpatient treatment of substance use disorder at in-
5 network facilities. The services for the treatment of substance use
6 disorder shall be prescribed by a licensed physician, licensed
7 psychologist, or licensed psychiatrist and provided by licensed
8 health care professionals or licensed or certified substance use
9 disorder providers in licensed or otherwise State-approved facilities,
10 as required by the laws of the state in which the services are
11 rendered.

12 b. The benefits for the first 180 days per plan year of inpatient
13 and outpatient treatment of substance use disorder shall be provided
14 when determined medically necessary by the covered person's
15 physician, psychologist or psychiatrist without the imposition of
16 any prior authorization or other prospective utilization management
17 requirements. ¹The facility shall notify the benefit payer of both
18 the admission and the initial treatment plan within 48 hours of the
19 admission or initiation of treatment.¹ If there is no in-network
20 facility immediately available for a covered person, the contract
21 shall provide necessary exceptions to their network to ensure
22 admission in a treatment facility within 24 hours.

23 c. Providers of treatment for substance use disorder to persons
24 covered under a covered contract shall not require pre-payment of
25 medical expenses during this 180 days in excess of applicable co-
26 payment, deductible, or co-insurance under the policy.

27 d. The benefits for outpatient visits shall not be subject to
28 concurrent or retrospective review of medical necessity or any other
29 utilization management review.

30 e. (1) The benefits for the first 28 days of an inpatient stay
31 during each plan year shall be provided without any retrospective
32 review or concurrent review of medical necessity and medical
33 necessity shall be as determined by the covered person's physician.

34 (2) The benefits for days 29 and thereafter of inpatient care shall
35 be subject to concurrent review as defined in this section. A request
36 for approval of inpatient care beyond the first 28 days shall be
37 submitted for concurrent review before the expiration of the initial
38 28 day period. A request for approval of inpatient care beyond any
39 period that is approved under concurrent review shall be submitted
40 within the period that was previously approved. The contract shall
41 not initiate concurrent review more frequently than ¹**[three-week]**
42 two-week¹ intervals. If it is determined that continued inpatient
43 care in a facility is no longer medically necessary, the contract shall
44 provide that within 24 hours, written notice shall be provided to the
45 covered person and the covered person's physician of its decision
46 and the right to file an expedited internal appeal of the
47 determination pursuant to an expedited process pursuant to sections
48 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13)

1 and N.J.A.C.11:24A-3.5, as applicable. A determination shall be
2 made with respect to the internal appeal within 24 hours and shall
3 be communicated to the covered person and the covered person's
4 physician. If the determination is to uphold the denial, the covered
5 person and the covered person's physician have the right to file an
6 expedited external appeal with the Independent Health Care
7 Appeals Program in the Department of Banking and Insurance
8 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
9 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
10 independent utilization review organization shall make a
11 determination within 24 hours. If the determination is upheld and it
12 is determined continued inpatient care is not medically necessary,
13 the contract shall state that benefits are provided for the inpatient
14 care through the day following the date the determination is made
15 and the covered person shall only be responsible for any applicable
16 co-payment, deductible and co-insurance for the stay through that
17 date as applicable under the contract. The covered person shall not
18 be discharged or released from the inpatient facility until all internal
19 appeals and independent utilization review organization appeals are
20 exhausted. For any costs incurred after the day following the date of
21 determination until the day of discharge, the covered person shall
22 only be responsible for any applicable cost-sharing, and any
23 additional charges shall be paid by the facility or provider.

24 f. (1) The benefits for the first 28 days of intensive outpatient
25 or partial hospitalization services shall be provided without any
26 retrospective review of medical necessity and medical necessity
27 shall be as determined by the covered person's physician.

28 (2) The benefits for days 29 and thereafter of intensive
29 outpatient or partial hospitalization services shall be subject to a
30 retrospective review of the medical necessity of the services.

31 g. Benefits for inpatient and outpatient treatment of substance
32 use disorder after the first 180 days per plan year shall be subject to
33 medical necessity determination and may be subject to prior
34 authorization or, retrospective review and other utilization
35 management requirements.

36 h. Medical necessity review shall utilize an evidence-based and
37 peer reviewed clinical review tool to be designated through
38 rulemaking by the Commissioner of Human Services in
39 consultation with the Department of Health.

40 i. The benefits for outpatient prescription drugs to treat
41 substance use disorder shall be provided when determined
42 medically necessary by the covered person's physician,
43 psychologist or psychiatrist without the imposition of any prior
44 authorization or other prospective utilization management
45 requirements.

46 j. The first 180 days per plan year of benefits shall be
47 computed based on inpatient days. One or more unused inpatient
48 days may be exchanged for two outpatient visits. All extended

1 outpatient services such as partial hospitalization and intensive
2 outpatient, shall be deemed inpatient days for the purpose of the
3 visit to day exchange provided in this subsection.

4 k. Except as stated above, the benefits and cost-sharing shall be
5 provided to the same extent as for any other medical condition
6 covered under the contract.

7 l. The benefits required by this section are to be provided to all
8 covered persons with a diagnosis of substance use disorder. The
9 presence of additional related or unrelated diagnoses shall not be a
10 basis to reduce or deny the benefits required by this section.

11 m. As used in this section:

12 “Concurrent review” means inpatient care is reviewed as it is
13 provided. Medically qualified reviewers monitor appropriateness of
14 the care, the setting, and patient progress, and as appropriate, the
15 discharge plans.

16 “Substance use disorder” is as defined by the American
17 Psychiatric Association in the Diagnostic and Statistical Manual of
18 Mental Disorders, Fifth Edition and any subsequent editions and
19 shall include substance use withdrawal.

20

21 10. (New section) a. The School Employees’ Health Benefits
22 Commission shall ensure that every contract purchased by the
23 commission on or after the effective date of this act provides
24 unlimited benefits for inpatient and outpatient treatment of
25 substance use disorder at in-network facilities. The services for the
26 treatment of substance use disorder shall be prescribed by a licensed
27 physician, licensed psychologist, or licensed psychiatrist and
28 provided by licensed health care professionals or licensed or
29 certified substance use disorder providers in licensed or otherwise
30 State-approved facilities, as required by the laws of the state in
31 which the services are rendered.

32 b. The benefits for the first 180 days per plan year of inpatient
33 and outpatient treatment of substance use disorder shall be provided
34 when determined medically necessary by the covered person’s
35 physician, psychologist or psychiatrist without the imposition of
36 any prior authorization or other prospective utilization management
37 requirements. ¹The facility shall notify the benefit payer of both
38 the admission and the initial treatment plan within 48 hours of the
39 admission or initiation of treatment.¹ If there is no in-network
40 facility immediately available for a covered person, the contract
41 shall provide necessary exceptions to their network to ensure
42 admission in a treatment facility within 24 hours.

43 c. Providers of treatment for substance use disorder to persons
44 covered under a covered contract shall not require pre-payment of
45 medical expenses during this 180 days in excess of applicable co-
46 payment, deductible, or co-insurance under the policy.

- 1 d. The benefits for outpatient visits shall not be subject to
2 concurrent or retrospective review of medical necessity or any other
3 utilization management review.
- 4 e. (1) The benefits for the first 28 days of an inpatient stay
5 during each plan year shall be provided without any retrospective
6 review or concurrent review of medical necessity and medical
7 necessity shall be as determined by the covered person's physician.
- 8 (2) The benefits for days 29 and thereafter of inpatient care shall
9 be subject to concurrent review as defined in this section. A request
10 for approval of inpatient care beyond the first 28 days shall be
11 submitted for concurrent review before the expiration of the initial
12 28 day period. A request for approval of inpatient care beyond any
13 period that is approved under concurrent review shall be submitted
14 within the period that was previously approved. The contract shall
15 not initiate concurrent review more frequently than ¹~~three-week~~
16 two-week¹ intervals. If it is determined that continued inpatient
17 care in a facility is no longer medically necessary, the contract shall
18 provide that within 24 hours, written notice shall be provided to the
19 covered person and the covered person's physician of its decision
20 and the right to file an expedited internal appeal of the
21 determination pursuant to an expedited process pursuant to sections
22 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13)
23 and N.J.A.C.11:24A-3.5, as applicable. A determination shall be
24 made with respect to the internal appeal within 24 hours and shall
25 be communicated to the covered person and the covered person's
26 physician. If the determination is to uphold the denial, the covered
27 person and the covered person's physician have the right to file an
28 expedited external appeal with the Independent Health Care
29 Appeals Program in the Department of Banking and Insurance
30 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
31 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
32 independent utilization review organization shall make a
33 determination within 24 hours. If the determination is upheld and it
34 is determined continued inpatient care is not medically necessary,
35 the contract shall state that benefits are provided for the inpatient
36 care through the day following the date the determination is made
37 and the covered person shall only be responsible for any applicable
38 co-payment, deductible and co-insurance for the stay through that
39 date as applicable under the contract. The covered person shall not
40 be discharged or released from the inpatient facility until all internal
41 appeals and independent utilization review organization appeals are
42 exhausted. For any costs incurred after the day following the date of
43 determination until the day of discharge, the covered person shall
44 only be responsible for any applicable cost-sharing, and any
45 additional charges shall be paid by the facility or provider.
- 46 f. (1) The benefits for the first 28 days of intensive outpatient
47 or partial hospitalization services shall be provided without any

1 retrospective review of medical necessity and medical necessity
2 shall be as determined by the covered person's physician.

3 (2) The benefits for days 29 and thereafter of intensive
4 outpatient or partial hospitalization services shall be subject to a
5 retrospective review of the medical necessity of the services.

6 g. Benefits for inpatient and outpatient treatment of substance
7 use disorder after the first 180 days per plan year shall be subject to
8 medical necessity determination and may be subject to prior
9 authorization or, retrospective review and other utilization
10 management requirements.

11 h. Medical necessity review shall utilize an evidence-based and
12 peer reviewed clinical review tool to be designated through
13 rulemaking by the Commissioner of Human Services in
14 consultation with the Department of Health.

15 i. The benefits for outpatient prescription drugs to treat
16 substance use disorder shall be provided when determined
17 medically necessary by the covered person's physician,
18 psychologist or psychiatrist without the imposition of any prior
19 authorization or other prospective utilization management
20 requirements.

21 j. The first 180 days per plan year of benefits shall be
22 computed based on inpatient days. One or more unused inpatient
23 days may be exchanged for two outpatient visits. All extended
24 outpatient services such as partial hospitalization and intensive
25 outpatient, shall be deemed inpatient days for the purpose of the
26 visit to day exchange provided in this subsection.

27 k. Except as stated above, the benefits and cost-sharing shall be
28 provided to the same extent as for any other medical condition
29 covered under the contract.

30 l. The benefits required by this section are to be provided to all
31 covered persons with a diagnosis of substance use disorder. The
32 presence of additional related or unrelated diagnoses shall not be a
33 basis to reduce or deny the benefits required by this section.

34 m. As used in this section:

35 "Concurrent review" means inpatient care is reviewed as it is
36 provided. Medically qualified reviewers monitor appropriateness of
37 the care, the setting, and patient progress, and as appropriate, the
38 discharge plans.

39 "Substance use disorder" is as defined by the American
40 Psychiatric Association in the Diagnostic and Statistical Manual of
41 Mental Disorders, Fifth Edition and any subsequent editions and
42 shall include substance use withdrawal.

43

44 11. (New section) a. A practitioner shall not issue an initial
45 prescription for an opioid drug which is a prescription drug as
46 defined in section 2 of P.L.2003, c.280 (C.45:14-41) in a quantity
47 exceeding a five-day supply for treatment of acute pain. ¹Any

1 prescription for acute pain pursuant to this subsection shall be for
2 the lowest effective dose of immediate-release opioid drug.¹

3 b. Prior to issuing an initial prescription of a ¹【course of
4 treatment that includes a】¹ Schedule II controlled dangerous
5 substance or any other opioid drug which is a prescription drug as
6 defined in section 2 of P.L.2003, c.280 (C.45:14-41) ¹in a course of
7 treatment¹ for acute or chronic pain, a practitioner shall:

8 (1) take and document the results of a thorough medical history,
9 including the patient's experience with non-opioid medication and
10 non-pharmacological pain management approaches and substance
11 abuse history;

12 (2) conduct, as appropriate, and document the results of a
13 physical examination;

14 (3) develop a treatment plan, with particular attention focused
15 on determining the cause of the patient's pain;

16 (4) access relevant prescription monitoring information under
17 the Prescription Monitoring Program pursuant to section 8 of
18 P.L.2015, c.74 (C. 45:1-46.1); and

19 (5) limit the supply of any opioid drug prescribed for acute pain
20 to a duration of no more than five days as determined by the
21 directed dosage and frequency of dosage.

22 c. No less than four days after issuing the initial prescription
23 ¹pursuant to subsection a. of this subsection¹, the practitioner, after
24 consultation with the patient, may issue a subsequent prescription
25 for the drug to the patient in any quantity that complies with
26 applicable State and federal laws, provided that:

27 (1) the subsequent prescription would not be deemed an initial
28 prescription under this section;

29 (2) the practitioner determines the prescription is necessary and
30 appropriate to the patient's treatment needs and documents the
31 rationale for the issuance of the subsequent prescription; and

32 (3) the practitioner determines that issuance of the subsequent
33 prescription does not present an undue risk of abuse, addiction, or
34 diversion and documents that determination.

35 d. Prior to issuing the initial prescription of ¹【a course of
36 treatment that includes】¹ a Schedule II controlled dangerous
37 substance or any other opioid drug which is a prescription drug as
38 defined in section 2 of P.L.2003, c.280 (C.45:14-41) ¹in a course of
39 treatment for acute or chronic pain¹ and again prior to issuing the
40 third prescription of the course of treatment, a practitioner shall
41 discuss with the patient, or the patient's parent or guardian if the
42 patient is under 18 years of age and is not an emancipated minor,
43 the risks associated with the drugs being prescribed, including but
44 not limited to:

45 (1) the risks of addiction and overdose associated with opioid
46 drugs and the dangers of taking opioid drugs with alcohol,
47 benzodiazepines and other central nervous system depressants;

- 1 (2) the reasons why the prescription is necessary;
- 2 (3) alternative treatments that may be available; and
- 3 (4) risks associated with the use of the drugs being prescribed,
- 4 specifically that opioids are highly addictive, even when taken as
- 5 prescribed, that there is a risk of developing a physical or
- 6 psychological dependence on the controlled dangerous substance,
- 7 and that the risks of taking more opioids than prescribed, or mixing
- 8 sedatives, benzodiazepines or alcohol with opioids, can result in
- 9 fatal respiratory depression.

10 The practitioner shall ¹【obtain a written acknowledgement, on a
11 form developed and made available by the Division of Consumer
12 Affairs,】 include a note in the patient's medical record¹ that the
13 patient or the patient's parent or guardian, as applicable, has
14 discussed with the practitioner the risks of developing a physical or
15 psychological dependence on the controlled dangerous substance
16 and alternative treatments that may be available. The Division of
17 Consumer Affairs shall develop and make available to practitioners
18 guidelines for the discussion required pursuant to this subsection.

19 e. At the time of the issuance of the third prescription for a
20 prescription opioid drug, the practitioner shall enter into a pain
21 management agreement with the patient.

22 f. When a Schedule II controlled dangerous substance or any
23 other prescription opioid drug is continuously prescribed for three
24 months or more for chronic pain, the practitioner shall:

25 (1) review, at a minimum of every three months, the course of
26 treatment, any new information about the etiology of the pain, and
27 the patient's progress toward treatment objectives and document the
28 results of that review;

29 (2) assess the patient prior to every renewal to determine
30 whether the patient is experiencing problems associated with
31 physical and psychological dependence and document the results of
32 that assessment;

33 (3) periodically make reasonable efforts, unless clinically
34 contraindicated, to either stop the use of the controlled substance,
35 decrease the dosage, try other drugs or treatment modalities in an
36 effort to reduce the potential for abuse or the development of
37 physical or psychological dependence and document with
38 specificity the efforts undertaken;

39 (4) review the Prescription Drug Monitoring information in
40 accordance with section 8 of P.L.2015, c.74 (C. 45:1-46.1); and

41 (5) monitor compliance with the pain management agreement
42 and any recommendations that the patient seek a referral.

43 g. As used in this section:

44 "Acute pain" means pain, whether resulting from disease,
45 accidental or intentional trauma, or other cause, that the practitioner
46 reasonably expects to last only a short period of time. "Acute pain"
47 does not include chronic pain, pain being treated as part of cancer

1 care, hospice or other end of life care, or pain being treated as part
2 of palliative care.

3 “Initial prescription” means a prescription issued to a patient
4 who:

5 (1) has never previously been issued a prescription for the drug
6 or its pharmaceutical equivalent; or

7 (2) was previously issued a prescription for the drug or its
8 pharmaceutical equivalent, but the date on which the current
9 prescription is being issued is more than one year after the date the
10 patient last used or was administered the drug or its equivalent.

11 When determining whether a patient was previously issued a
12 prescription for a drug or its pharmaceutical equivalent, the
13 practitioner shall consult with the patient and review the patient’s
14 medical record and prescription monitoring information.

15 “Pain management agreement” means a written contract or
16 agreement that is executed between a practitioner and a patient,
17 prior to the commencement of treatment for chronic pain using a
18 Schedule II controlled dangerous substance or any other opioid drug
19 which is a prescription drug as defined in section 2 of P.L. 2003, c.
20 280 (C.45:14-41), as a means to:

21 (1) prevent the possible development of physical or
22 psychological dependence in the patient;

23 (2) document the understanding of both the practitioner and the
24 patient regarding the patient’s pain management plan;

25 (3) establish the patient’s rights in association with treatment,
26 and the patient’s obligations in relation to the responsible use,
27 discontinuation of use, and storage of Schedule II controlled
28 dangerous substances, including any restrictions on the refill of
29 prescriptions or the acceptance of Schedule II prescriptions from
30 practitioners;

31 (4) identify the specific medications and other modes of
32 treatment, including physical therapy or exercise, relaxation, or
33 psychological counseling, that are included ¹as¹ a part of the pain
34 management plan;

35 (5) specify the measures the practitioner may employ to monitor
36 the patient’s compliance, including but not limited to random
37 specimen screens and pill counts; and

38 (6) delineate the process for terminating the agreement,
39 including the consequences if the practitioner has reason to believe
40 that the patient is not complying with the terms of the agreement.

41 “Practitioner” means a medical doctor, doctor of osteopathy,
42 dentist, optometrist, podiatrist, physician assistant, certified nurse
43 midwife, or advanced practice nurse ¹, acting within the scope of
44 practice of their professional license pursuant to Title 45 of the
45 Revised Statutes¹.

46 h. This section shall not apply to a prescription for a patient
47 who is currently in active treatment for cancer, receiving hospice
48 care from a licensed hospice or palliative care, or is a resident of a

1 long term care facility, or to any medications that are being
2 prescribed for use in the treatment of substance abuse or opioid
3 dependence.

4 ¹i. Every policy, contract or plan delivered, issued, executed or
5 renewed in this State, or approved for issuance or renewal in this
6 State by the Commissioner of Banking and Insurance, and every
7 contract purchased by the School Employees' Health Benefits
8 Commission or State Health Benefits Commission, on or after the
9 effective date of this act, that provides coverage for prescription
10 drugs subject to a co-payment, coinsurance or deductible shall
11 charge a co-payment, coinsurance or deductible for an initial
12 prescription of an opioid drug prescribed pursuant to this section
13 that is either:

14 (1) proportional between the cost sharing for a 30-day supply
15 and the amount of drugs the patient was prescribed; or

16 (2) equivalent to the cost sharing for a full 30-day supply of the
17 opioid drug, provided that no additional cost sharing may be
18 charged for any additional prescriptions for the remainder of the 30-
19 day supply.¹

20

21 12. Section 1 of P.L.1997, c.249 (C.45:9-22.19) is amended to
22 read as follows:

23 1. a. **[A]** Except in the case of an initial prescription issued
24 pursuant to section 11 of P.L. , c. (C.) (pending before the
25 Legislature as this bill), a physician licensed pursuant to chapter 9
26 of Title 45 of the Revised Statutes may prescribe a Schedule II
27 controlled dangerous substance for the use of a patient in any
28 quantity which does not exceed a 30-day supply, as defined by
29 regulations adopted by the State Board of Medical Examiners in
30 consultation with the Department of Health **[and Senior Services]**.
31 The physician shall document the diagnosis and the medical need
32 for the prescription in the patient's medical record, in accordance
33 with guidelines established by the State Board of Medical
34 Examiners.

35 b. **[A]** Except in the case of an initial prescription issued
36 pursuant to section 11 of P.L. , c. (C.) (pending before the
37 Legislature as this bill), a physician may issue multiple
38 prescriptions authorizing the patient to receive a total of up to a 90-
39 day supply of a Schedule II controlled dangerous substance,
40 provided that the following conditions are met:

41 (1) each separate prescription is issued for a legitimate medical
42 purpose by the physician acting in the usual course of professional
43 practice;

44 (2) the physician provides written instructions on each
45 prescription, other than the first prescription if it is to be filled
46 immediately, indicating the earliest date on which a pharmacy may
47 fill each prescription;

1 (3) the physician determines that providing the patient with
2 multiple prescriptions in this manner does not create an undue risk
3 of diversion or abuse; and

4 (4) the physician complies with all other applicable State and
5 federal laws and regulations.

6 (cf: P.L.2009, c.165, s.1)

7
8 13. (New section) a. The Director of the Division of Consumer
9 Affairs, pursuant to the “Administrative Procedure Act,” P.L.1968,
10 c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to
11 effectuate the purposes of sections 11 and 12 of P.L. , c. (C.)
12 (pending before the Legislature as this bill).

13 b. Notwithstanding the provision of the “Administrative
14 Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.) to the
15 contrary, the Director of the Division of Consumer Affairs may
16 adopt, immediately upon filing with the Office of Administrative
17 Law, and no later than the 90th day after the effective date of this
18 act, such regulations as the director deems necessary to implement
19 any of the provisions of P.L. , c. (C.) (pending before the
20 Legislature as this bill). Regulations adopted pursuant to this
21 subsection shall be effective until the adoption of rules and
22 regulations pursuant to subsection a. of this section, and may be
23 amended, adopted, or readopted by the director in accordance with
24 the requirements of P.L.1968, c.410 (C.52:14B-1 et seq.).

25
26 14. Section 3 of P.L.1991, c.97 (C.45:10-19) is amended to read
27 as follows:

28 3. To qualify to prescribe drugs pursuant to section 2 of **[this**
29 **act]** P.L.1991, c.97 (C.45:10-18), a certified nurse midwife shall
30 have completed 30 contact hours, as defined by the National Task
31 Force on the Continuing Education Unit, in pharmacology or a
32 pharmacology course, acceptable to the board, in an accredited
33 institution of higher education approved by the Department of
34 Higher Education or the board. Such contact hours shall include
35 one credit of educational programs or topics on issues concerning
36 prescription opioid drugs, including responsible prescribing
37 practices, alternatives to opioids for managing and treating pain,
38 and the risks and signs of opioid abuse, addiction, and diversion.

39 (cf: P.L.1991, c.97, s.3)

40
41 15. Section 10 of P.L.1991, c.377 (C.45:11-49) is amended to
42 read as follows:

43 10. a. In addition to all other tasks which a registered
44 professional nurse may, by law, perform, an advanced practice
45 nurse may manage preventive care services and diagnose and
46 manage deviations from wellness and long-term illnesses, consistent
47 with the needs of the patient and within the scope of practice of the
48 advanced practice nurse, by:

- 1 (1) initiating laboratory and other diagnostic tests;
- 2 (2) prescribing or ordering medications and devices, as
3 authorized by subsections b. and c. of this section; and
- 4 (3) prescribing or ordering treatments, including referrals to
5 other licensed health care professionals, and performing specific
6 procedures in accordance with the provisions of this subsection.
- 7 b. An advanced practice nurse may order medications and
8 devices in the inpatient setting, subject to the following conditions:
- 9 (1) the collaborating physician and advanced practice nurse
10 shall address in the joint protocols whether prior consultation with
11 the collaborating physician is required to initiate an order for a
12 controlled dangerous substance;
- 13 (2) the order is written in accordance with standing orders or
14 joint protocols developed in agreement between a collaborating
15 physician and the advanced practice nurse, or pursuant to the
16 specific direction of a physician;
- 17 (3) the advanced practice nurse authorizes the order by signing
18 the nurse's own name, printing the name and certification number,
19 and printing the collaborating physician's name;
- 20 (4) the physician is present or readily available through
21 electronic communications;
- 22 (5) the charts and records of the patients treated by the advanced
23 practice nurse are reviewed by the collaborating physician and the
24 advanced practice nurse within the period of time specified by rule
25 adopted by the Commissioner of Health pursuant to section 13 of
26 P.L.1991, c.377 (C.45:11-52);
- 27 (6) the joint protocols developed by the collaborating physician
28 and the advanced practice nurse are reviewed, updated, and signed
29 at least annually by both parties; and
- 30 (7) the advanced practice nurse has completed six contact hours
31 of continuing professional education in pharmacology related to
32 controlled substances, including pharmacologic therapy **[and]**,
33 addiction prevention and management, and issues concerning
34 prescription opioid drugs, including responsible prescribing
35 practices, alternatives to opioids for managing and treating pain,
36 and the risks and signs of opioid abuse, addiction, and diversion, in
37 accordance with regulations adopted by the New Jersey Board of
38 Nursing. The six contact hours shall be in addition to New Jersey
39 Board of Nursing pharmacology education requirements for
40 advanced practice nurses related to initial certification and
41 recertification of an advanced practice nurse as set forth in
42 N.J.A.C.13:37-7.2.
- 43 c. An advanced practice nurse may prescribe medications and
44 devices in all other medically appropriate settings, subject to the
45 following conditions:
- 46 (1) the collaborating physician and advanced practice nurse
47 shall address in the joint protocols whether prior consultation with

- 1 the collaborating physician is required to initiate a prescription for a
2 controlled dangerous substance;
- 3 (2) the prescription is written in accordance with standing orders
4 or joint protocols developed in agreement between a collaborating
5 physician and the advanced practice nurse, or pursuant to the
6 specific direction of a physician;
- 7 (3) the advanced practice nurse writes the prescription on a New
8 Jersey Prescription Blank pursuant to P.L.2003, c.280 (C.45:14-40
9 et seq.), signs the nurse's own name to the prescription and prints
10 the nurse's name and certification number;
- 11 (4) the prescription is dated and includes the name of the patient
12 and the name, address, and telephone number of the collaborating
13 physician;
- 14 (5) the physician is present or readily available through
15 electronic communications;
- 16 (6) the charts and records of the patients treated by the advanced
17 practice nurse are periodically reviewed by the collaborating
18 physician and the advanced practice nurse;
- 19 (7) the joint protocols developed by the collaborating physician
20 and the advanced practice nurse are reviewed, updated, and signed
21 at least annually by both parties; and
- 22 (8) the advanced practice nurse has completed six contact hours
23 of continuing professional education in pharmacology related to
24 controlled substances, including pharmacologic therapy **[and]**,
25 addiction prevention and management, and issues concerning
26 prescription opioid drugs, including responsible prescribing
27 practices, alternatives to opioids for managing and treating pain,
28 and the risks and signs of opioid abuse, addiction, and diversion, in
29 accordance with regulations adopted by the New Jersey Board of
30 Nursing. The six contact hours shall be in addition to New Jersey
31 Board of Nursing pharmacology education requirements for
32 advanced practice nurses related to initial certification and
33 recertification of an advanced practice nurse as set forth in
34 N.J.A.C.13:37-7.2.
- 35 d. The joint protocols employed pursuant to subsections b. and
36 c. of this section shall conform with standards adopted by the
37 Director of the Division of Consumer Affairs pursuant to section 12
38 of P.L.1991, c.377 (C.45:11-51) or section 10 of P.L.1999, c.85
39 (C.45:11-49.2), as applicable.
- 40 e. (Deleted by amendment, P.L.2004, c.122.)
- 41 f. An attending advanced practice nurse may determine and
42 certify the cause of death of the nurse's patient and execute the
43 death certification pursuant to R.S.26:6-8 if no collaborating
44 physician is available to do so and the nurse is the patient's primary
45 caregiver.
- 46 (cf: P.L.2015, c.38, s.3)
- 47
- 48 16. R.S.45:12-1 is amended to read as follows:

1 45:12-1. Optometry is hereby declared to be a profession, and
2 the practice of optometry is defined to be the employment of
3 objective or subjective means, or both, for the examination of the
4 human eye and adnexae for the purposes of ascertaining any
5 departure from the normal, measuring its powers of vision and
6 adapting lenses or prisms for the aid thereof, or the use and
7 prescription of pharmaceutical agents, excluding injections, except
8 for injections to counter anaphylactic reaction **[.]**; and excluding
9 controlled dangerous substances as provided in sections 5 and 6 of
10 P.L.1970, c.226 (C.24:21-5 and C.24:21-6), except as otherwise
11 authorized by section 9 of P.L.1991, c.385 (C.45:12-9.11), for the
12 purposes of treating deficiencies, deformities, diseases, or
13 abnormalities of the human eye and adnexae, including the removal
14 of superficial foreign bodies from the eye and adnexae.

15 An optometrist utilizing pharmaceutical agents for the purposes
16 of treatment of ocular conditions and diseases shall be held to a
17 standard of patient care in the use of such agents commensurate to
18 that of a physician utilizing pharmaceutical agents for treatment
19 purposes.

20 A person shall be deemed to be practicing optometry within the
21 meaning of this chapter who in any way advertises himself as an
22 optometrist, or who shall employ any means for the measurement of
23 the powers of vision or the adaptation of lenses or prisms for the aid
24 thereof, practice, offer or attempt to practice optometry as herein
25 defined, either on his own behalf or as an employee or student of
26 another, whether under the personal supervision of his employer or
27 perceptor or not, or to use testing appliances for the purposes of
28 measurement of the powers of vision or diagnose any ocular
29 deficiency or deformity, visual or muscular anomaly of the human
30 eye and adnexae or prescribe lenses, prisms or ocular exercise for
31 the correction or the relief thereof, or who uses or prescribes
32 pharmaceutical agents for the purposes of diagnosing and treating
33 deficiencies, deformities, diseases or abnormalities of the human
34 eye and adnexae or who holds himself out as qualified to practice
35 optometry.

36 (cf: P.L.2004, c.115, s.1)

37

38 17. Section 3 of P.L.1975, c.24 (C.45:12-9.3) is amended to read
39 as follows:

40 3. Fifty credits of continuing professional optometric education
41 shall be required biennially of each New Jersey optometrist holding
42 an active license during the period preceding the established license
43 renewal date. Each credit shall represent or be equivalent to one
44 hour of actual course attendance or in the case of those electing an
45 alternative method of satisfying the requirements of this act shall be
46 approved by the board and certified to the board on forms to be
47 provided for that purpose. Of the 50 credits biennially required
48 under this section, at least one credit shall be for educational

1 programs or topics that concern the prescription of hydrocodone, or
2 the prescription of opioid drugs in general, including responsible
3 prescribing practices, the alternatives to the use of opioids for the
4 management and treatment of pain, and the risks and signs of opioid
5 abuse, addiction, and diversion.

6 (cf: P.L.1975, c.24, s.3)

7
8 18. (New section) a. The New Jersey State Board of Dentistry
9 shall require that the number of credits of continuing dental
10 education required of each person licensed as a dentist, as a
11 condition of biennial registration pursuant to R.S.45:6-10 and
12 section 1 of P.L.1972, c.108 (C.45:1-7), include one credit of
13 educational programs or topics concerning prescription opioid
14 drugs, including responsible prescribing practices, alternatives to
15 opioids for managing and treating pain, and the risks and signs of
16 opioid abuse, addiction, and diversion. The continuing dental
17 education requirement in this subsection shall be subject to the
18 provisions of P.L.1991, c.490 (C.45:6-10.1 et seq.), including, but
19 not limited to, the authority of the board to waive the provisions of
20 this section for a specific individual if the board deems it is
21 appropriate to do so.

22 b. The New Jersey State Board of Dentistry, pursuant to the
23 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
24 seq.), shall adopt such rules and regulations as are necessary to
25 effectuate the purposes of this section.

26
27 19. (New section) a. The State Board of Medical Examiners
28 shall require that the number of credits of continuing medical
29 education required of each person licensed as a physician, as a
30 condition of biennial registration pursuant to section 1 of P.L.1971,
31 c.236 (C.45:9-6.1), include one credit of educational programs or
32 topics concerning prescription opioid drugs, including responsible
33 prescribing practices, alternatives to opioids for managing and
34 treating pain, and the risks and signs of opioid abuse, addiction, and
35 diversion. The continuing medical education requirement in this
36 subsection shall be subject to the provisions of section 10 of
37 P.L.2001, c.307 (C.45:9-7.1), including, but not limited to, the
38 authority of the board to waive the provisions of this section for a
39 specific individual if the board deems it is appropriate to do so.

40 b. The State Board of Medical Examiners, pursuant to the
41 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
42 seq.), shall adopt such rules and regulations as are necessary to
43 effectuate the purposes of this section.

44
45 20. (New section) a. The State Board of Medical Examiners
46 shall require that the number of credits of continuing medical
47 education required of each person licensed as a physician assistant,
48 as a condition of biennial renewal pursuant to section 4 of P.L.1991,

1 c.378 (C.45:9-27.13), include one credit of educational programs or
2 topics concerning prescription opioid drugs, including responsible
3 prescribing practices, alternatives to opioids for managing and
4 treating pain, and the risks and signs of opioid abuse, addiction, and
5 diversion. The continuing medical education requirement in this
6 subsection shall be subject to the provisions of section 16 of
7 P.L.1991, c.378 (C.45:9-27.25), including, but not limited to, the
8 authority of the board to waive the provisions of this section for a
9 specific individual if the board deems it is appropriate to do so.

10 b. The State Board of Medical Examiners, pursuant to the
11 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
12 seq.), shall adopt such rules and regulations as are necessary to
13 effectuate the purposes of this section.

14

15 21. (New section) a. The New Jersey Board of Nursing shall
16 require that the number of credits of continuing education required
17 of each person licensed as a professional nurse or a practical nurse,
18 as a condition of biennial license renewal, include one credit of
19 educational programs or topics concerning prescription opioid
20 drugs, including alternatives to opioids for managing and treating
21 pain and the risks and signs of opioid abuse, addiction, and
22 diversion.

23 b. The board may, in its discretion, waive the continuing
24 education requirement in subsection a. of this section on an
25 individual basis for reasons of hardship, such as illness or disability,
26 retirement of the license, or other good cause. A waiver shall apply
27 only to the current biennial renewal period at the time of board
28 issuance.

29 c. The New Jersey Board of Nursing, pursuant to the
30 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
31 seq.), shall adopt such rules and regulations as are necessary to
32 effectuate the purposes of this section.

33

34 22. (New section) a. The New Jersey State Board of Pharmacy
35 shall require that the number of credits of continuing pharmacy
36 education required of each person registered as a pharmacist, as a
37 condition of biennial renewal certification, include one credit of
38 educational programs or topics concerning prescription opioid
39 drugs, including alternatives to opioids for managing and treating
40 pain and the risks and signs of opioid abuse, addiction, and
41 diversion. The continuing pharmacy education requirement in this
42 subsection shall be subject to the provisions of section 15 of
43 P.L.2003, c.280 (C.45:14-54), including, but not limited to, the
44 authority of the board to waive the provisions of this section for a
45 specific individual if the board deems it is appropriate to do so.

46 b. The New Jersey State Board of Pharmacy, pursuant to the
47 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et

1 seq.), shall adopt such rules and regulations as are necessary to
2 effectuate the purposes of this section.

3
4 23. (New section) The Commissioner of Health, in consultation
5 with the Commissioner of Banking and Insurance, shall submit
6 reports at two intervals to the Legislature, pursuant to section 2 of
7 P.L.1991, c.164 (C.52:14-19.1), and the Governor. The first report
8 shall be submitted six months, and the second report shall be
9 submitted 12 months, after the date of enactment of this act. The
10 reports shall evaluate the implementation and impact of the act's
11 provisions and make recommendations regarding revisions to the
12 statutes that may be appropriate. The report shall include, but not
13 be limited to, an evaluation of the following:

14 a. The effects of the five-day supply limitation on
15 prescriptions, and other requirements concerning the prescribing of
16 opioids and other drugs pursuant to section 11 of the act, including
17 the impact of these provisions on patients with chronic pain and the
18 impact on patient cost sharing; and

19 b. The effects of the provisions of the bill providing that if
20 there is no in-network facility immediately available for a covered
21 person to receive treatment, a carrier shall provide necessary
22 exceptions to their network to ensure admission in a treatment
23 facility within 24 hours, including the impact of these provisions on
24 the availability of treatment beds for patients, the impact on
25 facilities in the State, and the costs associated with these provisions.

26
27 24. The following sections are repealed:
28 P.L.1977, c.115 (C.17:48-6a);
29 P.L.1977, c.116 (C.17B:27-46.1);
30 P.L.1977, c.117 (C.17:48A-7a);
31 P.L.1977, c.118 (C.17B:26-2.1); and
32 Section 34 of P.L.1985, c.236 (C.17:48E-34).

33
34 25. This bill shall take effect on the 90th day next after
35 enactment.

36
37
38 _____
39
40 Requires health insurance coverage for treatment of substance
41 use disorders; places certain restrictions on the prescription of
42 opioid and certain other drugs; concerns continuing education
43 related thereto.

SENATE, No. 3

STATE OF NEW JERSEY 217th LEGISLATURE

INTRODUCED JANUARY 30, 2017

Sponsored by:

Senator JOSEPH F. VITALE

District 19 (Middlesex)

Senator STEPHEN M. SWEENEY

District 3 (Cumberland, Gloucester and Salem)

Senator THOMAS H. KEAN, JR.

District 21 (Morris, Somerset and Union)

Co-Sponsored by:

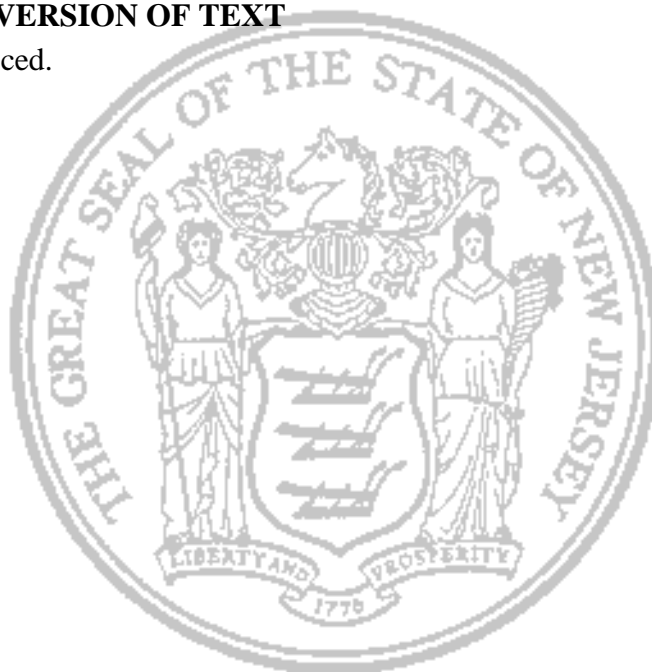
Senators Addiego, Gordon, Madden and Turner

SYNOPSIS

Requires health insurance coverage for treatment of substance use disorders; places certain restrictions on the prescription of opioid and certain other drugs; concerns continuing education related thereto.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 1/31/2017)

1 AN ACT concerning substance use disorders and revising and
2 supplementing various parts of the statutory law.

3

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

6

7 1. (New section) a. A hospital service corporation contract
8 that provides hospital or medical expense benefits and is delivered,
9 issued, executed or renewed in this State, or approved for issuance
10 or renewal in this State by the Commissioner of Banking and
11 Insurance, on or after the effective date of this act, shall provide
12 unlimited benefits for inpatient and outpatient treatment of
13 substance use disorder at in-network facilities. The services for the
14 treatment of substance use disorder shall be prescribed by a licensed
15 physician, licensed psychologist, or licensed psychiatrist and
16 provided by licensed health care professionals or licensed or
17 certified substance use disorder providers in licensed or otherwise
18 State-approved facilities, as required by the laws of the state in
19 which the services are rendered.

20 b. The benefits for the first 180 days per plan year of inpatient
21 and outpatient treatment of substance use disorder shall be provided
22 when determined medically necessary by the covered person's
23 physician, psychologist or psychiatrist without the imposition of
24 any prior authorization or other prospective utilization management
25 requirements. If there is no in-network facility immediately
26 available for a covered person, a hospital service corporation shall
27 provide necessary exceptions to its network to ensure admission in
28 a treatment facility within 24 hours.

29 c. Providers of treatment for substance use disorder to persons
30 covered under a covered contract shall not require pre-payment of
31 medical expenses during this 180 days in excess of applicable co-
32 payment, deductible, or co-insurance under the contract.

33 d. The benefits for outpatient visits shall not be subject to
34 concurrent or retrospective review of medical necessity or any other
35 utilization management review.

36 e. (1) The benefits for the first 28 days of an inpatient stay
37 during each plan year shall be provided without any retrospective
38 review or concurrent review of medical necessity and medical
39 necessity shall be as determined by the covered person's physician.

40 (2) The benefits for days 29 and thereafter of inpatient care shall
41 be subject to concurrent review as defined in this section. A request
42 for approval of inpatient care beyond the first 28 days shall be
43 submitted for concurrent review before the expiration of the initial
44 28 day period. A request for approval of inpatient care beyond any
45 period that is approved under concurrent review shall be submitted

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 within the period that was previously approved. No hospital service
2 corporation shall initiate concurrent review more frequently than
3 three-week intervals. If a hospital service corporation determines
4 that continued inpatient care in a facility is no longer medically
5 necessary, the hospital service corporation shall within 24 hours
6 provide written notice to the covered person and the covered
7 person's physician of its decision and the right to file an expedited
8 internal appeal of the determination pursuant to an expedited
9 process pursuant to sections 11 through 13 of P.L.1997, c.192
10 (C.26:2S-11 through 26:2S-13) and N.J.AC.11:24A-3.5, as
11 applicable. The hospital service corporation shall review and make
12 a determination with respect to the internal appeal within 24 hours
13 and communicate such determination to the covered person and the
14 covered person's physician. If the determination is to uphold the
15 denial, the covered person and the covered person's physician have
16 the right to file an expedited external appeal with the Independent
17 Health Care Appeals Program in the Department of Banking and
18 Insurance pursuant to sections 11 through 13 of P.L.1997, c.192
19 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as
20 applicable. An independent utilization review organization shall
21 make a determination within 24 hours. If the hospital service
22 corporation's determination is upheld and it is determined
23 continued inpatient care is not medically necessary, the hospital
24 service corporation shall remain responsible to provide benefits for
25 the inpatient care through the day following the date the
26 determination is made and the covered person shall only be
27 responsible for any applicable co-payment, deductible and co-
28 insurance for the stay through that date as applicable under the
29 contract. The covered person shall not be discharged or released
30 from the inpatient facility until all internal appeals and independent
31 utilization review organization appeals are exhausted. For any costs
32 incurred after the day following the date of determination until the
33 day of discharge, the covered person shall only be responsible for
34 any applicable cost-sharing, and any additional charges shall be
35 paid by the facility or provider.

36 f. (1) The benefits for the first 28 days of intensive outpatient
37 or partial hospitalization services shall be provided without any
38 retrospective review of medical necessity and medical necessity
39 shall be as determined by the covered person's physician.

40 (2) The benefits for days 29 and thereafter of intensive
41 outpatient or partial hospitalization services shall be subject to a
42 retrospective review of the medical necessity of the services.

43 g. Benefits for inpatient and outpatient treatment of substance
44 use disorder after the first 180 days per plan year shall be subject to
45 the medical necessity determination of the hospital service
46 corporation and may be subject to prior authorization or,
47 retrospective review and other utilization management
48 requirements.

- 1 h. Medical necessity review shall utilize an evidence-based and
2 peer reviewed clinical review tool to be designated through
3 rulemaking by the Commissioner of Human Services in
4 consultation with the Department of Health.
- 5 i. The benefits for outpatient prescription drugs to treat
6 substance use disorder shall be provided when determined
7 medically necessary by the covered person's physician,
8 psychologist or psychiatrist without the imposition of any prior
9 authorization or other prospective utilization management
10 requirements.
- 11 j. The first 180 days per plan year of benefits shall be
12 computed based on inpatient days. One or more unused inpatient
13 days may be exchanged for two outpatient visits. All extended
14 outpatient services such as partial hospitalization and intensive
15 outpatient, shall be deemed inpatient days for the purpose of the
16 visit to day exchange provided in this subsection.
- 17 k. Except as stated above, the benefits and cost-sharing shall be
18 provided to the same extent as for any other medical condition
19 covered under the contract.
- 20 l. The benefits required by this section are to be provided to all
21 covered persons with a diagnosis of substance use disorder. The
22 presence of additional related or unrelated diagnoses shall not be a
23 basis to reduce or deny the benefits required by this section.
- 24 m. The provisions of this section shall apply to all hospital
25 service corporation contracts in which the hospital service
26 corporation has reserved the right to change the premium.
- 27 n. The Attorney General's Office shall be responsible for
28 overseeing any violations of law that may result from P.L. ,
29 c. (C.) (pending before the Legislature as this bill), including
30 fraud, abuse, waste, and mistreatment of covered persons. The
31 Attorney General's Office is authorized to adopt, pursuant to the
32 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
33 seq.), rules and regulations to implement any of the provisions of
34 P.L. , c. (C.) (pending before the Legislature as this bill).
- 35 o. The provisions of this section shall not apply to a hospital
36 service corporation contract which, pursuant to a contract between
37 the hospital service corporation and the Department of Human
38 Services, provides benefits to persons who are eligible for medical
39 assistance under P.L.168, c.413 (C.30:4D-1 et seq.), the "Family
40 Health Care Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.), or
41 any other program administered by the Division of Medical
42 Assistance and Health Services in the Department of Human
43 Services.
- 44 p. As used in this section:
45 "Concurrent review" means inpatient care is reviewed as it is
46 provided. Medically qualified reviewers monitor appropriateness of
47 the care, the setting, and patient progress, and as appropriate, the
48 discharge plans.

1 “Substance use disorder” is as defined by the American
2 Psychiatric Association in the Diagnostic and Statistical Manual of
3 Mental Disorders, Fifth Edition and any subsequent editions and
4 shall include substance use withdrawal.

5
6 2. (New section) a. A medical service corporation contract
7 that provides hospital or medical expense benefits and is delivered,
8 issued, executed or renewed in this State, or approved for issuance
9 or renewal in this State by the Commissioner of Banking and
10 Insurance, on or after the effective date of this act, shall provide
11 unlimited benefits for inpatient and outpatient treatment of
12 substance use disorder at in-network facilities. The services for the
13 treatment of substance use disorder shall be prescribed by a licensed
14 physician, licensed psychologist, or licensed psychiatrist and
15 provided by licensed health care professionals or licensed or
16 certified substance use disorder providers in licensed or otherwise
17 State-approved facilities, as required by the laws of the state in
18 which the services are rendered.

19 b. The benefits for the first 180 days per plan year of inpatient
20 and outpatient treatment of substance use disorder shall be provided
21 when determined medically necessary by the covered person’s
22 physician, psychologist or psychiatrist without the imposition of
23 any prior authorization or other prospective utilization management
24 requirements. If there is no in-network facility immediately
25 available for a covered person, a medical service corporation shall
26 provide necessary exceptions to its network to ensure admission in
27 a treatment facility within 24 hours.

28 c. Providers of treatment for substance use disorder to persons
29 covered under a covered contract shall not require pre-payment of
30 medical expenses during this 180 days in excess of applicable co-
31 payment, deductible, or co-insurance under the contract.

32 d. The benefits for outpatient visits shall not be subject to
33 concurrent or retrospective review of medical necessity or any other
34 utilization management review.

35 e. (1) The benefits for the first 28 days of an inpatient stay
36 during each plan year shall be provided without any retrospective
37 review or concurrent review of medical necessity and medical
38 necessity shall be as determined by the covered person’s physician.

39 (2) The benefits for days 29 and thereafter of inpatient care shall
40 be subject to concurrent review as defined in this section. A request
41 for approval of inpatient care beyond the first 28 days shall be
42 submitted for concurrent review before the expiration of the initial
43 28 day period. A request for approval of inpatient care beyond any
44 period that is approved under concurrent review shall be submitted
45 within the period that was previously approved. No medical service
46 corporation shall initiate concurrent review more frequently than
47 three-week intervals. If a medical service corporation determines
48 that continued inpatient confinement in a facility is no longer

1 medically necessary, the medical service corporation shall within 24
2 hours provide written notice to the covered person and the covered
3 person's physician of its decision and the right to file an expedited
4 internal appeal of the determination pursuant to an expedited
5 process pursuant to sections 11 through 13 of P.L.1997, c.192
6 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as
7 applicable. The medical service corporation shall review and make
8 a determination with respect to the internal appeal within 24 hours
9 and communicate such determination to the covered person and the
10 covered person's physician. If the determination is to uphold the
11 denial, the covered person and the covered person's physician have
12 the right to file an expedited external appeal with the Independent
13 Health Care Appeals Program in the Department of Banking and
14 Insurance pursuant to sections 11 through 13 of P.L.1997, c.192
15 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as
16 applicable. An independent utilization review organization shall
17 make a determination within 24 hours. If the medical service
18 corporation's determination is upheld and it is determined
19 continued inpatient care is not medically necessary, the medical
20 service corporation shall remain responsible to provide benefits for
21 the inpatient care through the day following the date the
22 determination is made and the covered person shall only be
23 responsible for any applicable co-payment, deductible and co-
24 insurance for the stay through that date as applicable under the
25 contract. The covered person shall not be discharged or released
26 from the inpatient facility until all internal appeals and independent
27 utilization review organization appeals are exhausted. For any costs
28 incurred after the day following the date of determination until the
29 day of discharge, the covered person shall only be responsible for
30 any applicable cost-sharing, and any additional charges shall be
31 paid by the facility or provider.

32 f. (1) The benefits for the first 28 days of intensive outpatient
33 or partial hospitalization services shall be provided without any
34 retrospective review of medical necessity and medical necessity
35 shall be as determined by the covered person's physician.

36 (2) The benefits for days 29 and thereafter of intensive
37 outpatient or partial hospitalization services shall be subject to a
38 retrospective review of the medical necessity of the services.

39 g. Benefits for inpatient and outpatient treatment of substance
40 use disorder after the first 180 days per plan year shall be subject to
41 the medical necessity determination of the medical service
42 corporation and may be subject to prior authorization or,
43 retrospective review and other utilization management
44 requirements.

45 h. Medical necessity review shall utilize an evidence-based and
46 peer reviewed clinical review tool to be designated through
47 rulemaking by the Commissioner of Human Services in
48 consultation with the Department of Health.

1 i. The benefits for medication-assisted treatments for
2 substance use disorder shall be provided when determined
3 medically necessary by the covered person's physician,
4 psychologist or psychiatrist without the imposition of any prior
5 authorization or other prospective utilization management
6 requirements.

7 j. The first 180 days per plan year of benefits shall be
8 computed based on inpatient days. One or more unused inpatient
9 days may be exchanged for two outpatient visits. All extended
10 outpatient services such as partial hospitalization and intensive
11 outpatient, shall be deemed inpatient days for the purpose of the
12 visit to day exchange provided in this subsection.

13 k. Except as stated above, the benefits and cost-sharing shall be
14 provided to the same extent as for any other medical condition
15 covered under the contract.

16 l. The benefits required by this section are to be provided to all
17 covered persons with a diagnosis of substance use disorder. The
18 presence of additional related or unrelated diagnoses shall not be a
19 basis to reduce or deny the benefits required by this section.

20 m. The provisions of this section shall apply to all medical
21 service corporation contracts in which the medical service
22 corporation has reserved the right to change the premium.

23 n. The Attorney General's office shall be responsible for
24 overseeing any violations of law that may result from P.L. ,
25 c. (C.) (pending before the Legislature as this bill), including
26 fraud, abuse, waste, and mistreatment of covered persons. The
27 Attorney General's office is authorized to adopt, pursuant to the
28 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
29 eq.), rules and regulations to implement any of the provisions of
30 P.L. , c. (C.) (pending before the Legislature as this bill).

31 o. The provisions of this section shall not apply to a medical
32 service corporation contract which, pursuant to a contract between
33 the medical service corporation and the Department of Human
34 Services, provides benefits to persons who are eligible for medical
35 assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family
36 Health Care Coverage Act," P.L.2005, c.156 (C.30:2J-8 et seq.), or
37 any other program administered by the Division of Medical
38 Assistance and Health Services in the Department of Human
39 Services.

40 p. As used in this section:

41 "Concurrent review" means inpatient care is reviewed as it is
42 provided. Medically qualified reviewers monitor appropriateness of
43 the care, the setting, and patient progress, and as appropriate, the
44 discharge plans.

45 "Substance use disorder" is as defined by the American
46 Psychiatric Association in the Diagnostic and Statistical Manual of
47 Mental Disorders, Fifth Edition and any subsequent editions and
48 shall include substance use withdrawal.

1 3. (New section) a. A health service corporation contract that
2 provides hospital or medical expense benefits and is delivered,
3 issued, executed or renewed in this State, or approved for issuance
4 or renewal in this State by the Commissioner of Banking and
5 Insurance, on or after the effective date of this act shall provide
6 unlimited benefits for inpatient and outpatient treatment of
7 substance use disorder at in-network facilities. The services for the
8 treatment of substance use disorder shall be prescribed by a licensed
9 physician, licensed psychologist, or licensed psychiatrist and
10 provided by licensed health care professionals or licensed or
11 certified substance use disorder providers in licensed or otherwise
12 State-approved facilities, as required by the laws of the state in
13 which the services are rendered.

14 b. The benefits for the first 180 days per plan year of inpatient
15 and outpatient treatment of substance use disorder shall be provided
16 when determined medically necessary by the covered person's
17 physician, psychologist or psychiatrist without the imposition of
18 any prior authorization or other prospective utilization management
19 requirements. If there is no in-network facility immediately
20 available for a covered person, a health service corporation shall
21 provide necessary exceptions to its network to ensure admission in
22 a treatment facility within 24 hours.

23 c. Providers of treatment for substance use disorder to persons
24 covered under a covered contract shall not require pre-payment of
25 medical expenses during this 180 days in excess of applicable co-
26 payment, deductible, or co-insurance under the contract.

27 d. The benefits for outpatient visits shall not be subject to
28 concurrent or retrospective review of medical necessity or any other
29 utilization management review.

30 e. (1) The benefits for the first 28 days of an inpatient stay
31 during each plan year shall be provided without any retrospective
32 review or concurrent review of medical necessity and medical
33 necessity shall be as determined by the covered person's physician.

34 (2) The benefits for days 29 and thereafter of inpatient care shall
35 be subject to concurrent review as defined in this section. A request
36 for approval of inpatient care beyond the first 28 days shall be
37 submitted for concurrent review before the expiration of the initial
38 28 day period. A request for approval of inpatient care beyond any
39 period that is approved under concurrent review shall be submitted
40 within the period that was previously approved. No health service
41 corporation shall initiate concurrent review more frequently than
42 three-week intervals. If a health service corporation determines that
43 continued inpatient care in a facility is no longer medically
44 necessary, the health service corporation shall within 24 hours
45 provide written notice to the covered person and the covered
46 person's physician of its decision and the right to file an expedited
47 internal appeal of the determination pursuant to an expedited
48 process pursuant to sections 11 through 13 of P.L.1997, c.192

1 (C.26:2S-11 through 26:2S-13) and N.J.AC.11:24A-3.5, as
2 applicable. The health service corporation shall review and make a
3 determination with respect to the internal appeal within 24 hours
4 and communicate such determination to the covered person and the
5 covered person's physician. If the determination is to uphold the
6 denial, the covered person and the covered person's physician have
7 the right to file an expedited external appeal with the Independent
8 Health Care Appeals Program in the Department of Banking and
9 Insurance pursuant to sections 11 through 13 of P.L.1997, c.192
10 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as
11 applicable. An independent utilization review organization shall
12 make a determination within 24 hours. If the health service
13 corporation's determination is upheld and it is determined
14 continued inpatient care is not medically necessary, the health
15 service corporation shall remain responsible to provide benefits for
16 the inpatient care through the day following the date the
17 determination is made and the covered person shall only be
18 responsible for any applicable co-payment, deductible and co-
19 insurance for the stay through that date as applicable under the
20 policy. The covered person shall not be discharged or released
21 from the inpatient facility until all internal appeals and independent
22 utilization review organization appeals are exhausted. For any costs
23 incurred after the day following the date of determination until the
24 day of discharge, the covered person shall only be responsible for
25 any applicable cost-sharing, and any additional charges shall be
26 paid by the facility or provider.

27 f. (1) The benefits for the first 28 days of intensive outpatient
28 or partial hospitalization services shall be provided without any
29 retrospective review of medical necessity and medical necessity
30 shall be as determined by the covered person's physician.

31 (2) The benefits for days 29 and thereafter of intensive
32 outpatient or partial hospitalization services shall be subject to a
33 retrospective review of the medical necessity of the services.

34 g. Benefits for inpatient and outpatient treatment of substance
35 use disorder after the first 180 days per plan year shall be subject to
36 the medical necessity determination of the health service
37 corporation and may be subject to prior authorization or,
38 retrospective review and other utilization management
39 requirements.

40 h. Medical necessity review shall utilize an evidence-based and
41 peer reviewed clinical review tool to be designated through
42 rulemaking by the Commissioner of Human Services in
43 consultation with the Department of Health.

44 i. The benefits for outpatient prescription drugs to treat
45 substance use disorder shall be provided when determined
46 medically necessary by the covered person's physician,
47 psychologist or psychiatrist without the imposition of any prior

1 authorization or other prospective utilization management
2 requirements.

3 j. The first 180 days per plan year of benefits shall be
4 computed based on inpatient days. One or more unused inpatient
5 days may be exchanged for two outpatient visits. All extended
6 outpatient services such as partial hospitalization and intensive
7 outpatient, shall be deemed inpatient days for the purpose of the
8 visit to day exchange provided in this subsection.

9 k. Except as stated above, the benefits and cost-sharing shall be
10 provided to the same extent as for any other medical condition
11 covered under the contract.

12 l. The benefits required by this section are to be provided to all
13 covered persons with a diagnosis of substance use disorder. The
14 presence of additional related or unrelated diagnoses shall not be a
15 basis to reduce or deny the benefits required by this section.

16 m. The provisions of this section shall apply to all health
17 service corporation contracts in which the health service
18 corporation has reserved the right to change the premium.

19 n. The Attorney General's Office shall be responsible for
20 overseeing any violations of law that may result from P.L. ,
21 c. (C.) (pending before the Legislature as this bill), including
22 fraud, abuse, waste, and mistreatment of covered persons. The
23 Attorney General's office is authorized to adopt, pursuant to the
24 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
25 seq.), rules and regulations to implement any of the provisions of
26 P.L. , c. (C.) (pending before the Legislature as this bill).

27 o. The provisions of this section shall not apply to a health
28 service corporation contract which, pursuant to a contract between
29 the health service corporation and the Department of Human
30 Services, provides benefits to persons who are eligible for medical
31 assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family
32 Health Care Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.) or
33 any other program administered by the Division of Medical
34 Assistance and Health Services in the Department of Human
35 Services.

36 p. As used in this section:

37 "Concurrent review" means inpatient care is reviewed as it is
38 provided. Medically qualified reviewers monitor appropriateness of
39 the care, the setting, and patient progress, and as appropriate, the
40 discharge plans.

41 "Substance use disorder" is as defined by the American
42 Psychiatric Association in the Diagnostic and Statistical Manual of
43 Mental Disorders, Fifth Edition and any subsequent editions and
44 shall include substance use withdrawal.

45

46 4. (New section) a. An individual health insurance policy that
47 provides hospital or medical expense benefits and is delivered,
48 issued, executed or renewed in this State, or approved for issuance

1 or renewal in this State by the Commissioner of Banking and
2 Insurance, on or after the effective date of this act, shall provide
3 unlimited benefits for inpatient and outpatient treatment of
4 substance use disorder at in-network facilities. The services for the
5 treatment of substance use disorder shall be prescribed by a licensed
6 physician, licensed psychologist, or licensed psychiatrist and
7 provided by licensed health care professionals or licensed or
8 certified substance use disorder providers in licensed or otherwise
9 State-approved facilities, as required by the laws of the state in
10 which the services are rendered.

11 b. The benefits for the first 180 days per plan year of inpatient
12 and outpatient treatment of substance use disorder shall be provided
13 when determined medically necessary by the covered person's
14 physician, psychologist or psychiatrist without the imposition of
15 any prior authorization or other prospective utilization management
16 requirements. If there is no in-network facility immediately
17 available for a covered person, an insurer shall provide necessary
18 exceptions to their network to ensure admission in a treatment
19 facility within 24 hours.

20 c. Providers of treatment for substance use disorder to persons
21 covered under a covered policy shall not require pre-payment of
22 medical expenses during this 180 days in excess of applicable co-
23 payment, deductible, or co-insurance under the policy.

24 d. The benefits for outpatient visits shall not be subject to
25 concurrent or retrospective review of medical necessity or any other
26 utilization management review.

27 e. (1) The benefits for the first 28 days of an inpatient stay
28 during each plan year shall be provided without any retrospective
29 review or concurrent review of medical necessity and medical
30 necessity shall be as determined by the covered person's physician.

31 (2) The benefits for days 29 and thereafter of inpatient care shall
32 be subject to concurrent review as defined in this section. A request
33 for approval of inpatient care beyond the first 28 days shall be
34 submitted for concurrent review before the expiration of the initial
35 28 day period. A request for approval of inpatient care beyond any
36 period that is approved under concurrent review shall be submitted
37 within the period that was previously approved. No insurer shall
38 initiate concurrent review more frequently than three-week
39 intervals. If an insurer determines that continued inpatient care in a
40 facility is no longer medically necessary, the insurer shall within 24
41 hours provide written notice to the covered person and the covered
42 person's physician of its decision and the right to file an expedited
43 internal appeal of the determination pursuant to an expedited
44 process pursuant to sections 11 through 13 of P.L.1997, c.192
45 (C.26:2S-11 through 26:2S-13) and N.J.AC.11:24A-3.5, as
46 applicable. The insurer shall review and make a determination with
47 respect to the internal appeal within 24 hours and communicate
48 such determination to the covered person and the covered person's

1 physician. If the determination is to uphold the denial, the covered
2 person and the covered person's physician have the right to file an
3 expedited external appeal with the Independent Health Care
4 Appeals Program in the Department of Banking and Insurance
5 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
6 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
7 independent utilization review organization shall make a
8 determination within 24 hours. If the insurer's determination is
9 upheld and it is determined continued inpatient care is not
10 medically necessary, the insurer shall remain responsible to provide
11 benefits for the inpatient care through the day following the date the
12 determination is made and the covered person shall only be
13 responsible for any applicable co-payment, deductible and co-
14 insurance for the stay through that date as applicable under the
15 policy. The covered person shall not be discharged or released
16 from the inpatient facility until all internal appeals and independent
17 utilization review organization appeals are exhausted. For any costs
18 incurred after the day following the date of determination until the
19 day of discharge, the covered person shall only be responsible for
20 any applicable cost-sharing, and any additional charges shall be
21 paid by the facility or provider.

22 f. (1) The benefits for the first 28 days of intensive outpatient
23 or partial hospitalization services shall be provided without any
24 retrospective review of medical necessity and medical necessity
25 shall be as determined by the covered person's physician.

26 (2) The benefits for days 29 and thereafter of intensive
27 outpatient or partial hospitalization services shall be subject to a
28 retrospective review of the medical necessity of the services.

29 g. Benefits for inpatient and outpatient treatment of substance
30 use disorder after the first 180 days per plan year shall be subject to
31 the medical necessity determination of the insurer and may be
32 subject to prior authorization or, retrospective review and other
33 utilization management requirements.

34 h. Medical necessity review shall utilize an evidence-based and
35 peer reviewed clinical review tool to be designated through
36 rulemaking by the Commissioner of Human Services in
37 consultation with the Department of Health.

38 i. The benefits for outpatient prescription drugs to treat
39 substance use disorder shall be provided when determined
40 medically necessary by the covered person's physician,
41 psychologist or psychiatrist without the imposition of any prior
42 authorization or other prospective utilization management
43 requirements.

44 j. The first 180 days per plan year of benefits shall be
45 computed based on inpatient days. One or more unused inpatient
46 days may be exchanged for two outpatient visits. All extended
47 outpatient services such as partial hospitalization and intensive

- 1 outpatient, shall be deemed inpatient days for the purpose of the
2 visit to day exchange provided in this subsection.
- 3 k. Except as stated above, the benefits and cost-sharing shall be
4 provided to the same extent as for any other medical condition
5 covered under the policy.
- 6 l. The benefits required by this section are to be provided to all
7 covered persons with a diagnosis of substance use disorder. The
8 presence of additional related or unrelated diagnoses shall not be a
9 basis to reduce or deny the benefits required by this section.
- 10 m. The provisions of this section shall apply to those policies in
11 which the insurer has reserved the right to change the premium.
- 12 n. The Attorney General's Office shall be responsible for
13 overseeing any violations of law that may result from P.L. ,
14 c. (C.) (pending before the Legislature as this bill), including
15 fraud, abuse, waste, and mistreatment of covered persons. The
16 Attorney General's Office is authorized to adopt, pursuant to the
17 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
18 seq.), rules and regulations to implement any of the provisions of
19 P.L. , c. (C.) (pending before the Legislature as this bill).
- 20 o. The provisions of this section shall not apply to an
21 individual health insurance policy which, pursuant to a contract
22 between the insurer and the Department of Human Services,
23 provides benefits to persons who are eligible for medical assistance
24 under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family Health Care
25 Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.), or any other
26 program administered by the Division of Medical Assistance and
27 Health Services in the Department of Human Services.
- 28 p. As used in this section:
- 29 "Concurrent review" means inpatient care is reviewed as it is
30 provided. Medically qualified reviewers monitor appropriateness of
31 the care, the setting, and patient progress, and as appropriate, the
32 discharge plans.
- 33 "Substance use disorder" is as defined by the American
34 Psychiatric Association in the Diagnostic and Statistical Manual of
35 Mental Disorders, Fifth Edition and any subsequent editions and
36 shall include substance use withdrawal.
- 37
- 38 5. (New section) a. A group health insurance policy that
39 provides hospital or medical expense benefits and is delivered,
40 issued, executed or renewed in this State, or approved for issuance
41 or renewal in this State by the Commissioner of Banking and
42 Insurance, on or after the effective date of this act, shall provide
43 unlimited benefits for inpatient and outpatient treatment of
44 substance use disorder at in-network facilities. The services for the
45 treatment of substance use disorder shall be prescribed by a licensed
46 physician, licensed psychologist, or licensed psychiatrist and
47 provided by licensed health care professionals or licensed or
48 certified substance use disorder providers in licensed or otherwise

1 State-approved facilities, as required by the laws of the state in
2 which the services are rendered.

3 b. The benefits for the first 180 days per plan year of inpatient
4 and outpatient treatment of substance use disorder shall be provided
5 when determined medically necessary by the covered person's
6 physician, psychologist or psychiatrist without the imposition of
7 any prior authorization or other prospective utilization management
8 requirements. If there is no in-network facility immediately
9 available for a covered person, an insurer shall provide necessary
10 exceptions to its network to ensure admission in a treatment facility
11 within 24 hours.

12 c. Providers of treatment for substance use disorder to persons
13 covered under a covered insurance policy shall not require pre-
14 payment of medical expenses during this 180 days in excess of
15 applicable co-payment, deductible, or co-insurance under the
16 policy.

17 d. The benefits for outpatient visits shall not be subject to
18 concurrent or retrospective review of medical necessity or any other
19 utilization management review.

20 e. (1) The benefits for the first 28 days of an inpatient stay
21 during each plan year shall be provided without any retrospective
22 review or concurrent review of medical necessity and medical
23 necessity shall be as determined by the covered person's physician.

24 (2) The benefits for days 29 and thereafter of inpatient care shall
25 be subject to concurrent review as defined in this section. A request
26 for approval of inpatient care beyond the first 28 days shall be
27 submitted for concurrent review before the expiration of the initial
28 28 day period. A request for approval of inpatient care beyond any
29 period that is approved under concurrent review shall be submitted
30 within the period that was previously approved. No insurer shall
31 initiate concurrent review more frequently than three-week
32 intervals. If an insurer determines that continued inpatient care in a
33 facility is no longer medically necessary, the insurer shall within 24
34 hours provide written notice to the covered person and the covered
35 person's physician of its decision and the right to file an expedited
36 internal appeal of the determination pursuant to an expedited
37 process pursuant to sections 11 through 13 of P.L.1997, c.192
38 (C.26:2S-11 through 26:2S-13) and N.J.AC.11:24A-3.5, as
39 applicable. The insurer shall review and make a determination with
40 respect to the internal appeal within 24 hours and communicate
41 such determination to the covered person and the covered person's
42 physician. If the determination is to uphold the denial, the covered
43 person and the covered person's physician have the right to file an
44 expedited external appeal with the Independent Health Care
45 Appeals Program in the Department of Banking and Insurance
46 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
47 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
48 independent utilization review organization shall make a

1 determination within 24 hours. If the insurer's determination is
2 upheld and it is determined continued inpatient care is not
3 medically necessary, the insurer shall remain responsible to provide
4 benefits for the inpatient care through the day following the date the
5 determination is made and the covered person shall only be
6 responsible for any applicable co-payment, deductible and co-
7 insurance for the stay through that date as applicable under the
8 policy. The covered person shall not be discharged or released
9 from the inpatient facility until all internal appeals and independent
10 utilization review organization appeals are exhausted. For any costs
11 incurred after the day following the date of determination until the
12 day of discharge, the covered person shall only be responsible for
13 any applicable cost-sharing, and any additional charges shall be
14 paid by the facility or provider.

15 f. (1) The benefits for the first 28 days of intensive outpatient
16 or partial hospitalization services shall be provided without any
17 retrospective review of medical necessity and medical necessity
18 shall be as determined by the covered person's physician.

19 (2) The benefits for days 29 and thereafter of intensive
20 outpatient or partial hospitalization services shall be subject to a
21 retrospective review of the medical necessity of the services.

22 g. Benefits for inpatient and outpatient treatment of substance
23 use disorder after the first 180 days per plan year shall be subject to
24 the medical necessity determination of the insurer and may be
25 subject to prior authorization or, retrospective review and other
26 utilization management requirements.

27 h. Medical necessity review shall utilize an evidence-based and
28 peer reviewed clinical review tool to be designated through
29 rulemaking by the Commissioner of Human Services in
30 consultation with the Department of Health.

31 i. The benefits for outpatient prescription drugs to treat
32 substance use disorder shall be provided when determined
33 medically necessary by the covered person's physician,
34 psychologist or psychiatrist without the imposition of any prior
35 authorization or other prospective utilization management
36 requirements.

37 j. The first 180 days per plan year of benefits shall be
38 computed based on inpatient days. One or more unused inpatient
39 days may be exchanged for two outpatient visits. All extended
40 outpatient services such as partial hospitalization and intensive
41 outpatient, shall be deemed inpatient days for the purpose of the
42 visit to day exchange provided in this subsection.

43 k. Except as stated above, the benefits and cost-sharing shall be
44 provided to the same extent as for any other medical condition
45 covered under the policy.

46 l. The benefits required by this section are to be provided to all
47 covered persons with a diagnosis of substance use disorder. The

1 presence of additional related or unrelated diagnoses shall not be a
2 basis to reduce or deny the benefits required by this section.

3 m. The provisions of this section shall apply to those policies in
4 which the insurer has reserved the right to change the premium.

5 n. The Attorney General's Office shall be responsible for
6 overseeing any violations of law that may result from P.L. ,
7 c. (C.) (pending before the Legislature as this bill), including
8 fraud, abuse, waste, and mistreatment of covered persons. The
9 Attorney General's Office is authorized to adopt, pursuant to the
10 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
11 seq.), rules and regulations to implement any of the provisions of
12 P.L. , c. (C.) (pending before the Legislature as this bill).

13 o. The provisions of this section shall not apply to a group
14 health insurance policy which, pursuant to a contract between the
15 insurer and the Department of Human Services, provides benefits to
16 persons who are eligible for medical assistance under P.L.1968,
17 c.413 (C.30:4D-1 et seq.), the "Family Health Care Coverage Act,"
18 P.L.2005, c.156 (C.30:4J-8 et seq.), or any other program
19 administered by the Division of Medical Assistance and Health
20 Services in the Department of Human Services.

21 p. As used in this section:

22 "Concurrent review" means inpatient care is reviewed as it is
23 provided. Medically qualified reviewers monitor appropriateness of
24 the care, the setting, and patient progress, and as appropriate, the
25 discharge plans.

26 "Substance use disorder" is as defined by the American
27 Psychiatric Association in the Diagnostic and Statistical Manual of
28 Mental Disorders, Fifth Edition and any subsequent editions and
29 shall include substance use withdrawal.

30

31 6. (New section) a. An individual health benefits plan that
32 provides hospital or medical expense benefits and is delivered,
33 issued, executed or renewed in this State, or approved for issuance
34 or renewal in this State by the Commissioner of Banking and
35 Insurance, on or after the effective date of this act, shall provide
36 unlimited benefits for inpatient and outpatient treatment of
37 substance use disorder at in-network facilities. The services for the
38 treatment of substance use disorder shall be prescribed by a licensed
39 physician, licensed psychologist, or licensed psychiatrist and
40 provided by licensed health care professionals or licensed or
41 certified substance use disorder providers in licensed or otherwise
42 State-approved facilities, as required by the laws of the state in
43 which the services are rendered.

44 b. The benefits for the first 180 days per plan year of inpatient
45 and outpatient treatment of substance use disorder shall be provided
46 when determined medically necessary by the covered person's
47 physician, psychologist or psychiatrist without the imposition of
48 any prior authorization or other prospective utilization management

1 requirements. If there is no in-network facility immediately
2 available for a covered person, a carrier shall provide necessary
3 exceptions to their network to ensure admission in a treatment
4 facility within 24 hours.

5 c. Providers of treatment for substance use disorder to persons
6 covered under a covered health benefits plan shall not require pre-
7 payment of medical expenses during this 180 days in excess of
8 applicable co-payment, deductible, or co-insurance under the plan.

9 d. The benefits for outpatient visits shall not be subject to
10 concurrent or retrospective review of medical necessity or any other
11 utilization management review.

12 e. (1) The benefits for the first 28 days of an inpatient stay
13 during each plan year shall be provided without any retrospective
14 review or concurrent review of medical necessity and medical
15 necessity shall be as determined by the covered person's physician.

16 (2) The benefits for days 29 and thereafter of inpatient care shall
17 be subject to concurrent review as defined in this section. A request
18 for approval of inpatient care beyond the first 28 days shall be
19 submitted for concurrent review before the expiration of the initial
20 28 day period. A request for approval of inpatient care beyond any
21 period that is approved under concurrent review shall be submitted
22 within the period that was previously approved. No carrier shall
23 initiate concurrent review more frequently than three-week
24 intervals. If a carrier determines that continued inpatient care in a
25 facility is no longer medically necessary, the carrier shall within 24
26 hours provide written notice to the covered person and the covered
27 person's physician of its decision and the right to file an expedited
28 internal appeal of the determination pursuant to an expedited
29 process pursuant to sections 11 through 13 of P.L.1997, c.192
30 (C.26:2S-11 through 26:2S-13) and N.J.AC.11:24A-3.5, as
31 applicable. The carrier shall review and make a determination with
32 respect to the internal appeal within 24 hours and communicate
33 such determination to the covered person and the covered person's
34 physician. If the determination is to uphold the denial, the covered
35 person and the covered person's physician have the right to file an
36 expedited external appeal with the Independent Health Care
37 Appeals Program in the Department of Banking and Insurance
38 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
39 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
40 independent utilization review organization shall make a
41 determination within 24 hours. If the carrier's determination is
42 upheld and it is determined continued inpatient care is not
43 medically necessary, the carrier shall remain responsible to provide
44 benefits for the inpatient care through the day following the date the
45 determination is made and the covered person shall only be
46 responsible for any applicable co-payment, deductible and co-
47 insurance for the stay through that date as applicable under the
48 policy. The covered person shall not be discharged or released

1 from the inpatient facility until all internal appeals and independent
2 utilization review organization appeals are exhausted. For any costs
3 incurred after the day following the date of determination until the
4 day of discharge, the covered person shall only be responsible for
5 any applicable cost-sharing, and any additional charges shall be
6 paid by the facility or provider.

7 f. (1) The benefits for the first 28 days of intensive outpatient
8 or partial hospitalization services shall be provided without any
9 retrospective review of medical necessity and medical necessity
10 shall be as determined by the covered person's physician.

11 (2) The benefits for days 29 and thereafter of intensive
12 outpatient or partial hospitalization services shall be subject to a
13 retrospective review of the medical necessity of the services.

14 g. Benefits for inpatient and outpatient treatment of substance
15 use disorder after the first 180 days per plan year shall be subject to
16 the medical necessity determination of the insurer and may be
17 subject to prior authorization or, retrospective review and other
18 utilization management requirements.

19 h. Medical necessity review shall utilize an evidence-based and
20 peer reviewed clinical review tool to be designated through
21 rulemaking by the Commissioner of Human Services in
22 consultation with the Department of Health.

23 i. The benefits for outpatient prescription drugs to treat
24 substance use disorder shall be provided when determined
25 medically necessary by the covered person's physician,
26 psychologist or psychiatrist without the imposition of any prior
27 authorization or other prospective utilization management
28 requirements.

29 j. The first 180 days per plan year of benefits shall be
30 computed based on inpatient days. One or more unused inpatient
31 days may be exchanged for two outpatient visits. All extended
32 outpatient services such as partial hospitalization and intensive
33 outpatient, shall be deemed inpatient days for the purpose of the
34 visit to day exchange provided in this subsection.

35 k. Except as stated above, the benefits and cost-sharing shall be
36 provided to the same extent as for any other medical condition
37 covered under the health benefits plan.

38 l. The benefits required by this section are to be provided to all
39 covered persons with a diagnosis of substance use disorder. The
40 presence of additional related or unrelated diagnoses shall not be a
41 basis to reduce or deny the benefits required by this section.

42 m. The provisions of this section shall apply to all individual
43 health benefits plans in which the carrier has reserved the right to
44 change the premium.

45 n. The Attorney General's Office shall be responsible for
46 overseeing any violations of law that may result from P.L. ,

47 c. (C.) (pending before the Legislature as this bill), including
48 fraud, abuse, waste, and mistreatment of covered persons. The

1 Attorney General's Office is authorized to adopt, pursuant to the
2 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
3 seq.), rules and regulations to implement any of the provisions of
4 P.L. , c. (C.) (pending before the Legislature as this bill).

5 o. The provisions of this section shall not apply to an
6 individual health benefits plan which, pursuant to a contract
7 between the carrier and the Department of Human Services,
8 provides benefits to persons who are eligible for medical assistance
9 under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family Health Care
10 Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.), or any other
11 program administered by the Division of Medical Assistance and
12 Health Services in the Department of Human Services.

13 p. As used in this section:

14 "Concurrent review" means inpatient care is reviewed as it is
15 provided. Medically qualified reviewers monitor appropriateness of
16 the care, the setting, and patient progress, and as appropriate, the
17 discharge plans.

18 "Substance use disorder" is as defined by the American
19 Psychiatric Association in the Diagnostic and Statistical Manual of
20 Mental Disorders, Fifth Edition and any subsequent editions and
21 shall include substance use withdrawal.

22

23 7. (New section) a. A small employer health benefits plan that
24 provides hospital or medical expense benefits and is delivered,
25 issued, executed or renewed in this State, or approved for issuance
26 or renewal in this State by the Commissioner of Banking and
27 Insurance, on or after the effective date of this act, shall provide
28 unlimited benefits for inpatient and outpatient treatment of
29 substance use disorder at in-network facilities. The services for the
30 treatment of substance use disorder shall be prescribed by a licensed
31 physician, licensed psychologist, or licensed psychiatrist and
32 provided by licensed health care professionals or licensed or
33 certified substance use disorder providers in licensed or otherwise
34 State-approved facilities, as required by the laws of the state in
35 which the services are rendered.

36 b. The benefits for the first 180 days per plan year of inpatient
37 and outpatient treatment of substance use disorder shall be provided
38 when determined medically necessary by the covered person's
39 physician, psychologist or psychiatrist without the imposition of
40 any prior authorization or other prospective utilization management
41 requirements. If there is no in-network facility immediately
42 available for a covered person, a carrier shall provide necessary
43 exceptions to their network to ensure admission in a treatment
44 facility within 24 hours.

45 c. Providers of treatment for substance use disorder to persons
46 covered under a covered health benefits plan shall not require pre-
47 payment of medical expenses during this 180 days in excess of
48 applicable co-payment, deductible, or co-insurance under the plan.

1 d. The benefits for outpatient visits shall not be subject to
2 concurrent or retrospective review of medical necessity or any other
3 utilization management review.

4 e. (1) The benefits for the first 28 days of an inpatient stay
5 during each plan year shall be provided without any retrospective
6 review or concurrent review of medical necessity and medical
7 necessity shall be as determined by the covered person's physician.

8 (2) The benefits for days 29 and thereafter of inpatient care shall
9 be subject to concurrent review as defined in this section. A request
10 for approval of inpatient care beyond the first 28 days shall be
11 submitted for concurrent review before the expiration of the initial
12 28 day period. A request for approval of inpatient care beyond any
13 period that is approved under concurrent review shall be submitted
14 within the period that was previously approved. No carrier shall
15 initiate concurrent review more frequently than three-week
16 intervals. If a carrier determines that continued inpatient care in a
17 facility is no longer medically necessary, the carrier shall within 24
18 hours provide written notice to the covered person and the covered
19 person's physician of its decision and the right to file an expedited
20 internal appeal of the determination pursuant to an expedited
21 process pursuant to sections 11 through 13 of P.L.1997, c.192
22 (C.26:2S-11 through 26:2S-13) and N.J.AC.11:24A-3.5, as
23 applicable. The carrier shall review and make a determination with
24 respect to the internal appeal within 24 hours and communicate
25 such determination to the covered person and the covered person's
26 physician. If the determination is to uphold the denial, the covered
27 person and the covered person's physician have the right to file an
28 expedited external appeal with the Independent Health Care
29 Appeals Program in the Department of Banking and Insurance
30 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
31 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
32 independent utilization review organization shall make a
33 determination within 24 hours. If the carrier's determination is
34 upheld and it is determined continued inpatient care is not
35 medically necessary, the carrier shall remain responsible to provide
36 benefits for the inpatient care through the day following the date the
37 determination is made and the covered person shall only be
38 responsible for any applicable co-payment, deductible and co-
39 insurance for the stay through that date as applicable under the
40 policy. The covered person shall not be discharged or released
41 from the inpatient facility until all internal appeals and independent
42 utilization review organization appeals are exhausted. For any costs
43 incurred after the day following the date of determination until the
44 day of discharge, the covered person shall only be responsible for
45 any applicable cost-sharing, and any additional charges shall be
46 paid by the facility or provider.

47 f. (1) The benefits for the first 28 days of intensive outpatient
48 or partial hospitalization services shall be provided without any

1 retrospective review of medical necessity and medical necessity
2 shall be as determined by the covered person's physician.

3 (2) The benefits for days 29 and thereafter of intensive
4 outpatient or partial hospitalization services shall be subject to a
5 retrospective review of the medical necessity of the services.

6 g. Benefits for inpatient and outpatient treatment of substance
7 use disorder after the first 180 days per plan year shall be subject to
8 the medical necessity determination of the carrier and may be
9 subject to prior authorization or, retrospective review and other
10 utilization management requirements.

11 h. Medical necessity review shall utilize an evidence-based and
12 peer reviewed clinical review tool to be designated through
13 rulemaking by the Commissioner of Human Services in
14 consultation with the Department of Health.

15 i. The benefits for outpatient prescription drugs to treat
16 substance use disorder shall be provided when determined
17 medically necessary by the covered person's physician,
18 psychologist or psychiatrist without the imposition of any prior
19 authorization or other prospective utilization management
20 requirements.

21 j. The first 180 days per plan year of benefits shall be
22 computed based on inpatient days. One or more unused inpatient
23 days may be exchanged for two outpatient visits. All extended
24 outpatient services such as partial hospitalization and intensive
25 outpatient, shall be deemed inpatient days for the purpose of the
26 visit to day exchange provided in this subsection.

27 k. Except as stated above, the benefits and cost-sharing shall be
28 provided to the same extent as for any other medical condition
29 covered under the health benefits plan.

30 l. The benefits required by this section are to be provided to all
31 covered persons with a diagnosis of substance use disorder. The
32 presence of additional related or unrelated diagnoses shall not be a
33 basis to reduce or deny the benefits required by this section.

34 m. The provisions of this section shall apply to all small
35 employer health benefits plans in which the carrier has reserved the
36 right to change the premium.

37 n. The Attorney General's Office shall be responsible for
38 overseeing any violations of law that may result from P.L. ,

39 c. (C.) (pending before the Legislature as this bill), including
40 fraud, abuse, waste, and mistreatment of covered persons. The
41 Attorney General's Office is authorized to adopt, pursuant to the
42 Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
43 seq.), rules and regulations to implement any of the provisions of
44 P.L. , c. (C.) (pending before the Legislature as this bill).

45 o. As used in this section:

46 "Concurrent review" means inpatient care is reviewed as it is
47 provided. Medically qualified reviewers monitor appropriateness of

1 the care, the setting, and patient progress, and as appropriate, the
2 discharge plans.

3 “Substance use disorder” is as defined by the American
4 Psychiatric Association in the Diagnostic and Statistical Manual of
5 Mental Disorders, Fifth Edition and any subsequent editions and
6 shall include substance abuse withdrawal.

7
8 8. (New section) a. A health maintenance organization contract
9 that provides hospital or medical expense benefits and is delivered,
10 issued, executed or renewed in this State, or approved for issuance
11 or renewal in this State by the Commissioner of Banking and
12 Insurance, on or after the effective date of this act, shall provide
13 unlimited benefits for inpatient and outpatient treatment of
14 substance use disorder at in-network facilities. The services for the
15 treatment of substance use disorder shall be prescribed by a licensed
16 physician, licensed psychologist, or licensed psychiatrist and
17 provided by licensed health care professionals or licensed or
18 certified substance use disorder providers in licensed or otherwise
19 State-approved facilities, as required by the laws of the state in
20 which the services are rendered.

21 b. The benefits for the first 180 days per plan year of inpatient
22 and outpatient treatment of substance use disorder shall be provided
23 when determined medically necessary by the covered person’s
24 physician, psychologist or psychiatrist without the imposition of
25 any prior authorization or other prospective utilization management
26 requirements. If there is no in-network facility immediately
27 available for a covered person, a health maintenance organization
28 shall provide necessary exceptions to their network to ensure
29 admission in a treatment facility within 24 hours.

30 c. Providers of treatment for substance use disorder to persons
31 covered under a covered contract shall not require pre-payment of
32 medical expenses during this 180 days in excess of applicable co-
33 payment, deductible, or co-insurance under the policy.

34 d. The benefits for outpatient visits shall not be subject to
35 concurrent or retrospective review of medical necessity or any other
36 utilization management review.

37 e. (1) The benefits for the first 28 days of an inpatient stay
38 during each plan year shall be provided without any retrospective
39 review or concurrent review of medical necessity and medical
40 necessity shall be as determined by the covered person’s physician.

41 (2) The benefits for days 29 and thereafter of inpatient care shall
42 be subject to concurrent review as defined in this section. A request
43 for approval of inpatient care beyond the first 28 days shall be
44 submitted for concurrent review before the expiration of the initial
45 28 day period. A request for approval of inpatient care beyond any
46 period that is approved under concurrent review shall be submitted
47 within the period that was previously approved. No health
48 maintenance organization shall initiate concurrent review more

1 frequently than three-week intervals. If a health maintenance
2 organization determines that continued inpatient confinement in a
3 facility is no longer medically necessary, the health insurance
4 organization shall within 24 hours provide written notice to the
5 covered person and the covered person's physician of its decision
6 and the right to file an expedited internal appeal of the
7 determination pursuant to an expedited process pursuant to sections
8 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13)
9 and N.J.AC.11:24A-3.5, as applicable. The health maintenance
10 organization shall review and make a determination with respect to
11 the internal appeal within 24 hours and communicate such
12 determination to the covered person and the covered person's
13 physician. If the determination is to uphold the denial, the covered
14 person and the covered person's physician have the right to file an
15 expedited external appeal with the Independent Health Care
16 Appeals Program in the Department of Banking and Insurance
17 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
18 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
19 independent utilization review organization shall make a
20 determination within 24 hours. If the health maintenance
21 organization's determination is upheld and it is determined
22 continued inpatient care is not medically necessary, the carrier shall
23 remain responsible to provide benefits for the inpatient care through
24 the day following the date the determination is made and the
25 covered person shall only be responsible for any applicable co-
26 payment, deductible and co-insurance for the stay through that date
27 as applicable under the policy. The covered person shall not be
28 discharged or released from the inpatient facility until all internal
29 appeals and independent utilization review organization appeals are
30 exhausted. For any costs incurred after the day following the date of
31 determination until the day of discharge, the covered person shall
32 only be responsible for any applicable cost-sharing, and any
33 additional charges shall be paid by the facility or provider.

34 f. (1) The benefits for the first 28 days of intensive outpatient
35 or partial hospitalization services shall be provided without any
36 retrospective review of medical necessity and medical necessity
37 shall be as determined by the covered person's physician.

38 (2) The benefits for days 29 and thereafter of intensive
39 outpatient or partial hospitalization services shall be subject to a
40 retrospective review of the medical necessity of the services.

41 g. Benefits for inpatient and outpatient treatment of substance
42 use disorder after the first 180 days per plan year shall be subject to
43 the medical necessity determination of the health maintenance
44 organization and may be subject to prior authorization or,
45 retrospective review and other utilization management
46 requirements.

47 h. Medical necessity review shall utilize an evidence-based and
48 peer reviewed clinical review tool to be designated through

1 rulemaking by the Commissioner of Human Services in
2 consultation with the Department of Health.

3 i. The benefits for outpatient prescription drugs to treat
4 substance use disorder shall be provided when determined
5 medically necessary by the covered person's physician,
6 psychologist or psychiatrist without the imposition of any prior
7 authorization or other prospective utilization management
8 requirements.

9 j. The first 180 days per plan year of benefits shall be
10 computed based on inpatient days. One or more unused inpatient
11 days may be exchanged for two outpatient visits. All extended
12 outpatient services such as partial hospitalization and intensive
13 outpatient, shall be deemed inpatient days for the purpose of the
14 visit to day exchange provided in this subsection.

15 k. Except as stated above, the benefits and cost-sharing shall be
16 provided to the same extent as for any other medical condition
17 covered under the contract.

18 l. The benefits required by this section are to be provided to all
19 covered persons with a diagnosis of substance use disorder. The
20 presence of additional related or unrelated diagnoses shall not be a
21 basis to reduce or deny the benefits required by this section.

22 m. The provisions of this section shall apply to those contracts
23 in which the health maintenance organization has reserved the right
24 to change the premium.

25 n. The Attorney General's Office shall be responsible for
26 overseeing any violations of law that may result from P.L. ,
27 c. (C.) (pending before the Legislature as this bill), including
28 fraud, abuse, waste, and mistreatment of covered persons. The
29 Attorney General's Office is authorized to adopt, pursuant to the
30 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
31 seq.), rules and regulations to implement any of the provisions of
32 P.L. , c. (C.) (pending before the Legislature as this bill).

33 o. The provisions of this section shall not apply to a health
34 maintenance organization contract which, pursuant to a contract
35 between the health maintenance organization and the Department of
36 Human Services, provides benefits to persons who are eligible for
37 medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the
38 "Family Health Care Coverage Act," P.L.2005, c.156 (C.30:4J-8 et
39 seq.), or any other program administered by the Division of Medical
40 Assistance and Health Services in the Department of Human
41 Services.

42 p. As used in this section:

43 "Concurrent review" means inpatient care is reviewed as it is
44 provided. Medically qualified reviewers monitor appropriateness of
45 the care, the setting, and patient progress, and as appropriate, the
46 discharge plans.

47 "Substance use disorder" is as defined by the American
48 Psychiatric Association in the Diagnostic and Statistical Manual of

1 Mental Disorders, Fifth Edition and any subsequent editions and
2 shall include substance use withdrawal.

3
4 9. (New section) a. The State Health Benefits Commission
5 shall ensure that every contract purchased by the commission on or
6 after the effective date of this act provides unlimited benefits for
7 inpatient and outpatient treatment of substance use disorder at in-
8 network facilities. The services for the treatment of substance use
9 disorder shall be prescribed by a licensed physician, licensed
10 psychologist, or licensed psychiatrist and provided by licensed
11 health care professionals or licensed or certified substance use
12 disorder providers in licensed or otherwise State-approved facilities,
13 as required by the laws of the state in which the services are
14 rendered.

15 b. The benefits for the first 180 days per plan year of inpatient
16 and outpatient treatment of substance use disorder shall be provided
17 when determined medically necessary by the covered person's
18 physician, psychologist or psychiatrist without the imposition of
19 any prior authorization or other prospective utilization management
20 requirements. If there is no in-network facility immediately
21 available for a covered person, the contract shall provide necessary
22 exceptions to their network to ensure admission in a treatment
23 facility within 24 hours.

24 c. Providers of treatment for substance use disorder to persons
25 covered under a covered contract shall not require pre-payment of
26 medical expenses during this 180 days in excess of applicable co-
27 payment, deductible, or co-insurance under the policy.

28 d. The benefits for outpatient visits shall not be subject to
29 concurrent or retrospective review of medical necessity or any other
30 utilization management review.

31 e. (1) The benefits for the first 28 days of an inpatient stay
32 during each plan year shall be provided without any retrospective
33 review or concurrent review of medical necessity and medical
34 necessity shall be as determined by the covered person's physician.

35 (2) The benefits for days 29 and thereafter of inpatient care shall
36 be subject to concurrent review as defined in this section. A request
37 for approval of inpatient care beyond the first 28 days shall be
38 submitted for concurrent review before the expiration of the initial
39 28 day period. A request for approval of inpatient care beyond any
40 period that is approved under concurrent review shall be submitted
41 within the period that was previously approved. The contract shall
42 not initiate concurrent review more frequently than three-week
43 intervals. If it is determined that continued inpatient care in a
44 facility is no longer medically necessary, the contract shall provide
45 that within 24 hours, written notice shall be provided to the covered
46 person and the covered person's physician of its decision and the
47 right to file an expedited internal appeal of the determination
48 pursuant to an expedited process pursuant to sections 11 through 13

1 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and
2 N.J.AC.11:24A-3.5, as applicable. A determination shall be made
3 with respect to the internal appeal within 24 hours and shall be
4 communicated to the covered person and the covered person's
5 physician. If the determination is to uphold the denial, the covered
6 person and the covered person's physician have the right to file an
7 expedited external appeal with the Independent Health Care
8 Appeals Program in the Department of Banking and Insurance
9 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
10 through 26:2s-13) and N.J.A.C.11:24A-3.6, as applicable. An
11 independent utilization review organization shall make a
12 determination within 24 hours. If the determination is upheld and it
13 is determined continued inpatient care is not medically necessary,
14 the contract shall state that benefits are provided for the inpatient
15 care through the day following the date the determination is made
16 and the covered person shall only be responsible for any applicable
17 co-payment, deductible and co-insurance for the stay through that
18 date as applicable under the contract. The covered person shall not
19 be discharged or released from the inpatient facility until all internal
20 appeals and independent utilization review organization appeals are
21 exhausted. For any costs incurred after the day following the date of
22 determination until the day of discharge, the covered person shall
23 only be responsible for any applicable cost-sharing, and any
24 additional charges shall be paid by the facility or provider.

25 f. (1) The benefits for the first 28 days of intensive outpatient
26 or partial hospitalization services shall be provided without any
27 retrospective review of medical necessity and medical necessity
28 shall be as determined by the covered person's physician.

29 (2) The benefits for days 29 and thereafter of intensive
30 outpatient or partial hospitalization services shall be subject to a
31 retrospective review of the medical necessity of the services.

32 g. Benefits for inpatient and outpatient treatment of substance
33 use disorder after the first 180 days per plan year shall be subject to
34 medical necessity determination and may be subject to prior
35 authorization or, retrospective review and other utilization
36 management requirements.

37 h. Medical necessity review shall utilize an evidence-based and
38 peer reviewed clinical review tool to be designated through
39 rulemaking by the Commissioner of Human Services in
40 consultation with the Department of Health.

41 i. The benefits for outpatient prescription drugs to treat
42 substance use disorder shall be provided when determined
43 medically necessary by the covered person's physician,
44 psychologist or psychiatrist without the imposition of any prior
45 authorization or other prospective utilization management
46 requirements.

47 j. The first 180 days per plan year of benefits shall be
48 computed based on inpatient days. One or more unused inpatient

1 days may be exchanged for two outpatient visits. All extended
2 outpatient services such as partial hospitalization and intensive
3 outpatient, shall be deemed inpatient days for the purpose of the
4 visit to day exchange provided in this subsection.

5 k. Except as stated above, the benefits and cost-sharing shall be
6 provided to the same extent as for any other medical condition
7 covered under the contract.

8 l. The benefits required by this section are to be provided to all
9 covered persons with a diagnosis of substance use disorder. The
10 presence of additional related or unrelated diagnoses shall not be a
11 basis to reduce or deny the benefits required by this section.

12 m. As used in this section:

13 “Concurrent review” means inpatient care is reviewed as it is
14 provided. Medically qualified reviewers monitor appropriateness of
15 the care, the setting, and patient progress, and as appropriate, the
16 discharge plans.

17 “Substance use disorder” is as defined by the American
18 Psychiatric Association in the Diagnostic and Statistical Manual of
19 Mental Disorders, Fifth Edition and any subsequent editions and
20 shall include substance use withdrawal.

21

22 10. (New section) a. The School Employees’ Health Benefits
23 Commission shall ensure that every contract purchased by the
24 commission on or after the effective date of this act provides
25 unlimited benefits for inpatient and outpatient treatment of
26 substance use disorder at in-network facilities. The services for the
27 treatment of substance use disorder shall be prescribed by a licensed
28 physician, licensed psychologist, or licensed psychiatrist and
29 provided by licensed health care professionals or licensed or
30 certified substance use disorder providers in licensed or otherwise
31 State-approved facilities, as required by the laws of the state in
32 which the services are rendered.

33 b. The benefits for the first 180 days per plan year of inpatient
34 and outpatient treatment of substance use disorder shall be provided
35 when determined medically necessary by the covered person’s
36 physician, psychologist or psychiatrist without the imposition of
37 any prior authorization or other prospective utilization management
38 requirements. If there is no in-network facility immediately
39 available for a covered person, the contract shall provide necessary
40 exceptions to their network to ensure admission in a treatment
41 facility within 24 hours.

42 c. Providers of treatment for substance use disorder to persons
43 covered under a covered contract shall not require pre-payment of
44 medical expenses during this 180 days in excess of applicable co-
45 payment, deductible, or co-insurance under the policy.

46 d. The benefits for outpatient visits shall not be subject to
47 concurrent or retrospective review of medical necessity or any other
48 utilization management review.

- 1 e. (1) The benefits for the first 28 days of an inpatient stay
2 during each plan year shall be provided without any retrospective
3 review or concurrent review of medical necessity and medical
4 necessity shall be as determined by the covered person's physician.
- 5 (2) The benefits for days 29 and thereafter of inpatient care shall
6 be subject to concurrent review as defined in this section. A request
7 for approval of inpatient care beyond the first 28 days shall be
8 submitted for concurrent review before the expiration of the initial
9 28 day period. A request for approval of inpatient care beyond any
10 period that is approved under concurrent review shall be submitted
11 within the period that was previously approved. The contract shall
12 not initiate concurrent review more frequently than three-week
13 intervals. If it is determined that continued inpatient care in a
14 facility is no longer medically necessary, the contract shall provide
15 that within 24 hours, written notice shall be provided to the covered
16 person and the covered person's physician of its decision and the
17 right to file an expedited internal appeal of the determination
18 pursuant to an expedited process pursuant to sections 11 through 13
19 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and
20 N.J.AC.11:24A-3.5, as applicable. A determination shall be made
21 with respect to the internal appeal within 24 hours and shall be
22 communicated to the covered person and the covered person's
23 physician. If the determination is to uphold the denial, the covered
24 person and the covered person's physician have the right to file an
25 expedited external appeal with the Independent Health Care
26 Appeals Program in the Department of Banking and Insurance
27 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
28 through 26:2s-13) and N.J.A.C.11:24A-3.6, as applicable. An
29 independent utilization review organization shall make a
30 determination within 24 hours. If the determination is upheld and it
31 is determined continued inpatient care is not medically necessary,
32 the contract shall state that benefits are provided for the inpatient
33 care through the day following the date the determination is made
34 and the covered person shall only be responsible for any applicable
35 co-payment, deductible and co-insurance for the stay through that
36 date as applicable under the contract. The covered person shall not
37 be discharged or released from the inpatient facility until all internal
38 appeals and independent utilization review organization appeals are
39 exhausted. For any costs incurred after the day following the date of
40 determination until the day of discharge, the covered person shall
41 only be responsible for any applicable cost-sharing, and any
42 additional charges shall be paid by the facility or provider.
- 43 f. (1) The benefits for the first 28 days of intensive outpatient
44 or partial hospitalization services shall be provided without any
45 retrospective review of medical necessity and medical necessity
46 shall be as determined by the covered person's physician.

1 (2) The benefits for days 29 and thereafter of intensive
2 outpatient or partial hospitalization services shall be subject to a
3 retrospective review of the medical necessity of the services.

4 g. Benefits for inpatient and outpatient treatment of substance
5 use disorder after the first 180 days per plan year shall be subject to
6 medical necessity determination and may be subject to prior
7 authorization or, retrospective review and other utilization
8 management requirements.

9 h. Medical necessity review shall utilize an evidence-based and
10 peer reviewed clinical review tool to be designated through
11 rulemaking by the Commissioner of Human Services in
12 consultation with the Department of Health.

13 i. The benefits for outpatient prescription drugs to treat
14 substance use disorder shall be provided when determined
15 medically necessary by the covered person's physician,
16 psychologist or psychiatrist without the imposition of any prior
17 authorization or other prospective utilization management
18 requirements.

19 j. The first 180 days per plan year of benefits shall be
20 computed based on inpatient days. One or more unused inpatient
21 days may be exchanged for two outpatient visits. All extended
22 outpatient services such as partial hospitalization and intensive
23 outpatient, shall be deemed inpatient days for the purpose of the
24 visit to day exchange provided in this subsection.

25 k. Except as stated above, the benefits and cost-sharing shall be
26 provided to the same extent as for any other medical condition
27 covered under the contract.

28 l. The benefits required by this section are to be provided to all
29 covered persons with a diagnosis of substance use disorder. The
30 presence of additional related or unrelated diagnoses shall not be a
31 basis to reduce or deny the benefits required by this section.

32 m. As used in this section:

33 "Concurrent review" means inpatient care is reviewed as it is
34 provided. Medically qualified reviewers monitor appropriateness of
35 the care, the setting, and patient progress, and as appropriate, the
36 discharge plans.

37 "Substance use disorder" is as defined by the American
38 Psychiatric Association in the Diagnostic and Statistical Manual of
39 Mental Disorders, Fifth Edition and any subsequent editions and
40 shall include substance use withdrawal.

41

42 11. (New section) a. A practitioner shall not issue an initial
43 prescription for an opioid drug which is a prescription drug as
44 defined in section 2 of P.L.2003, c.280 (C.45:14-41) in a quantity
45 exceeding a five-day supply for treatment of acute pain.

46 b. Prior to issuing an initial prescription of a course of
47 treatment that includes a Schedule II controlled dangerous
48 substance or any other opioid drug which is a prescription drug as

1 defined in section 2 of P.L.2003, c.280 (C.45:14-41) for acute or
2 chronic pain, a practitioner shall:

3 (1) take and document the results of a thorough medical history,
4 including the patient's experience with non-opioid medication and
5 non-pharmacological pain management approaches and substance
6 abuse history;

7 (2) conduct, as appropriate, and document the results of a
8 physical examination;

9 (3) develop a treatment plan, with particular attention focused
10 on determining the cause of the patient's pain;

11 (4) access relevant prescription monitoring information under
12 the Prescription Monitoring Program pursuant to section 8 of
13 P.L.2015, c.74 (C. 45:1-46.1); and

14 (5) limit the supply of any opioid drug prescribed for acute pain
15 to a duration of no more than five days as determined by the
16 directed dosage and frequency of dosage.

17 c. No less than four days after issuing the initial prescription,
18 the practitioner, after consultation with the patient, may issue a
19 subsequent prescription for the drug to the patient in any quantity
20 that complies with applicable State and federal laws, provided that:

21 (1) the subsequent prescription would not be deemed an initial
22 prescription under this section;

23 (2) the practitioner determines the prescription is necessary and
24 appropriate to the patient's treatment needs and documents the
25 rationale for the issuance of the subsequent prescription; and

26 (3) the practitioner determines that issuance of the subsequent
27 prescription does not present an undue risk of abuse, addiction, or
28 diversion and documents that determination.

29 d. Prior to issuing the initial prescription of a course of
30 treatment that includes a Schedule II controlled dangerous
31 substance or any other opioid drug which is a prescription drug as
32 defined in section 2 of P.L.2003, c.280 (C.45:14-41) and again prior
33 to issuing the third prescription of the course of treatment, a
34 practitioner shall discuss with the patient, or the patient's parent or
35 guardian if the patient is under 18 years of age and is not an
36 emancipated minor, the risks associated with the drugs being
37 prescribed, including but not limited to:

38 (1) the risks of addiction and overdose associated with opioid
39 drugs and the dangers of taking opioid drugs with alcohol,
40 benzodiazepines and other central nervous system depressants;

41 (2) the reasons why the prescription is necessary;

42 (3) alternative treatments that may be available; and

43 (4) risks associated with the use of the drugs being prescribed,
44 specifically that opioids are highly addictive, even when taken as
45 prescribed, that there is a risk of developing a physical or
46 psychological dependence on the controlled dangerous substance,
47 and that the risks of taking more opioids than prescribed, or mixing

1 sedatives, benzodiazepines or alcohol with opioids, can result in
2 fatal respiratory depression.

3 The practitioner shall obtain a written acknowledgement, on a
4 form developed and made available by the Division of Consumer
5 Affairs, that the patient or the patient's parent or guardian, as
6 applicable, has discussed with the practitioner the risks of
7 developing a physical or psychological dependence on the
8 controlled dangerous substance and alternative treatments that may
9 be available. The Division of Consumer Affairs shall develop and
10 make available to practitioners guidelines for the discussion
11 required pursuant to this subsection.

12 e. At the time of the issuance of the third prescription for a
13 prescription opioid drug, the practitioner shall enter into a pain
14 management agreement with the patient.

15 f. When a Schedule II controlled dangerous substance or any
16 other prescription opioid drug is continuously prescribed for three
17 months or more for chronic pain, the practitioner shall:

18 (1) review, at a minimum of every three months, the course of
19 treatment, any new information about the etiology of the pain, and
20 the patient's progress toward treatment objectives and document the
21 results of that review;

22 (2) assess the patient prior to every renewal to determine
23 whether the patient is experiencing problems associated with
24 physical and psychological dependence and document the results of
25 that assessment;

26 (3) periodically make reasonable efforts, unless clinically
27 contraindicated, to either stop the use of the controlled substance,
28 decrease the dosage, try other drugs or treatment modalities in an
29 effort to reduce the potential for abuse or the development of
30 physical or psychological dependence and document with
31 specificity the efforts undertaken;

32 (4) review the Prescription Drug Monitoring information in
33 accordance with section 8 of P.L.2015, c.74 (C. 45:1-46.1); and

34 (5) monitor compliance with the pain management agreement
35 and any recommendations that the patient seek a referral.

36 g. As used in this section:

37 "Acute pain" means pain, whether resulting from disease,
38 accidental or intentional trauma, or other cause, that the practitioner
39 reasonably expects to last only a short period of time. "Acute pain"
40 does not include chronic pain, pain being treated as part of cancer
41 care, hospice or other end of life care, or pain being treated as part
42 of palliative care.

43 "Initial prescription" means a prescription issued to a patient
44 who:

45 (1) has never previously been issued a prescription for the drug
46 or its pharmaceutical equivalent; or

47 (2) was previously issued a prescription for the drug or its
48 pharmaceutical equivalent, but the date on which the current

1 prescription is being issued is more than one year after the date the
2 patient last used or was administered the drug or its equivalent.

3 When determining whether a patient was previously issued a
4 prescription for a drug or its pharmaceutical equivalent, the
5 practitioner shall consult with the patient and review the patient's
6 medical record and prescription monitoring information.

7 "Pain management agreement" means a written contract or
8 agreement that is executed between a practitioner and a patient,
9 prior to the commencement of treatment for chronic pain using a
10 Schedule II controlled dangerous substance or any other opioid
11 drug which is a prescription drug as defined in section 2 of P.L.
12 2003, c. 280 (C.45:14-41), as a means to:

13 (1) prevent the possible development of physical or
14 psychological dependence in the patient;

15 (2) document the understanding of both the practitioner and the
16 patient regarding the patient's pain management plan;

17 (3) establish the patient's rights in association with treatment,
18 and the patient's obligations in relation to the responsible use,
19 discontinuation of use, and storage of Schedule II controlled
20 dangerous substances, including any restrictions on the refill of
21 prescriptions or the acceptance of Schedule II prescriptions from
22 practitioners;

23 (4) identify the specific medications and other modes of
24 treatment, including physical therapy or exercise, relaxation, or
25 psychological counseling, that are included a part of the pain
26 management plan;

27 (5) specify the measures the practitioner may employ to monitor
28 the patient's compliance, including but not limited to random
29 specimen screens and pill counts; and

30 (6) delineate the process for terminating the agreement,
31 including the consequences if the practitioner has reason to believe
32 that the patient is not complying with the terms of the agreement.

33 "Practitioner" means a medical doctor, doctor of osteopathy,
34 dentist, optometrist, podiatrist, physician assistant, certified nurse
35 midwife, or advanced practice nurse.

36 h. This section shall not apply to a prescription for a patient
37 who is currently in active treatment for cancer, receiving hospice
38 care from a licensed hospice or palliative care, or is a resident of a
39 long term care facility, or to any medications that are being
40 prescribed for use in the treatment of substance abuse or opioid
41 dependence.

42

43 12. Section 1 of P.L.1997, c.249 (C.45:9-22.19) is amended to
44 read as follows:

45 1. a. **[A]** Except in the case of an initial prescription issued
46 pursuant to section 11 of P.L. , c. (C.) (pending before the
47 Legislature as this bill), a physician licensed pursuant to chapter 9
48 of Title 45 of the Revised Statutes may prescribe a Schedule II

1 controlled dangerous substance for the use of a patient in any
2 quantity which does not exceed a 30-day supply, as defined by
3 regulations adopted by the State Board of Medical Examiners in
4 consultation with the Department of Health **【and Senior Services】**.
5 The physician shall document the diagnosis and the medical need
6 for the prescription in the patient's medical record, in accordance
7 with guidelines established by the State Board of Medical
8 Examiners.

9 b. **【A】** Except in the case of an initial prescription issued
10 pursuant to section 11 of P.L. , c. (C.) (pending before the
11 Legislature as this bill), a physician may issue multiple
12 prescriptions authorizing the patient to receive a total of up to a 90-
13 day supply of a Schedule II controlled dangerous substance,
14 provided that the following conditions are met:

15 (1) each separate prescription is issued for a legitimate medical
16 purpose by the physician acting in the usual course of professional
17 practice;

18 (2) the physician provides written instructions on each
19 prescription, other than the first prescription if it is to be filled
20 immediately, indicating the earliest date on which a pharmacy may
21 fill each prescription;

22 (3) the physician determines that providing the patient with
23 multiple prescriptions in this manner does not create an undue risk
24 of diversion or abuse; and

25 (4) the physician complies with all other applicable State and
26 federal laws and regulations.

27 (cf: P.L.2009, c.165, s.1)

28

29 13. (New section) a. The Director of the Division of Consumer
30 Affairs, pursuant to the “Administrative Procedure Act,” P.L.1968,
31 c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to
32 effectuate the purposes of sections 11 and 12 of P.L. , c. (C.)
33 (pending before the Legislature as this bill).

34 b. Notwithstanding the provision of the “Administrative
35 Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.) to the
36 contrary, the Director of the Division of Consumer Affairs may
37 adopt, immediately upon filing with the Office of Administrative
38 Law, and no later than the 90th day after the effective date of this
39 act, such regulations as the director deems necessary to implement
40 any of the provisions of P.L. , c. (C.)(pending before the
41 Legislature as this bill). Regulations adopted pursuant to this
42 subsection shall be effective until the adoption of rules and
43 regulations pursuant to subsection a. of this section, and may be
44 amended, adopted, or readopted by the director in accordance with
45 the requirements of P.L.1968, c.410 (C.52:14B-1 et seq.).

46

47 14. Section 3 of P.L.1991, c.97 (C.45:10-19) is amended to read
48 as follows:

1 3. To qualify to prescribe drugs pursuant to section 2 of **【this**
2 **act】** P.L.1991, c.97 (C.45:10-18), a certified nurse midwife shall
3 have completed 30 contact hours, as defined by the National Task
4 Force on the Continuing Education Unit, in pharmacology or a
5 pharmacology course, acceptable to the board, in an accredited
6 institution of higher education approved by the Department of
7 Higher Education or the board. Such contact hours shall include
8 one credit of educational programs or topics on issues concerning
9 prescription opioid drugs, including responsible prescribing
10 practices, alternatives to opioids for managing and treating pain,
11 and the risks and signs of opioid abuse, addiction, and diversion.
12 (cf: P.L.1991, c.97, s.3)
13

14 15. Section 10 of P.L.1991, c.377 (C.45:11-49) is amended to
15 read as follows:

16 10. a. In addition to all other tasks which a registered
17 professional nurse may, by law, perform, an advanced practice
18 nurse may manage preventive care services and diagnose and
19 manage deviations from wellness and long-term illnesses, consistent
20 with the needs of the patient and within the scope of practice of the
21 advanced practice nurse, by:

22 (1) initiating laboratory and other diagnostic tests;
23 (2) prescribing or ordering medications and devices, as
24 authorized by subsections b. and c. of this section; and
25 (3) prescribing or ordering treatments, including referrals to
26 other licensed health care professionals, and performing specific
27 procedures in accordance with the provisions of this subsection.

28 b. An advanced practice nurse may order medications and
29 devices in the inpatient setting, subject to the following conditions:

30 (1) the collaborating physician and advanced practice nurse
31 shall address in the joint protocols whether prior consultation with
32 the collaborating physician is required to initiate an order for a
33 controlled dangerous substance;

34 (2) the order is written in accordance with standing orders or
35 joint protocols developed in agreement between a collaborating
36 physician and the advanced practice nurse, or pursuant to the
37 specific direction of a physician;

38 (3) the advanced practice nurse authorizes the order by signing
39 the nurse's own name, printing the name and certification number,
40 and printing the collaborating physician's name;

41 (4) the physician is present or readily available through
42 electronic communications;

43 (5) the charts and records of the patients treated by the advanced
44 practice nurse are reviewed by the collaborating physician and the
45 advanced practice nurse within the period of time specified by rule
46 adopted by the Commissioner of Health pursuant to section 13 of
47 P.L.1991, c.377 (C.45:11-52);

1 (6) the joint protocols developed by the collaborating physician
2 and the advanced practice nurse are reviewed, updated, and signed
3 at least annually by both parties; and

4 (7) the advanced practice nurse has completed six contact hours
5 of continuing professional education in pharmacology related to
6 controlled substances, including pharmacologic therapy **[and]**,
7 addiction prevention and management, and issues concerning
8 prescription opioid drugs, including responsible prescribing
9 practices, alternatives to opioids for managing and treating pain,
10 and the risks and signs of opioid abuse, addiction, and diversion, in
11 accordance with regulations adopted by the New Jersey Board of
12 Nursing. The six contact hours shall be in addition to New Jersey
13 Board of Nursing pharmacology education requirements for
14 advanced practice nurses related to initial certification and
15 recertification of an advanced practice nurse as set forth in
16 N.J.A.C.13:37-7.2.

17 c. An advanced practice nurse may prescribe medications and
18 devices in all other medically appropriate settings, subject to the
19 following conditions:

20 (1) the collaborating physician and advanced practice nurse
21 shall address in the joint protocols whether prior consultation with
22 the collaborating physician is required to initiate a prescription for a
23 controlled dangerous substance;

24 (2) the prescription is written in accordance with standing orders
25 or joint protocols developed in agreement between a collaborating
26 physician and the advanced practice nurse, or pursuant to the
27 specific direction of a physician;

28 (3) the advanced practice nurse writes the prescription on a New
29 Jersey Prescription Blank pursuant to P.L.2003, c.280 (C.45:14-40
30 et seq.), signs the nurse's own name to the prescription and prints
31 the nurse's name and certification number;

32 (4) the prescription is dated and includes the name of the patient
33 and the name, address, and telephone number of the collaborating
34 physician;

35 (5) the physician is present or readily available through
36 electronic communications;

37 (6) the charts and records of the patients treated by the advanced
38 practice nurse are periodically reviewed by the collaborating
39 physician and the advanced practice nurse;

40 (7) the joint protocols developed by the collaborating physician
41 and the advanced practice nurse are reviewed, updated, and signed
42 at least annually by both parties; and

43 (8) the advanced practice nurse has completed six contact hours
44 of continuing professional education in pharmacology related to
45 controlled substances, including pharmacologic therapy **[and]**,
46 addiction prevention and management, and issues concerning
47 prescription opioid drugs, including responsible prescribing
48 practices, alternatives to opioids for managing and treating pain,

1 and the risks and signs of opioid abuse, addiction, and diversion, in
2 accordance with regulations adopted by the New Jersey Board of
3 Nursing. The six contact hours shall be in addition to New Jersey
4 Board of Nursing pharmacology education requirements for
5 advanced practice nurses related to initial certification and
6 recertification of an advanced practice nurse as set forth in
7 N.J.A.C.13:37-7.2.

8 d. The joint protocols employed pursuant to subsections b. and
9 c. of this section shall conform with standards adopted by the
10 Director of the Division of Consumer Affairs pursuant to section 12
11 of P.L.1991, c.377 (C.45:11-51) or section 10 of P.L.1999, c.85
12 (C.45:11-49.2), as applicable.

13 e. (Deleted by amendment, P.L.2004, c.122.)

14 f. An attending advanced practice nurse may determine and
15 certify the cause of death of the nurse's patient and execute the
16 death certification pursuant to R.S.26:6-8 if no collaborating
17 physician is available to do so and the nurse is the patient's primary
18 caregiver.

19 (cf: P.L.2015, c.38, s.3)

20

21 16. R.S.45:12-1 is amended to read as follows:

22 45:12-1. Optometry is hereby declared to be a profession, and
23 the practice of optometry is defined to be the employment of
24 objective or subjective means, or both, for the examination of the
25 human eye and adnexae for the purposes of ascertaining any
26 departure from the normal, measuring its powers of vision and
27 adapting lenses or prisms for the aid thereof, or the use and
28 prescription of pharmaceutical agents, excluding injections, except
29 for injections to counter anaphylactic reaction **[.]**; and excluding
30 controlled dangerous substances as provided in sections 5 and 6 of
31 P.L.1970, c.226 (C.24:21-5 and C.24:21-6), except as otherwise
32 authorized by section 9 of P.L.1991, c.385 (C.45:12-9.11), for the
33 purposes of treating deficiencies, deformities, diseases, or
34 abnormalities of the human eye and adnexae, including the removal
35 of superficial foreign bodies from the eye and adnexae.

36 An optometrist utilizing pharmaceutical agents for the purposes
37 of treatment of ocular conditions and diseases shall be held to a
38 standard of patient care in the use of such agents commensurate to
39 that of a physician utilizing pharmaceutical agents for treatment
40 purposes.

41 A person shall be deemed to be practicing optometry within the
42 meaning of this chapter who in any way advertises himself as an
43 optometrist, or who shall employ any means for the measurement of
44 the powers of vision or the adaptation of lenses or prisms for the aid
45 thereof, practice, offer or attempt to practice optometry as herein
46 defined, either on his own behalf or as an employee or student of
47 another, whether under the personal supervision of his employer or
48 perceptor or not, or to use testing appliances for the purposes of

1 measurement of the powers of vision or diagnose any ocular
2 deficiency or deformity, visual or muscular anomaly of the human
3 eye and adnexae or prescribe lenses, prisms or ocular exercise for
4 the correction or the relief thereof, or who uses or prescribes
5 pharmaceutical agents for the purposes of diagnosing and treating
6 deficiencies, deformities, diseases or abnormalities of the human
7 eye and adnexae or who holds himself out as qualified to practice
8 optometry.

9 (cf: P.L.2004, c.115, s.1)

10

11 17. Section 3 of P.L.1975, c.24 (C.45:12-9.3) is amended to read
12 as follows:

13 3. Fifty credits of continuing professional optometric education
14 shall be required biennially of each New Jersey optometrist holding
15 an active license during the period preceding the established license
16 renewal date. Each credit shall represent or be equivalent to one
17 hour of actual course attendance or in the case of those electing an
18 alternative method of satisfying the requirements of this act shall be
19 approved by the board and certified to the board on forms to be
20 provided for that purpose. Of the 50 credits biennially required
21 under this section, at least one credit shall be for educational
22 programs or topics that concern the prescription of hydrocodone, or
23 the prescription of opioid drugs in general, including responsible
24 prescribing practices, the alternatives to the use of opioids for the
25 management and treatment of pain, and the risks and signs of opioid
26 abuse, addiction, and diversion.

27 (cf: P.L.1975, c.24, s.3)

28

29 18. (New section) a. The New Jersey State Board of Dentistry
30 shall require that the number of credits of continuing dental
31 education required of each person licensed as a dentist, as a
32 condition of biennial registration pursuant to R.S.45:6-10 and
33 section 1 of P.L.1972, c.108 (C.45:1-7), include one credit of
34 educational programs or topics concerning prescription opioid
35 drugs, including responsible prescribing practices, alternatives to
36 opioids for managing and treating pain, and the risks and signs of
37 opioid abuse, addiction, and diversion. The continuing dental
38 education requirement in this subsection shall be subject to the
39 provisions of P.L.1991, c.490 (C.45:6-10.1 et seq.), including, but
40 not limited to, the authority of the board to waive the provisions of
41 this section for a specific individual if the board deems it is
42 appropriate to do so.

43 b. The New Jersey State Board of Dentistry, pursuant to the
44 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
45 seq.), shall adopt such rules and regulations as are necessary to
46 effectuate the purposes of this section.

1 19. (New section) a. The State Board of Medical Examiners
2 shall require that the number of credits of continuing medical
3 education required of each person licensed as a physician, as a
4 condition of biennial registration pursuant to section 1 of P.L.1971,
5 c.236 (C.45:9-6.1), include one credit of educational programs or
6 topics concerning prescription opioid drugs, including responsible
7 prescribing practices, alternatives to opioids for managing and
8 treating pain, and the risks and signs of opioid abuse, addiction, and
9 diversion. The continuing medical education requirement in this
10 subsection shall be subject to the provisions of section 10 of
11 P.L.2001, c.307 (C.45:9-7.1), including, but not limited to, the
12 authority of the board to waive the provisions of this section for a
13 specific individual if the board deems it is appropriate to do so.

14 b. The State Board of Medical Examiners, pursuant to the
15 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
16 seq.), shall adopt such rules and regulations as are necessary to
17 effectuate the purposes of this section.

18

19 20. (New section) a. The State Board of Medical Examiners
20 shall require that the number of credits of continuing medical
21 education required of each person licensed as a physician assistant,
22 as a condition of biennial renewal pursuant to section 4 of P.L.1991,
23 c.378 (C.45:9-27.13), include one credit of educational programs or
24 topics concerning prescription opioid drugs, including responsible
25 prescribing practices, alternatives to opioids for managing and
26 treating pain, and the risks and signs of opioid abuse, addiction, and
27 diversion. The continuing medical education requirement in this
28 subsection shall be subject to the provisions of section 16 of
29 P.L.1991, c.378 (C.45:9-27.25), including, but not limited to, the
30 authority of the board to waive the provisions of this section for a
31 specific individual if the board deems it is appropriate to do so.

32 b. The State Board of Medical Examiners, pursuant to the
33 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
34 seq.), shall adopt such rules and regulations as are necessary to
35 effectuate the purposes of this section.

36

37 21. (New section) a. The New Jersey Board of Nursing shall
38 require that the number of credits of continuing education required
39 of each person licensed as a professional nurse or a practical nurse,
40 as a condition of biennial license renewal, include one credit of
41 educational programs or topics concerning prescription opioid
42 drugs, including alternatives to opioids for managing and treating
43 pain and the risks and signs of opioid abuse, addiction, and
44 diversion.

45 b. The board may, in its discretion, waive the continuing
46 education requirement in subsection a. of this section on an
47 individual basis for reasons of hardship, such as illness or disability,
48 retirement of the license, or other good cause. A waiver shall apply

1 only to the current biennial renewal period at the time of board
2 issuance.

3 c. The New Jersey Board of Nursing, pursuant to the
4 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
5 seq.), shall adopt such rules and regulations as are necessary to
6 effectuate the purposes of this section.

7
8 22. (New section) a. The New Jersey State Board of Pharmacy
9 shall require that the number of credits of continuing pharmacy
10 education required of each person registered as a pharmacist, as a
11 condition of biennial renewal certification, include one credit of
12 educational programs or topics concerning prescription opioid
13 drugs, including alternatives to opioids for managing and treating
14 pain and the risks and signs of opioid abuse, addiction, and
15 diversion. The continuing pharmacy education requirement in this
16 subsection shall be subject to the provisions of section 15 of
17 P.L.2003, c.280 (C.45:14-54), including, but not limited to, the
18 authority of the board to waive the provisions of this section for a
19 specific individual if the board deems it is appropriate to do so.

20 b. The New Jersey State Board of Pharmacy, pursuant to the
21 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
22 seq.), shall adopt such rules and regulations as are necessary to
23 effectuate the purposes of this section.

24
25 23. (New section) The Commissioner of Health, in consultation
26 with the Commissioner of Banking and Insurance, shall submit
27 reports at two intervals to the Legislature, pursuant to section 2 of
28 P.L.1991, c.164 (C.52:14-19.1), and the Governor. The first report
29 shall be submitted six months, and the second report shall be
30 submitted 12 months, after the date of enactment of this act. The
31 reports shall evaluate the implementation and impact of the act’s
32 provisions and make recommendations regarding revisions to the
33 statutes that may be appropriate. The report shall include, but not
34 be limited to, an evaluation of the following:

35 a. The effects of the five-day supply limitation on
36 prescriptions, and other requirements concerning the prescribing of
37 opioids and other drugs pursuant to section 11 of the act, including
38 the impact of these provisions on patients with chronic pain and the
39 impact on patient cost sharing; and

40 b. The effects of the provisions of the bill providing that if
41 there is no in-network facility immediately available for a covered
42 person to receive treatment, a carrier shall provide necessary
43 exceptions to their network to ensure admission in a treatment
44 facility within 24 hours, including the impact of these provisions on
45 the availability of treatment beds for patients, the impact on
46 facilities in the State, and the costs associated with these provisions.

47

48 24. The following sections are repealed:

1 P.L. 1977, c. 115 (C. 17:48-6a);
2 P.L. 1977, c. 116 (C. 17B:27-46.1);
3 P.L. 1977, c. 117 (C. 17:48A-7a);
4 P.L. 1977, c. 118 (C. 17B:26-2.1); and
5 Section 34 of P.L. 1985, c. 236 (C. 17:48E-34).

6
7 25. This bill shall take effect on the 90th day next after
8 enactment.

9
10

11 STATEMENT

12

13 This bill requires health insurance coverage for substance use
14 disorders and regulates opioids and certain other prescription drugs
15 in several ways. The bill requires health insurance carriers, the State
16 Health Benefits Program, and the School Employees' Health
17 Benefits Program, to adhere to certain coverage requirements for
18 treatment of substance use disorders. The bill also places certain
19 restrictions on the prescription of opioids, and requires certain
20 notifications when prescribing Schedule II controlled dangerous
21 substances used to treat chronic or acute pain. The bill also requires
22 certain health care professionals to receive training on topics related
23 to prescription opioid drugs. Finally, the bill repeals certain
24 sections of law that are obviated by the bill's provisions.

25 Specifically, the bill requires insurers to provide unlimited
26 benefits for inpatient and outpatient treatment of substance use
27 disorders at in-network facilities. The bill further specifies that the
28 services for the treatment of substance use disorders shall be
29 prescribed by a licensed physician, licensed psychologist, or
30 licensed psychiatrist and provided by licensed health care
31 professionals or licensed or certified substance use disorder
32 providers in licensed or otherwise State-approved facilities, as
33 required by the laws of the state in which the services are rendered.

34 The bill provides that the benefits, for the first 180 days per plan
35 year of inpatient and outpatient treatment of substance use disorder,
36 shall be provided when determined medically necessary by the
37 covered person's physician, psychologist or psychiatrist without the
38 imposition of any prior authorization or other prospective utilization
39 management requirements. If there is no in-network facility
40 immediately available for a covered person, a carrier shall provide
41 necessary exceptions to their network to ensure admission in a
42 treatment facility within 24 hours.

43 Under the bill, providers of treatment for substance use disorders
44 to persons covered under a covered insurance policy shall not
45 require pre-payment of medical expenses during the 180 days in
46 excess of applicable co-payment, deductible, or co-insurance under
47 the policy. The benefits for outpatient visits shall not be subject to

1 concurrent or retrospective review of medical necessity or any other
2 utilization management review.

3 The benefits for the first 28 days of an inpatient stay during each
4 plan year shall be provided without any retrospective review or
5 concurrent review of medical necessity and medical necessity shall
6 be as determined by the covered person's physician. The benefits
7 for days 29 and thereafter of inpatient care shall be subject to
8 concurrent review as defined in the bill. The bill establishes a
9 process for concurrent review and an appeals process pursuant to
10 the Independent Health Care Appeals Program in the Department of
11 Banking and Insurance.

12 The benefits for the first 28 days of intensive outpatient or partial
13 hospitalization services shall be provided without any retrospective
14 review of medical necessity and medical necessity shall be as
15 determined by the covered person's physician. The benefits for
16 days 29 and thereafter of intensive outpatient or partial
17 hospitalization services shall be subject to a retrospective review of
18 the medical necessity of the services.

19 The bill specifies that benefits for inpatient and outpatient
20 treatment of substance use disorder after the first 180 days per plan
21 year shall be subject to the medical necessity determination of the
22 insurer and may be subject to prior authorization or, retrospective
23 review and other utilization management requirements.

24 The medical necessity review shall utilize an evidence-based and
25 peer reviewed clinical review tool to be designated through
26 rulemaking by the Commissioner of Human Services in
27 consultation with the Department of Health.

28 The benefits for outpatient prescription drugs used to treat
29 substance abuse disorder shall be provided when determined
30 medically necessary by the covered person's physician,
31 psychologist or psychiatrist without the imposition of any prior
32 authorization or other prospective utilization management
33 requirements.

34 The bill defines a "substance use disorder" as defined by the
35 American Psychiatric Association in the Diagnostic and Statistical
36 Manual of Mental Disorders, Fifth Edition and any subsequent
37 editions and includes substance use withdrawal. "Concurrent
38 review" is defined to mean inpatient care is reviewed as it is
39 provided. Medically qualified reviewers monitor appropriateness of
40 the care, the setting, and patient progress, and as appropriate, the
41 discharge plans.

42 The bill provides that the first 180 days per plan year of benefits
43 shall be computed based on inpatient days. One or more unused
44 inpatient days may be exchanged for two outpatient visits. All
45 extended outpatient services such as partial hospitalization and
46 intensive outpatient, shall be deemed inpatient days for the purpose
47 of the visit to day exchange as provided in the bill.

1 The bill stipulates that the Attorney General's Office shall be
2 responsible for overseeing any violations of law that may result
3 from the bill, including fraud, abuse, waste, and mistreatment of
4 covered persons. The bill also makes clear that the provisions
5 requiring health insurance coverage do not apply to plans
6 administered by the Department of Human Services.

7 The bill also places certain restrictions on how opioids and other
8 Schedule II controlled substances may be prescribed. In cases of
9 acute pain, the bill provides that a practitioner shall not issue an
10 initial prescription for an opioid drug in a quantity exceeding a five-
11 day supply. In cases of acute or chronic pain, prior to issuing an
12 initial prescription of a course of treatment that includes a Schedule
13 II controlled dangerous substance or any other opioid drug, a
14 practitioner shall:

15 (1) take and document the results of a thorough medical history,
16 including the patient's experience with non-opioid medication and
17 non-pharmacological pain management approaches and substance
18 abuse history;

19 (2) conduct, as appropriate, and document the results of a
20 physical examination;

21 (3) develop a treatment plan, with particular attention focused
22 on determining the cause of the patient's pain;

23 (4) access relevant prescription monitoring information under the
24 Prescription Monitoring Program; and

25 (5) limit the supply of any opioid drug prescribed for acute pain
26 to a duration of no more than five days as determined by the
27 directed dosage and frequency of dosage.

28 No less than four days after issuing the initial prescription, the
29 practitioner, after consultation with the patient, may issue a
30 subsequent prescription for the drug to the patient in any quantity
31 that complies with applicable State and federal laws, provided that:

32 (1) the subsequent prescription would not be deemed an initial
33 prescription under this section;

34 (2) the practitioner determines the prescription is necessary and
35 appropriate to the patient's treatment needs and documents the
36 rationale for the issuance of the subsequent prescription; and

37 (3) the practitioner determines that issuance of the subsequent
38 prescription does not present an undue risk of abuse, addiction, or
39 diversion and documents that determination.

40 The bill also requires, prior to issuing the initial prescription of a
41 course of treatment that includes a Schedule II controlled dangerous
42 substance or any other opioid drug and again prior to issuing the
43 third prescription of the course of treatment, a practitioner shall
44 discuss with the patient, or the patient's parent or guardian if the
45 patient is under 18 years of age and is not an emancipated minor,
46 the risks associated with the drugs being prescribed, including but
47 not limited to:

1 - the risks of addiction and overdose associated with opioid
2 drugs and the dangers of taking opioid drugs with alcohol,
3 benzodiazepines and other central nervous system depressants;
4 - the reasons why the prescription is necessary;
5 - alternative treatments that may be available; and
6 - risks associated with the use of the drugs being prescribed,
7 specifically that opioids are highly addictive, even when taken as
8 prescribed, that there is a risk of developing a physical or
9 psychological dependence on the controlled dangerous substance,
10 and that the risks of taking more opioids than prescribed, or mixing
11 sedatives, benzodiazepines or alcohol with opioids, can result in
12 fatal respiratory depression.

13 The practitioner shall obtain a written acknowledgement, on a
14 form developed and made available by the Division of Consumer
15 Affairs, that the patient or the patient's parent or guardian, as
16 applicable, has discussed with the practitioner the risks of
17 developing a physical or psychological dependence on the
18 controlled dangerous substance and alternative treatments that may
19 be available. The Division of Consumer Affairs shall develop and
20 make available to practitioners guidelines for the discussion
21 required pursuant to the bill.

22 At the time of the issuance of the third prescription for a
23 prescription opioid drug, the practitioner shall enter into a pain
24 management agreement with the patient. When a Schedule II
25 controlled dangerous substance or any other prescription opioid
26 drug is continuously prescribed for three months or more for
27 chronic pain, the practitioner shall:

28 (1) review, at a minimum of every three months, the course of
29 treatment, any new information about the etiology of the pain, and
30 the patient's progress toward treatment objectives and document the
31 results of that review;

32 (2) assess the patient prior to every renewal to determine whether
33 the patient is experiencing problems associated with physical and
34 psychological dependence and document the results of that
35 assessment;

36 (3) periodically make reasonable efforts, unless clinically
37 contraindicated, to either stop the use of the controlled substance,
38 decrease the dosage, try other drugs or treatment modalities in an
39 effort to reduce the potential for abuse or the development of
40 physical or psychological dependence and document with
41 specificity the efforts undertaken;

42 (4) review the Prescription Drug Monitoring information in
43 accordance with N.J.S.A.45:1-46; and

44 (5) monitor compliance with the pain management agreement
45 and any recommendations that the patient seek a referral.

46 The bill exempts from the prescription limitations above the
47 following: a patient who is currently in active treatment for cancer,
48 receiving hospice care from a licensed hospice or palliative care, or

1 is a resident of a long term care facility, and any medications that
2 are being prescribed for use in the treatment of substance abuse or
3 opioid dependence.

4 The bill also would require certain health care professionals to
5 receive training on topics related to prescription opioid drugs.
6 Health care professionals who have the authority to prescribe opioid
7 medications, including physicians, physician assistants, dentists,
8 and optometrists (who have limited authority to prescribe only
9 hydrocodone), will be required to complete one continuing
10 education credit on topics that include responsible prescribing
11 practices, alternatives to opioids for managing and treating pain,
12 and the risks and signs of opioid abuse, addiction, and diversion.
13 For advance practice nurses, who also have prescribing authority,
14 their required six contact hours of continuing professional education
15 in pharmacology related to controlled substances will include issues
16 concerning prescription opioid drugs, including responsible
17 prescribing practices, alternatives to opioids for managing and
18 treating pain, and the risks and signs of opioid abuse, addiction, and
19 diversion.

20 Health care professionals who do not have prescribing authority
21 but who frequently interact with patients who may be prescribed
22 opioids, including pharmacists, professional nurses, and practical
23 nurses, would also be required to complete one continuing
24 education credit on topics that include alternatives to opioids for
25 managing and treating pain and the risks and signs of opioid abuse,
26 addiction, and diversion. The continuing education credits required
27 under the bill will be part of a professional's regular continuing
28 education credits and will not increase the total number of
29 continuing education credits required.

30 The bill additionally provides that certified nurse midwives will
31 be required to complete one credit of educational programs or
32 topics related to prescription opioid drugs as part of the 30 contact
33 hours in pharmacology training that is required for them to be
34 authorized to prescribe drugs.

35 The bill also requires the Commissioner of Health, in
36 consultation with the Commissioner of Banking and Insurance, to
37 submit reports to the Legislature and the Governor concerning
38 implementation of the bill. One report is to be submitted six
39 months, and the second report is to be submitted 12 months, after
40 the date of enactment of the bill.

41 Finally the bill repeals several statutes, initially enacted in 1977
42 and 1985, which required coverage for the treatment of alcoholism.
43 Because the bill expands that coverage to include treatment for all
44 types of substance use disorder, including alcohol abuse, those
45 sections of law specific to alcoholism are no longer required.

SENATE HEALTH, HUMAN SERVICES AND SENIOR
CITIZENS COMMITTEE

STATEMENT TO

SENATE, No. 3

with committee amendments

STATE OF NEW JERSEY

DATED: JANUARY 30, 2017

The Senate Health, Human Services and Senior Citizens Committee reports favorably and with amendments Senate Bill No. 3.

As amended, this bill requires health insurance coverage for substance use disorders and regulates opioids and certain other prescription drugs in several ways. The bill requires health insurers, the State Health Benefits Program, and the School Employees' Health Benefits Program, to adhere to certain coverage requirements for treatment of substance use disorders. The bill also places certain restrictions on the prescription of opioids, and requires certain notifications when prescribing Schedule II controlled dangerous substances used to treat chronic or acute pain. The bill also requires certain health care professionals to receive training on topics related to prescription opioid drugs. Finally, the bill repeals certain sections of law that are obviated by the bill's provisions.

Specifically, the bill requires insurers to provide unlimited benefits for inpatient and outpatient treatment of substance use disorders at in-network facilities. The bill further specifies that the services for the treatment of substance use disorders shall be prescribed by a licensed physician, licensed psychologist, or licensed psychiatrist and provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise State-approved facilities, as required by the laws of the state in which the services are rendered.

The bill provides that the benefits, for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder, shall be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements. The facility shall notify the insurer of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment. If there is no in-network facility immediately available for a covered person, an insurer shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

Under the bill, providers of treatment for substance use disorders to persons covered under a covered insurance policy shall not require pre-payment of medical expenses during the 180 days in excess of applicable co-payment, deductible, or co-insurance under the policy. The benefits for outpatient visits shall not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

The benefits for the first 28 days of an inpatient stay during each plan year shall be provided without any retrospective review or concurrent review of medical necessity and medical necessity shall be as determined by the covered person's physician. The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in the bill, initiated no more frequently than every two weeks. The bill establishes a process for concurrent review and an appeals process pursuant to the Independent Health Care Appeals Program in the Department of Banking and Insurance.

The benefits for the first 28 days of intensive outpatient or partial hospitalization services shall be provided without any retrospective review of medical necessity and medical necessity shall be as determined by the covered person's physician. The benefits for days 29 and thereafter of intensive outpatient or partial hospitalization services shall be subject to a retrospective review of the medical necessity of the services.

The bill specifies that benefits for inpatient and outpatient treatment of substance use disorder after the first 180 days per plan year shall be subject to the medical necessity determination of the insurer and may be subject to prior authorization or, retrospective review and other utilization management requirements.

The medical necessity review shall utilize an evidence-based and peer reviewed clinical review tool to be designated through rulemaking by the Commissioner of Human Services in consultation with the Department of Health.

The benefits for outpatient prescription drugs used to treat substance abuse disorder shall be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements.

The bill defines a "substance use disorder" as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition and any subsequent editions and includes substance use withdrawal. "Concurrent review" is defined to mean inpatient care is reviewed as it is provided. Medically qualified reviewers monitor appropriateness of the care, the setting, and patient progress, and as appropriate, the discharge plans.

The bill provides that the first 180 days per plan year of benefits shall be computed based on inpatient days. One or more unused inpatient days may be exchanged for two outpatient visits. All

extended outpatient services such as partial hospitalization and intensive outpatient, shall be deemed inpatient days for the purpose of the visit to day exchange as provided in the bill.

The bill stipulates that the Attorney General's Office shall be responsible for overseeing any violations of law that may result from the bill, including fraud, abuse, waste, and mistreatment of covered persons. The bill also makes clear that the provisions requiring health insurance coverage do not apply to plans administered by the Department of Human Services.

The bill also places certain restrictions on how opioids and other Schedule II controlled substances may be prescribed. In cases of acute pain, the bill provides that a practitioner shall not issue an initial prescription for an opioid drug in a quantity exceeding a five-day supply, and must be for the lowest effective dose of an immediate-releasing opioid drug. In cases of acute or chronic pain, prior to issuing an initial prescription of a Schedule II controlled dangerous substance or any other opioid drug in a course of treatment for acute or chronic pain, a practitioner shall:

(1) take and document the results of a thorough medical history, including the patient's experience with non-opioid medication and non-pharmacological pain management approaches and substance abuse history;

(2) conduct, as appropriate, and document the results of a physical examination;

(3) develop a treatment plan, with particular attention focused on determining the cause of the patient's pain;

(4) access relevant prescription monitoring information under the Prescription Monitoring Program; and

(5) limit the supply of any opioid drug prescribed for acute pain to a duration of no more than five days as determined by the directed dosage and frequency of dosage.

No less than four days after issuing the initial prescription of an opioid drug that is subject to the 5-day limit, the practitioner, after consultation with the patient, may issue a subsequent prescription for the drug to the patient in any quantity that complies with applicable State and federal laws, provided that:

(1) the subsequent prescription would not be deemed an initial prescription under this section;

(2) the practitioner determines the prescription is necessary and appropriate to the patient's treatment needs and documents the rationale for the issuance of the subsequent prescription; and

(3) the practitioner determines that issuance of the subsequent prescription does not present an undue risk of abuse, addiction, or diversion and documents that determination.

The bill also requires, prior to issuing the initial prescription of a Schedule II controlled dangerous substance or any other opioid drug in a course of treatment for acute or chronic pain, and again prior to

issuing the third prescription of the course of treatment, a practitioner shall discuss with the patient, or the patient's parent or guardian if the patient is under 18 years of age and is not an emancipated minor, the risks associated with the drugs being prescribed, including but not limited to:

- the risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants;

- the reasons why the prescription is necessary;

- alternative treatments that may be available; and

- risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed, or mixing sedatives, benzodiazepines or alcohol with opioids, can result in fatal respiratory depression.

The practitioner shall include a note in the patient's medical record that the patient or the patient's parent or guardian, as applicable, has discussed with the practitioner the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available. The Division of Consumer Affairs shall develop and make available to practitioners guidelines for the discussion required pursuant to the bill.

At the time of the issuance of the third prescription for a prescription opioid drug, the practitioner shall enter into a pain management agreement with the patient. When a Schedule II controlled dangerous substance or any other prescription opioid drug is continuously prescribed for three months or more for chronic pain, the practitioner shall:

- (1) review, at a minimum of every three months, the course of treatment, any new information about the etiology of the pain, and the patient's progress toward treatment objectives and document the results of that review;

- (2) assess the patient prior to every renewal to determine whether the patient is experiencing problems associated with physical and psychological dependence and document the results of that assessment;

- (3) periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, try other drugs or treatment modalities in an effort to reduce the potential for abuse or the development of physical or psychological dependence and document with specificity the efforts undertaken;

- (4) review the Prescription Drug Monitoring information in accordance with section 8 of P.L.2015, c.74 (C. 45:1-46.1); and

(5) monitor compliance with the pain management agreement and any recommendations that the patient seek a referral.

The bill clarifies in its definition of “practitioner” that the bill is not intended to alter the scope of practice of any health care practitioner.

The bill exempts from the prescription limitations above the following: a patient who is currently in active treatment for cancer, receiving hospice care from a licensed hospice or palliative care, or is a resident of a long term care facility, and any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

The bill provides that the any State-regulated health benefits plan, and every contract purchased by the School Employees’ Health Benefits Commission or State Health Benefits Commission, that provides coverage for prescription drugs subject to a co-payment, coinsurance or deductible shall charge a co-payment, coinsurance or deductible for an initial prescription of an opioid drug prescribed pursuant to this section that is either: (1) proportional between the cost sharing for a 30-day supply and the amount of drugs the patient was prescribed; or (2) equivalent to the cost sharing for a full 30-day supply of the opioid drug, provided that no additional cost sharing may be charged for any additional prescriptions for the remainder of the 30-day supply.

The bill also would require certain health care professionals to receive training on topics related to prescription opioid drugs. Health care professionals who have the authority to prescribe opioid medications, including physicians, physician assistants, dentists, and optometrists (who have limited authority to prescribe only hydrocodone), will be required to complete one continuing education credit on topics that include responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion. For advance practice nurses, who also have prescribing authority, their required six contact hours of continuing professional education in pharmacology related to controlled substances will include issues concerning prescription opioid drugs, including responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion.

Health care professionals who do not have prescribing authority but who frequently interact with patients who may be prescribed opioids, including pharmacists, professional nurses, and practical nurses, would also be required to complete one continuing education credit on topics that include alternatives to opioids for managing and treating pain and the risks and signs of opioid abuse, addiction, and diversion. The continuing education credits required under the bill will be part of a professional’s regular continuing education credits

and will not increase the total number of continuing education credits required.

The bill additionally provides that certified nurse midwives will be required to complete one credit of educational programs or topics related to prescription opioid drugs as part of the 30 contact hours in pharmacology training that is required for them to be authorized to prescribe drugs.

The bill also requires the Commissioner of Health, in consultation with the Commissioner of Banking and Insurance, to submit reports to the Legislature and the Governor concerning implementation of the bill. One report is to be submitted six months, and the second report is to be submitted 12 months, after the date of enactment of the bill.

Finally the bill repeals several statutes, initially enacted in 1977 and 1985, which required coverage for the treatment of alcoholism. Because the bill expands that coverage to include treatment for all types of substance use disorder, including alcohol abuse, those sections of law specific to alcoholism are no longer required.

The committee amendments to the bill:

- Require that a facility providing inpatient or outpatient treatment of substance use disorder notify the patient's health coverage provider of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment;
- Provide that insurers may initiate concurrent review of medical necessity of inpatient treatment every two weeks, rather than every three weeks, after the first 28 days of treatment;
- Require that an initial prescription of an opioid drug for acute pain be for the lowest effective dose of an immediate-releasing opioid drug;
- Clarify that provisions of the bill concerning health care practitioners' prescribing apply to prescriptions of Schedule II controlled dangerous substance or any other opioid drug in a course of treatment for acute or chronic pain, excluding the five-day restriction on initial prescriptions, which applies only to acute pain;
- Require that a practitioner include a note in a patient's medical record, rather than a written acknowledgement, that the patient or the patient's parent or guardian, as applicable, has discussed with the practitioner the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available;
- Clarify that the bill's definition of "practitioner" applies only to those professionals acting within their licensed scope of practice; and
- Provide that health insurance contracts that provide coverage for prescription drugs subject to a co-payment, coinsurance or deductible shall charge a co-payment, coinsurance or deductible for an initial prescription of an opioid drug prescribed pursuant to

this section that is either: (1) proportional between the cost sharing for a 30-day supply and the amount of drugs the patient was prescribed; or (2) equivalent to the cost sharing for a full 30-day supply of the opioid drug, provided that no additional cost sharing may be charged for any additional prescriptions for the remainder of the 30-day supply.

LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

SENATE, No. 3

STATE OF NEW JERSEY 217th LEGISLATURE

DATED: FEBRUARY 10, 2017

SUMMARY

- Synopsis:** Requires health insurance coverage for treatment of substance use disorders; places certain restrictions on the prescription of opioid and certain other drugs; concerns continuing education related thereto.
- Type of Impact:** Expenditure increase to the State and to local governments (including school districts).
- Agencies Affected:** Division of Pensions and Benefits in the Department of the Treasury; local government entities (including school districts).

Office of Legislative Services Estimate

Fiscal Impact	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
State Cost	Indeterminate Increase – See comments below		
Local Cost	Indeterminate Increase – See comments below		

- The Office of Legislative Services (OLS) concludes that State and local expenditures for employee health benefits may increase by indeterminate amounts. To the extent that inpatient and outpatient treatment of substance use disorders at in-network facilities is provided without prior authorization or other prospective utilization management requirements, costs to the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP) will likely increase. It has been shown that prior authorization and utilization management reduces health care costs by curtailing unnecessary and inappropriate treatment.
- Local governments and school districts that do not participate in the SHBP and the SEHBP may experience significant expenditure increases if their plans do not cover treatment of substance abuse disorder to the extent mandated by the bill.
- The fiscal impact of the provisions restricting and regulating prescriptions for opioids is indeterminate, given that it depends on the price of the opioids; the volume of opioids being prescribed; and how restrictions that would be imposed would affect either the price or the volume.

- The cost to the State and local governments of prescription drugs also includes pharmacy dispensing fees. The bill will increase the number of prescriptions for the same opioid dosage, thereby increasing dispensing fees. However, if shorter-duration prescriptions actually reduce total dosages prescribed, savings may be realized.
- To the extent that physicians charge patients for a return consultation (follow-up visit) after the first five days of prescribing an opioid, or each additional time a prescription is needed, the SHBP/SEHBP could incur additional office visit costs.
- This bill would require health insurance plans to provide unlimited benefits for inpatient and outpatient treatment of substance use disorders at in-network facilities for treatment of substance use disorders; would place certain restrictions on the prescription of opioid and certain other drugs; and would require health care providers to attend related continuing education classes.

BILL DESCRIPTION

Senate Bill No. 3 (1R) of 2017 requires health insurance coverage for substance use disorders and regulates opioids and certain other prescription drugs in several ways. The bill requires health insurance carriers, and the State Health Benefits Program and the School Employees' Health Benefits Program, to adhere to certain coverage requirements for treatment of substance use disorders. The bill also places certain restrictions on the prescription of opioids, and requires certain notifications when prescribing Schedule II controlled dangerous substances used to treat chronic or acute pain. The bill also requires certain health care professionals to receive training on topics related to prescription opioid drugs.

Specifically, the bill requires insurers to provide unlimited benefits for inpatient and outpatient treatment of substance use disorders at in-network facilities. The bill specifies that the services for the treatment of substance use disorders must be prescribed by a licensed physician, licensed psychologist, or licensed psychiatrist and provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise State-approved facilities, as required by the laws of the state in which the services are rendered.

The bill provides that the benefits, for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder, would be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements. If there is no in-network facility immediately available for a covered person, insurers must provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

The benefits for the first 28 days of an inpatient stay during each plan year must be provided without any retrospective review or concurrent review of medical necessity and medical necessity as determined by the covered person's physician. The benefits for days 29 and thereafter of inpatient care would be subject to concurrent review as defined in the bill. The insurer cannot initiate concurrent review more frequently than two-week intervals.

The benefits for the first 28 days of intensive outpatient or partial hospitalization services must be provided without any retrospective review of medical necessity and medical necessity as determined by the covered person's physician. The benefits for days 29 and thereafter of intensive outpatient or partial hospitalization services would be subject to a retrospective review of the medical necessity of the services.

The bill specifies that benefits for inpatient and outpatient treatment of substance use disorder after the first 180 days per plan year would be subject to the medical necessity determination of the insurer and may be subject to prior authorization or retrospective review and other utilization management requirements.

Under the bill, the benefits for outpatient visits would not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

The benefits for outpatient prescription drugs used to treat substance abuse disorder must be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements.

The bill also places certain restrictions on how opioids and other Schedule II controlled substances may be prescribed. In cases of acute pain, the bill provides that a practitioner cannot issue an initial prescription for an opioid drug in a quantity exceeding a five-day supply. Any prescription for acute pain must be for the lowest effective dose of immediate-release opioid drug. In cases of acute or chronic pain, prior to issuing an initial prescription of a course of treatment that includes a Schedule II controlled dangerous substance or any other opioid drug, a practitioner must document the patient's medical history, develop a treatment plan, conform with a monitoring requirement, limit the supply of opioid drug prescriptions, and comply with State and federal laws.

The bill also would require certain health care professionals to receive training on topics related to prescription opioid drugs.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

Senate Bill No. 3 (1R) of 2017 would require the SHBP, the SEHBP and other insurance plans to provide the first 180 days of inpatient and outpatient treatment of substance abuse disorder, when determined medically necessary by the covered person's physician, psychologist, or psychiatrist, without prior authorization or other initial utilization management (UM) requirements. If there is no in-network facility immediately available, the contract must provide exceptions to the network to ensure admission to a treatment center within 24 hours.

This bill would also limit concurrent or retrospective review of medical necessity or any utilization management review for substance use disorder services. Prior authorization and utilization management are used by the SHBP and the SEHBP to contain costs. Currently, some specialty outpatient services require pre-approval and all inpatient substance use disorder services require pre-approval, whether or not the provider is in-network or out-of-network.

The OLS does not have information regarding how much the State pays Aetna and Horizon to provide utilization management services and the total cost for substance use disorder services. Therefore, the OLS is not able to determine the potential costs to the SHBP and the SEHBP of limiting utilization management for substance use disorder services.

According to the Centers for Medicare and Medicaid Services in the United States Department of Health and Human Services, "the components of UM that relate to certifying the necessity of the health care services provided includes, precertification, concurrent review, and

discharge planning to ensure that care is both medically necessary and covered for payment.” In a 2001 State of New Jersey, State Health Benefits Program and Consultant Review, commissioned by the State and conducted by Mercer Human Resource Consulting, the reported Horizon Utilization Management Return on Investment (ROI) was 3.6:1. This means that for every dollar the SHBP/SEHBP spends on UM, the SHBP/SEHBP saves \$3.60 in program costs. A June 2016 study by Accenture Consulting (formerly Anderson Consulting and a division of Arthur Anderson) and entitled, Risk Based. Data Driven. The New Face of Utilization Management, concluded that health care organizations employing network-centric utilization management can save in administrative and medical cost savings combined, with a 60 percent to 80 percent annual reduction in the number of billing codes requiring review, and a 17 percent to 40 percent reduction in administrative costs resulting from fewer billing codes.

The OLS notes that it is reasonable to assume that limiting UM practices would increase health care benefit costs accordingly.

The fiscal impact of the provisions regulating prescriptions for opioids depends on the price of the opioids, the volume of opioids being prescribed, and how restrictions that would be imposed would affect either the price or the volume. If opioid prescriptions are restricted, prescription drug costs to the SHBP/SEHBP would be reduced accordingly due to fewer prescriptions. If the number of people who need opioid prescriptions increases, even under the restrictions, opioid prescription costs to the SHBP/SEHBP could increase due to the increased new volume prescribed, although to a lesser degree because of the restrictions. Additionally, if the usage is restricted, prices may be increased by manufacturers to make up for the volume lost under the restrictions. Finally, if the prices do not change under the restrictions and the same number of opioids are prescribed after the restrictions are imposed, the bill could be cost neutral.

The cost to the State of prescription drugs also includes pharmacy dispensing fees. The bill will increase the number of prescriptions for the same opioid dosage, therefor increasing dispensing fees. However, if shorter-duration prescriptions actually reduce total dosages prescribed, savings may be realized.

To the extent that physicians charge patients for a return consultation after the first five days, or each additional time a prescription is needed, the SHBP/SEHBP could incur additional office visit costs.

Local governments that participate in the SHBP and SEHBP will experience indeterminate expenditure increases, due to the same factors affecting State costs as discussed above. Local governments that do not participate in the SHBP and SEHBP will not only be affected by these factors, but may also experience increased expenditures if their health insurance plans do not provide the level of coverage for substance use disorders mandated by the bill. The OLS does not have information on which to base an estimate of potential cost increases for these local governments.

Section: State Government

Analyst: Kimberly M. Clemmensen
Senior Fiscal Analyst

Approved: Frank W. Haines III
Legislative Budget and Finance Officer

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

ASSEMBLY, No. 3

STATE OF NEW JERSEY 217th LEGISLATURE

INTRODUCED JANUARY 30, 2017

Sponsored by:

Assemblyman VINCENT PRIETO

District 32 (Bergen and Hudson)

Assemblyman JON M. BRAMNICK

District 21 (Morris, Somerset and Union)

Assemblyman HERB CONAWAY, JR.

District 7 (Burlington)

Assemblyman DAVID P. RIBLE

District 30 (Monmouth and Ocean)

Assemblyman JOSEPH A. LAGANA

District 38 (Bergen and Passaic)

Assemblyman JOHN F. MCKEON

District 27 (Essex and Morris)

Assemblywoman SHAVONDA E. SUMTER

District 35 (Bergen and Passaic)

Assemblyman DANIEL R. BENSON

District 14 (Mercer and Middlesex)

Assemblywoman VALERIE VAINIERI HUTTLE

District 37 (Bergen)

Assemblyman DECLAN J. O'SCANLON, JR.

District 13 (Monmouth)

Co-Sponsored by:

Assemblyman Johnson

SYNOPSIS

Requires health insurance coverage for treatment of substance use disorders; places certain restrictions on the prescription of opioid and certain other drugs; concerns continuing education related thereto.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 1/31/2017)

1 AN ACT concerning substance use disorders and revising and
2 supplementing various parts of the statutory law.

3

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

6

7 1. (New section) a. A hospital service corporation contract
8 that provides hospital or medical expense benefits and is delivered,
9 issued, executed or renewed in this State, or approved for issuance
10 or renewal in this State by the Commissioner of Banking and
11 Insurance, on or after the effective date of this act, shall provide
12 unlimited benefits for inpatient and outpatient treatment of
13 substance use disorder at in-network facilities. The services for the
14 treatment of substance use disorder shall be prescribed by a licensed
15 physician, licensed psychologist, or licensed psychiatrist and
16 provided by licensed health care professionals or licensed or
17 certified substance use disorder providers in licensed or otherwise
18 State-approved facilities, as required by the laws of the state in
19 which the services are rendered.

20 b. The benefits for the first 180 days per plan year of inpatient
21 and outpatient treatment of substance use disorder shall be provided
22 when determined medically necessary by the covered person's
23 physician, psychologist or psychiatrist without the imposition of
24 any prior authorization or other prospective utilization management
25 requirements. If there is no in-network facility immediately
26 available for a covered person, a hospital service corporation shall
27 provide necessary exceptions to its network to ensure admission in
28 a treatment facility within 24 hours.

29 c. Providers of treatment for substance use disorder to persons
30 covered under a covered contract shall not require pre-payment of
31 medical expenses during this 180 days in excess of applicable co-
32 payment, deductible, or co-insurance under the contract.

33 d. The benefits for outpatient visits shall not be subject to
34 concurrent or retrospective review of medical necessity or any other
35 utilization management review.

36 e. (1) The benefits for the first 28 days of an inpatient stay
37 during each plan year shall be provided without any retrospective
38 review or concurrent review of medical necessity and medical
39 necessity shall be as determined by the covered person's physician.

40 (2) The benefits for days 29 and thereafter of inpatient care shall
41 be subject to concurrent review as defined in this section. A request
42 for approval of inpatient care beyond the first 28 days shall be
43 submitted for concurrent review before the expiration of the initial
44 28 day period. A request for approval of inpatient care beyond any
45 period that is approved under concurrent review shall be submitted

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 within the period that was previously approved. No hospital service
2 corporation shall initiate concurrent review more frequently than
3 three-week intervals. If a hospital service corporation determines
4 that continued inpatient care in a facility is no longer medically
5 necessary, the hospital service corporation shall within 24 hours
6 provide written notice to the covered person and the covered
7 person's physician of its decision and the right to file an expedited
8 internal appeal of the determination pursuant to an expedited
9 process pursuant to sections 11 through 13 of P.L.1997, c.192
10 (C.26:2S-11 through 26:2S-13) and N.J.AC.11:24A-3.5, as
11 applicable. The hospital service corporation shall review and make
12 a determination with respect to the internal appeal within 24 hours
13 and communicate such determination to the covered person and the
14 covered person's physician. If the determination is to uphold the
15 denial, the covered person and the covered person's physician have
16 the right to file an expedited external appeal with the Independent
17 Health Care Appeals Program in the Department of Banking and
18 Insurance pursuant to sections 11 through 13 of P.L.1997, c.192
19 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as
20 applicable. An independent utilization review organization shall
21 make a determination within 24 hours. If the hospital service
22 corporation's determination is upheld and it is determined
23 continued inpatient care is not medically necessary, the hospital
24 service corporation shall remain responsible to provide benefits for
25 the inpatient care through the day following the date the
26 determination is made and the covered person shall only be
27 responsible for any applicable co-payment, deductible and co-
28 insurance for the stay through that date as applicable under the
29 contract. The covered person shall not be discharged or released
30 from the inpatient facility until all internal appeals and independent
31 utilization review organization appeals are exhausted. For any costs
32 incurred after the day following the date of determination until the
33 day of discharge, the covered person shall only be responsible for
34 any applicable cost-sharing, and any additional charges shall be
35 paid by the facility or provider.

36 f. (1) The benefits for the first 28 days of intensive outpatient
37 or partial hospitalization services shall be provided without any
38 retrospective review of medical necessity and medical necessity
39 shall be as determined by the covered person's physician.

40 (2) The benefits for days 29 and thereafter of intensive
41 outpatient or partial hospitalization services shall be subject to a
42 retrospective review of the medical necessity of the services.

43 g. Benefits for inpatient and outpatient treatment of substance
44 use disorder after the first 180 days per plan year shall be subject to
45 the medical necessity determination of the hospital service
46 corporation and may be subject to prior authorization or,
47 retrospective review and other utilization management
48 requirements.

1 h. Medical necessity review shall utilize an evidence-based and
2 peer reviewed clinical review tool to be designated through
3 rulemaking by the Commissioner of Human Services in
4 consultation with the Department of Health.

5 i. The benefits for outpatient prescription drugs to treat
6 substance use disorder shall be provided when determined
7 medically necessary by the covered person's physician,
8 psychologist or psychiatrist without the imposition of any prior
9 authorization or other prospective utilization management
10 requirements.

11 j. The first 180 days per plan year of benefits shall be
12 computed based on inpatient days. One or more unused inpatient
13 days may be exchanged for two outpatient visits. All extended
14 outpatient services such as partial hospitalization and intensive
15 outpatient, shall be deemed inpatient days for the purpose of the
16 visit to day exchange provided in this subsection.

17 k. Except as stated above, the benefits and cost-sharing shall be
18 provided to the same extent as for any other medical condition
19 covered under the contract.

20 l. The benefits required by this section are to be provided to all
21 covered persons with a diagnosis of substance use disorder. The
22 presence of additional related or unrelated diagnoses shall not be a
23 basis to reduce or deny the benefits required by this section.

24 m. The provisions of this section shall apply to all hospital
25 service corporation contracts in which the hospital service
26 corporation has reserved the right to change the premium.

27 n. The Attorney General's Office shall be responsible for
28 overseeing any violations of law that may result from P.L. , c.
29 (C.) (pending before the Legislature as this bill), including fraud,
30 abuse, waste, and mistreatment of covered persons. The Attorney
31 General's Office is authorized to adopt, pursuant to the
32 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
33 seq.), rules and regulations to implement any of the provisions of
34 P.L. , c. (C.) (pending before the Legislature as this bill).

35 o. The provisions of this section shall not apply to a hospital
36 service corporation contract which, pursuant to a contract between
37 the hospital service corporation and the Department of Human
38 Services, provides benefits to persons who are eligible for medical
39 assistance under P.L.168, c.413 (C.30:4D-1 et seq.), the "Family
40 Health Care Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.), or
41 any other program administered by the Division of Medical
42 Assistance and Health Services in the Department of Human
43 Services.

44 p. As used in this section:

45 "Concurrent review" means inpatient care is reviewed as it is
46 provided. Medically qualified reviewers monitor appropriateness of
47 the care, the setting, and patient progress, and as appropriate, the
48 discharge plans.

1 “Substance use disorder” is as defined by the American
2 Psychiatric Association in the Diagnostic and Statistical Manual of
3 Mental Disorders, Fifth Edition and any subsequent editions and
4 shall include substance use withdrawal.

5
6 2. (New section) a. A medical service corporation contract
7 that provides hospital or medical expense benefits and is delivered,
8 issued, executed or renewed in this State, or approved for issuance
9 or renewal in this State by the Commissioner of Banking and
10 Insurance, on or after the effective date of this act, shall provide
11 unlimited benefits for inpatient and outpatient treatment of
12 substance use disorder at in-network facilities. The services for the
13 treatment of substance use disorder shall be prescribed by a licensed
14 physician, licensed psychologist, or licensed psychiatrist and
15 provided by licensed health care professionals or licensed or
16 certified substance use disorder providers in licensed or otherwise
17 State-approved facilities, as required by the laws of the state in
18 which the services are rendered.

19 b. The benefits for the first 180 days per plan year of inpatient
20 and outpatient treatment of substance use disorder shall be provided
21 when determined medically necessary by the covered person’s
22 physician, psychologist or psychiatrist without the imposition of
23 any prior authorization or other prospective utilization management
24 requirements. If there is no in-network facility immediately
25 available for a covered person, a medical service corporation shall
26 provide necessary exceptions to its network to ensure admission in
27 a treatment facility within 24 hours.

28 c. Providers of treatment for substance use disorder to persons
29 covered under a covered contract shall not require pre-payment of
30 medical expenses during this 180 days in excess of applicable co-
31 payment, deductible, or co-insurance under the contract.

32 d. The benefits for outpatient visits shall not be subject to
33 concurrent or retrospective review of medical necessity or any other
34 utilization management review.

35 e. (1) The benefits for the first 28 days of an inpatient stay
36 during each plan year shall be provided without any retrospective
37 review or concurrent review of medical necessity and medical
38 necessity shall be as determined by the covered person’s physician.

39 (2) The benefits for days 29 and thereafter of inpatient care shall
40 be subject to concurrent review as defined in this section. A request
41 for approval of inpatient care beyond the first 28 days shall be
42 submitted for concurrent review before the expiration of the initial
43 28 day period. A request for approval of inpatient care beyond any
44 period that is approved under concurrent review shall be submitted
45 within the period that was previously approved. No medical service
46 corporation shall initiate concurrent review more frequently than
47 three-week intervals. If a medical service corporation determines
48 that continued inpatient confinement in a facility is no longer

1 medically necessary, the medical service corporation shall within 24
2 hours provide written notice to the covered person and the covered
3 person's physician of its decision and the right to file an expedited
4 internal appeal of the determination pursuant to an expedited
5 process pursuant to sections 11 through 13 of P.L.1997, c.192
6 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as
7 applicable. The medical service corporation shall review and make
8 a determination with respect to the internal appeal within 24 hours
9 and communicate such determination to the covered person and the
10 covered person's physician. If the determination is to uphold the
11 denial, the covered person and the covered person's physician have
12 the right to file an expedited external appeal with the Independent
13 Health Care Appeals Program in the Department of Banking and
14 Insurance pursuant to sections 11 through 13 of P.L.1997, c.192
15 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as
16 applicable. An independent utilization review organization shall
17 make a determination within 24 hours. If the medical service
18 corporation's determination is upheld and it is determined
19 continued inpatient care is not medically necessary, the medical
20 service corporation shall remain responsible to provide benefits for
21 the inpatient care through the day following the date the
22 determination is made and the covered person shall only be
23 responsible for any applicable co-payment, deductible and co-
24 insurance for the stay through that date as applicable under the
25 contract. The covered person shall not be discharged or released
26 from the inpatient facility until all internal appeals and independent
27 utilization review organization appeals are exhausted. For any costs
28 incurred after the day following the date of determination until the
29 day of discharge, the covered person shall only be responsible for
30 any applicable cost-sharing, and any additional charges shall be
31 paid by the facility or provider.

32 f. (1) The benefits for the first 28 days of intensive outpatient
33 or partial hospitalization services shall be provided without any
34 retrospective review of medical necessity and medical necessity
35 shall be as determined by the covered person's physician.

36 (2) The benefits for days 29 and thereafter of intensive
37 outpatient or partial hospitalization services shall be subject to a
38 retrospective review of the medical necessity of the services.

39 g. Benefits for inpatient and outpatient treatment of substance
40 use disorder after the first 180 days per plan year shall be subject to
41 the medical necessity determination of the medical service
42 corporation and may be subject to prior authorization or,
43 retrospective review and other utilization management
44 requirements.

45 h. Medical necessity review shall utilize an evidence-based and
46 peer reviewed clinical review tool to be designated through
47 rulemaking by the Commissioner of Human Services in
48 consultation with the Department of Health.

1 i. The benefits for medication-assisted treatments for
2 substance use disorder shall be provided when determined
3 medically necessary by the covered person's physician,
4 psychologist or psychiatrist without the imposition of any prior
5 authorization or other prospective utilization management
6 requirements.

7 j. The first 180 days per plan year of benefits shall be
8 computed based on inpatient days. One or more unused inpatient
9 days may be exchanged for two outpatient visits. All extended
10 outpatient services such as partial hospitalization and intensive
11 outpatient, shall be deemed inpatient days for the purpose of the
12 visit to day exchange provided in this subsection.

13 k. Except as stated above, the benefits and cost-sharing shall be
14 provided to the same extent as for any other medical condition
15 covered under the contract.

16 l. The benefits required by this section are to be provided to all
17 covered persons with a diagnosis of substance use disorder. The
18 presence of additional related or unrelated diagnoses shall not be a
19 basis to reduce or deny the benefits required by this section.

20 m. The provisions of this section shall apply to all medical
21 service corporation contracts in which the medical service
22 corporation has reserved the right to change the premium.

23 n. The Attorney General's office shall be responsible for
24 overseeing any violations of law that may result from P.L. , c.
25 (C.) (pending before the Legislature as this bill), including fraud,
26 abuse, waste, and mistreatment of covered persons. The Attorney
27 General's office is authorized to adopt, pursuant to the
28 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
29 seq.), rules and regulations to implement any of the provisions of
30 P.L. , c. (C.) (pending before the Legislature as this bill).

31 o. The provisions of this section shall not apply to a medical
32 service corporation contract which, pursuant to a contract between
33 the medical service corporation and the Department of Human
34 Services, provides benefits to persons who are eligible for medical
35 assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family
36 Health Care Coverage Act," P.L.2005, c.156 (C.30:2J-8 et seq.), or
37 any other program administered by the Division of Medical
38 Assistance and Health Services in the Department of Human
39 Services.

40 p. As used in this section:

41 "Concurrent review" means inpatient care is reviewed as it is
42 provided. Medically qualified reviewers monitor appropriateness of
43 the care, the setting, and patient progress, and as appropriate, the
44 discharge plans.

45 "Substance use disorder" is as defined by the American
46 Psychiatric Association in the Diagnostic and Statistical Manual of
47 Mental Disorders, Fifth Edition and any subsequent editions and
48 shall include substance use withdrawal.

1 3. (New section) a. A health service corporation contract that
2 provides hospital or medical expense benefits and is delivered,
3 issued, executed or renewed in this State, or approved for issuance
4 or renewal in this State by the Commissioner of Banking and
5 Insurance, on or after the effective date of this act shall provide
6 unlimited benefits for inpatient and outpatient treatment of
7 substance use disorder at in-network facilities. The services for the
8 treatment of substance use disorder shall be prescribed by a licensed
9 physician, licensed psychologist, or licensed psychiatrist and
10 provided by licensed health care professionals or licensed or
11 certified substance use disorder providers in licensed or otherwise
12 State-approved facilities, as required by the laws of the state in
13 which the services are rendered.

14 b. The benefits for the first 180 days per plan year of inpatient
15 and outpatient treatment of substance use disorder shall be provided
16 when determined medically necessary by the covered person's
17 physician, psychologist or psychiatrist without the imposition of
18 any prior authorization or other prospective utilization management
19 requirements. If there is no in-network facility immediately
20 available for a covered person, a health service corporation shall
21 provide necessary exceptions to its network to ensure admission in
22 a treatment facility within 24 hours.

23 c. Providers of treatment for substance use disorder to persons
24 covered under a covered contract shall not require pre-payment of
25 medical expenses during this 180 days in excess of applicable co-
26 payment, deductible, or co-insurance under the contract.

27 d. The benefits for outpatient visits shall not be subject to
28 concurrent or retrospective review of medical necessity or any other
29 utilization management review.

30 e. (1) The benefits for the first 28 days of an inpatient stay
31 during each plan year shall be provided without any retrospective
32 review or concurrent review of medical necessity and medical
33 necessity shall be as determined by the covered person's physician.

34 (2) The benefits for days 29 and thereafter of inpatient care shall
35 be subject to concurrent review as defined in this section. A request
36 for approval of inpatient care beyond the first 28 days shall be
37 submitted for concurrent review before the expiration of the initial
38 28 day period. A request for approval of inpatient care beyond any
39 period that is approved under concurrent review shall be submitted
40 within the period that was previously approved. No health service
41 corporation shall initiate concurrent review more frequently than
42 three-week intervals. If a health service corporation determines that
43 continued inpatient care in a facility is no longer medically
44 necessary, the health service corporation shall within 24 hours
45 provide written notice to the covered person and the covered
46 person's physician of its decision and the right to file an expedited
47 internal appeal of the determination pursuant to an expedited
48 process pursuant to sections 11 through 13 of P.L.1997, c.192

1 (C.26:2S-11 through 26:2S-13) and N.J.AC.11:24A-3.5, as
2 applicable. The health service corporation shall review and make a
3 determination with respect to the internal appeal within 24 hours
4 and communicate such determination to the covered person and the
5 covered person's physician. If the determination is to uphold the
6 denial, the covered person and the covered person's physician have
7 the right to file an expedited external appeal with the Independent
8 Health Care Appeals Program in the Department of Banking and
9 Insurance pursuant to sections 11 through 13 of P.L.1997, c.192
10 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as
11 applicable. An independent utilization review organization shall
12 make a determination within 24 hours. If the health service
13 corporation's determination is upheld and it is determined
14 continued inpatient care is not medically necessary, the health
15 service corporation shall remain responsible to provide benefits for
16 the inpatient care through the day following the date the
17 determination is made and the covered person shall only be
18 responsible for any applicable co-payment, deductible and co-
19 insurance for the stay through that date as applicable under the
20 policy. The covered person shall not be discharged or released
21 from the inpatient facility until all internal appeals and independent
22 utilization review organization appeals are exhausted. For any costs
23 incurred after the day following the date of determination until the
24 day of discharge, the covered person shall only be responsible for
25 any applicable cost-sharing, and any additional charges shall be
26 paid by the facility or provider.

27 f. (1) The benefits for the first 28 days of intensive outpatient
28 or partial hospitalization services shall be provided without any
29 retrospective review of medical necessity and medical necessity
30 shall be as determined by the covered person's physician.

31 (2) The benefits for days 29 and thereafter of intensive
32 outpatient or partial hospitalization services shall be subject to a
33 retrospective review of the medical necessity of the services.

34 g. Benefits for inpatient and outpatient treatment of substance
35 use disorder after the first 180 days per plan year shall be subject to
36 the medical necessity determination of the health service
37 corporation and may be subject to prior authorization or,
38 retrospective review and other utilization management
39 requirements.

40 h. Medical necessity review shall utilize an evidence-based and
41 peer reviewed clinical review tool to be designated through
42 rulemaking by the Commissioner of Human Services in
43 consultation with the Department of Health.

44 i. The benefits for outpatient prescription drugs to treat
45 substance use disorder shall be provided when determined
46 medically necessary by the covered person's physician,
47 psychologist or psychiatrist without the imposition of any prior

1 authorization or other prospective utilization management
2 requirements.

3 j. The first 180 days per plan year of benefits shall be
4 computed based on inpatient days. One or more unused inpatient
5 days may be exchanged for two outpatient visits. All extended
6 outpatient services such as partial hospitalization and intensive
7 outpatient, shall be deemed inpatient days for the purpose of the
8 visit to day exchange provided in this subsection.

9 k. Except as stated above, the benefits and cost-sharing shall be
10 provided to the same extent as for any other medical condition
11 covered under the contract.

12 l. The benefits required by this section are to be provided to all
13 covered persons with a diagnosis of substance use disorder. The
14 presence of additional related or unrelated diagnoses shall not be a
15 basis to reduce or deny the benefits required by this section.

16 m. The provisions of this section shall apply to all health
17 service corporation contracts in which the health service
18 corporation has reserved the right to change the premium.

19 n. The Attorney General's Office shall be responsible for
20 overseeing any violations of law that may result from P.L. , c.
21 (C.) (pending before the Legislature as this bill), including fraud,
22 abuse, waste, and mistreatment of covered persons. The Attorney
23 General's office is authorized to adopt, pursuant to the
24 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
25 seq.), rules and regulations to implement any of the provisions of
26 P.L. , c. (C.) (pending before the Legislature as this bill).

27 o. The provisions of this section shall not apply to a health
28 service corporation contract which, pursuant to a contract between
29 the health service corporation and the Department of Human
30 Services, provides benefits to persons who are eligible for medical
31 assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family
32 Health Care Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.) or
33 any other program administered by the Division of Medical
34 Assistance and Health Services in the Department of Human
35 Services.

36 p. As used in this section:

37 "Concurrent review" means inpatient care is reviewed as it is
38 provided. Medically qualified reviewers monitor appropriateness of
39 the care, the setting, and patient progress, and as appropriate, the
40 discharge plans.

41 "Substance use disorder" is as defined by the American
42 Psychiatric Association in the Diagnostic and Statistical Manual of
43 Mental Disorders, Fifth Edition and any subsequent editions and
44 shall include substance use withdrawal.

45

46 4. (New section) a. An individual health insurance policy that
47 provides hospital or medical expense benefits and is delivered,
48 issued, executed or renewed in this State, or approved for issuance

1 or renewal in this State by the Commissioner of Banking and
2 Insurance, on or after the effective date of this act, shall provide
3 unlimited benefits for inpatient and outpatient treatment of
4 substance use disorder at in-network facilities. The services for the
5 treatment of substance use disorder shall be prescribed by a licensed
6 physician, licensed psychologist, or licensed psychiatrist and
7 provided by licensed health care professionals or licensed or
8 certified substance use disorder providers in licensed or otherwise
9 State-approved facilities, as required by the laws of the state in
10 which the services are rendered.

11 b. The benefits for the first 180 days per plan year of inpatient
12 and outpatient treatment of substance use disorder shall be provided
13 when determined medically necessary by the covered person's
14 physician, psychologist or psychiatrist without the imposition of
15 any prior authorization or other prospective utilization management
16 requirements. If there is no in-network facility immediately
17 available for a covered person, an insurer shall provide necessary
18 exceptions to their network to ensure admission in a treatment
19 facility within 24 hours.

20 c. Providers of treatment for substance use disorder to persons
21 covered under a covered policy shall not require pre-payment of
22 medical expenses during this 180 days in excess of applicable co-
23 payment, deductible, or co-insurance under the policy.

24 d. The benefits for outpatient visits shall not be subject to
25 concurrent or retrospective review of medical necessity or any other
26 utilization management review.

27 e. (1) The benefits for the first 28 days of an inpatient stay
28 during each plan year shall be provided without any retrospective
29 review or concurrent review of medical necessity and medical
30 necessity shall be as determined by the covered person's physician.

31 (2) The benefits for days 29 and thereafter of inpatient care shall
32 be subject to concurrent review as defined in this section. A request
33 for approval of inpatient care beyond the first 28 days shall be
34 submitted for concurrent review before the expiration of the initial
35 28 day period. A request for approval of inpatient care beyond any
36 period that is approved under concurrent review shall be submitted
37 within the period that was previously approved. No insurer shall
38 initiate concurrent review more frequently than three-week
39 intervals. If an insurer determines that continued inpatient care in a
40 facility is no longer medically necessary, the insurer shall within 24
41 hours provide written notice to the covered person and the covered
42 person's physician of its decision and the right to file an expedited
43 internal appeal of the determination pursuant to an expedited
44 process pursuant to sections 11 through 13 of P.L.1997, c.192
45 (C.26:2S-11 through 26:2S-13) and N.J.AC.11:24A-3.5, as
46 applicable. The insurer shall review and make a determination with
47 respect to the internal appeal within 24 hours and communicate
48 such determination to the covered person and the covered person's

1 physician. If the determination is to uphold the denial, the covered
2 person and the covered person's physician have the right to file an
3 expedited external appeal with the Independent Health Care
4 Appeals Program in the Department of Banking and Insurance
5 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
6 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
7 independent utilization review organization shall make a
8 determination within 24 hours. If the insurer's determination is
9 upheld and it is determined continued inpatient care is not
10 medically necessary, the insurer shall remain responsible to provide
11 benefits for the inpatient care through the day following the date the
12 determination is made and the covered person shall only be
13 responsible for any applicable co-payment, deductible and co-
14 insurance for the stay through that date as applicable under the
15 policy. The covered person shall not be discharged or released
16 from the inpatient facility until all internal appeals and independent
17 utilization review organization appeals are exhausted. For any costs
18 incurred after the day following the date of determination until the
19 day of discharge, the covered person shall only be responsible for
20 any applicable cost-sharing, and any additional charges shall be
21 paid by the facility or provider.

22 f. (1) The benefits for the first 28 days of intensive outpatient
23 or partial hospitalization services shall be provided without any
24 retrospective review of medical necessity and medical necessity
25 shall be as determined by the covered person's physician.

26 (2) The benefits for days 29 and thereafter of intensive
27 outpatient or partial hospitalization services shall be subject to a
28 retrospective review of the medical necessity of the services.

29 g. Benefits for inpatient and outpatient treatment of substance
30 use disorder after the first 180 days per plan year shall be subject to
31 the medical necessity determination of the insurer and may be
32 subject to prior authorization or, retrospective review and other
33 utilization management requirements.

34 h. Medical necessity review shall utilize an evidence-based and
35 peer reviewed clinical review tool to be designated through
36 rulemaking by the Commissioner of Human Services in
37 consultation with the Department of Health.

38 i. The benefits for outpatient prescription drugs to treat
39 substance use disorder shall be provided when determined
40 medically necessary by the covered person's physician,
41 psychologist or psychiatrist without the imposition of any prior
42 authorization or other prospective utilization management
43 requirements.

44 j. The first 180 days per plan year of benefits shall be
45 computed based on inpatient days. One or more unused inpatient
46 days may be exchanged for two outpatient visits. All extended
47 outpatient services such as partial hospitalization and intensive

1 outpatient, shall be deemed inpatient days for the purpose of the
2 visit to day exchange provided in this subsection.

3 k. Except as stated above, the benefits and cost-sharing shall be
4 provided to the same extent as for any other medical condition
5 covered under the policy.

6 l. The benefits required by this section are to be provided to all
7 covered persons with a diagnosis of substance use disorder. The
8 presence of additional related or unrelated diagnoses shall not be a
9 basis to reduce or deny the benefits required by this section.

10 m. The provisions of this section shall apply to those policies in
11 which the insurer has reserved the right to change the premium.

12 n. The Attorney General's Office shall be responsible for
13 overseeing any violations of law that may result from P.L. , c.
14 (C.) (pending before the Legislature as this bill), including fraud,
15 abuse, waste, and mistreatment of covered persons. The Attorney
16 General's Office is authorized to adopt, pursuant to the
17 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
18 seq.), rules and regulations to implement any of the provisions of
19 P.L. , c. (C.)(pending before the Legislature as this bill)

20 o. The provisions of this section shall not apply to an
21 individual health insurance policy which, pursuant to a contract
22 between the insurer and the Department of Human Services,
23 provides benefits to persons who are eligible for medical assistance
24 under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family Health Care
25 Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.), or any other
26 program administered by the Division of Medical Assistance and
27 Health Services in the Department of Human Services.

28 p. As used in this section:

29 "Concurrent review" means inpatient care is reviewed as it is
30 provided. Medically qualified reviewers monitor appropriateness of
31 the care, the setting, and patient progress, and as appropriate, the
32 discharge plans.

33 "Substance use disorder" is as defined by the American
34 Psychiatric Association in the Diagnostic and Statistical Manual of
35 Mental Disorders, Fifth Edition and any subsequent editions and
36 shall include substance use withdrawal.

37

38 5. (New section) a. A group health insurance policy that
39 provides hospital or medical expense benefits and is delivered,
40 issued, executed or renewed in this State, or approved for issuance
41 or renewal in this State by the Commissioner of Banking and
42 Insurance, on or after the effective date of this act, shall provide
43 unlimited benefits for inpatient and outpatient treatment of
44 substance use disorder at in-network facilities. The services for the
45 treatment of substance use disorder shall be prescribed by a licensed
46 physician, licensed psychologist, or licensed psychiatrist and
47 provided by licensed health care professionals or licensed or
48 certified substance use disorder providers in licensed or otherwise

1 State-approved facilities, as required by the laws of the state in
2 which the services are rendered.

3 b. The benefits for the first 180 days per plan year of inpatient
4 and outpatient treatment of substance use disorder shall be provided
5 when determined medically necessary by the covered person's
6 physician, psychologist or psychiatrist without the imposition of
7 any prior authorization or other prospective utilization management
8 requirements. If there is no in-network facility immediately
9 available for a covered person, an insurer shall provide necessary
10 exceptions to its network to ensure admission in a treatment facility
11 within 24 hours.

12 c. Providers of treatment for substance use disorder to persons
13 covered under a covered insurance policy shall not require pre-
14 payment of medical expenses during this 180 days in excess of
15 applicable co-payment, deductible, or co-insurance under the
16 policy.

17 d. The benefits for outpatient visits shall not be subject to
18 concurrent or retrospective review of medical necessity or any other
19 utilization management review.

20 e. (1) The benefits for the first 28 days of an inpatient stay
21 during each plan year shall be provided without any retrospective
22 review or concurrent review of medical necessity and medical
23 necessity shall be as determined by the covered person's physician.

24 (2) The benefits for days 29 and thereafter of inpatient care shall
25 be subject to concurrent review as defined in this section. A request
26 for approval of inpatient care beyond the first 28 days shall be
27 submitted for concurrent review before the expiration of the initial
28 28 day period. A request for approval of inpatient care beyond any
29 period that is approved under concurrent review shall be submitted
30 within the period that was previously approved. No insurer shall
31 initiate concurrent review more frequently than three-week
32 intervals. If an insurer determines that continued inpatient care in a
33 facility is no longer medically necessary, the insurer shall within 24
34 hours provide written notice to the covered person and the covered
35 person's physician of its decision and the right to file an expedited
36 internal appeal of the determination pursuant to an expedited
37 process pursuant to sections 11 through 13 of P.L.1997, c.192
38 (C.26:2S-11 through 26:2S-13) and N.J.AC.11:24A-3.5, as
39 applicable. The insurer shall review and make a determination with
40 respect to the internal appeal within 24 hours and communicate
41 such determination to the covered person and the covered person's
42 physician. If the determination is to uphold the denial, the covered
43 person and the covered person's physician have the right to file an
44 expedited external appeal with the Independent Health Care
45 Appeals Program in the Department of Banking and Insurance
46 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
47 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
48 independent utilization review organization shall make a

1 determination within 24 hours. If the insurer's determination is
2 upheld and it is determined continued inpatient care is not
3 medically necessary, the insurer shall remain responsible to provide
4 benefits for the inpatient care through the day following the date the
5 determination is made and the covered person shall only be
6 responsible for any applicable co-payment, deductible and co-
7 insurance for the stay through that date as applicable under the
8 policy. The covered person shall not be discharged or released
9 from the inpatient facility until all internal appeals and independent
10 utilization review organization appeals are exhausted. For any costs
11 incurred after the day following the date of determination until the
12 day of discharge, the covered person shall only be responsible for
13 any applicable cost-sharing, and any additional charges shall be
14 paid by the facility or provider.

15 f. (1) The benefits for the first 28 days of intensive outpatient
16 or partial hospitalization services shall be provided without any
17 retrospective review of medical necessity and medical necessity
18 shall be as determined by the covered person's physician.

19 (2) The benefits for days 29 and thereafter of intensive
20 outpatient or partial hospitalization services shall be subject to a
21 retrospective review of the medical necessity of the services.

22 g. Benefits for inpatient and outpatient treatment of substance
23 use disorder after the first 180 days per plan year shall be subject to
24 the medical necessity determination of the insurer and may be
25 subject to prior authorization or, retrospective review and other
26 utilization management requirements.

27 h. Medical necessity review shall utilize an evidence-based and
28 peer reviewed clinical review tool to be designated through
29 rulemaking by the Commissioner of Human Services in
30 consultation with the Department of Health.

31 i. The benefits for outpatient prescription drugs to treat
32 substance use disorder shall be provided when determined
33 medically necessary by the covered person's physician,
34 psychologist or psychiatrist without the imposition of any prior
35 authorization or other prospective utilization management
36 requirements.

37 j. The first 180 days per plan year of benefits shall be
38 computed based on inpatient days. One or more unused inpatient
39 days may be exchanged for two outpatient visits. All extended
40 outpatient services such as partial hospitalization and intensive
41 outpatient, shall be deemed inpatient days for the purpose of the
42 visit to day exchange provided in this subsection.

43 k. Except as stated above, the benefits and cost-sharing shall be
44 provided to the same extent as for any other medical condition
45 covered under the policy.

46 l. The benefits required by this section are to be provided to all
47 covered persons with a diagnosis of substance use disorder. The

1 presence of additional related or unrelated diagnoses shall not be a
2 basis to reduce or deny the benefits required by this section.

3 m. The provisions of this section shall apply to those policies in
4 which the insurer has reserved the right to change the premium.

5 n. The Attorney General's Office shall be responsible for
6 overseeing any violations of law that may result from P.L. , c.
7 (C.) (pending before the Legislature as this bill), including fraud,
8 abuse, waste, and mistreatment of covered persons. The Attorney
9 General's Office is authorized to adopt, pursuant to the
10 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
11 seq.), rules and regulations to implement any of the provisions of
12 P.L. , c. (C.) (pending before the Legislature as this bill).

13 o. The provisions of this section shall not apply to a group
14 health insurance policy which, pursuant to a contract between the
15 insurer and the Department of Human Services, provides benefits to
16 persons who are eligible for medical assistance under P.L.1968,
17 c.413 (C.30:4D-1 et seq.), the "Family Health Care Coverage Act,"
18 P.L.2005, c.156 (C.30:4J-8 et seq.), or any other program
19 administered by the Division of Medical Assistance and Health
20 Services in the Department of Human Services.

21 p. As used in this section:

22 "Concurrent review" means inpatient care is reviewed as it is
23 provided. Medically qualified reviewers monitor appropriateness of
24 the care, the setting, and patient progress, and as appropriate, the
25 discharge plans.

26 "Substance use disorder" is as defined by the American
27 Psychiatric Association in the Diagnostic and Statistical Manual of
28 Mental Disorders, Fifth Edition and any subsequent editions and
29 shall include substance use withdrawal.

30

31 6. (New section) a. An individual health benefits plan that
32 provides hospital or medical expense benefits and is delivered,
33 issued, executed or renewed in this State, or approved for issuance
34 or renewal in this State by the Commissioner of Banking and
35 Insurance, on or after the effective date of this act, shall provide
36 unlimited benefits for inpatient and outpatient treatment of
37 substance use disorder at in-network facilities. The services for the
38 treatment of substance use disorder shall be prescribed by a licensed
39 physician, licensed psychologist, or licensed psychiatrist and
40 provided by licensed health care professionals or licensed or
41 certified substance use disorder providers in licensed or otherwise
42 State-approved facilities, as required by the laws of the state in
43 which the services are rendered.

44 b. The benefits for the first 180 days per plan year of inpatient
45 and outpatient treatment of substance use disorder shall be provided
46 when determined medically necessary by the covered person's
47 physician, psychologist or psychiatrist without the imposition of
48 any prior authorization or other prospective utilization management

1 requirements. If there is no in-network facility immediately
2 available for a covered person, a carrier shall provide necessary
3 exceptions to their network to ensure admission in a treatment
4 facility within 24 hours.

5 c. Providers of treatment for substance use disorder to persons
6 covered under a covered health benefits plan shall not require pre-
7 payment of medical expenses during this 180 days in excess of
8 applicable co-payment, deductible, or co-insurance under the plan.

9 d. The benefits for outpatient visits shall not be subject to
10 concurrent or retrospective review of medical necessity or any other
11 utilization management review.

12 e. (1) The benefits for the first 28 days of an inpatient stay
13 during each plan year shall be provided without any retrospective
14 review or concurrent review of medical necessity and medical
15 necessity shall be as determined by the covered person's physician.

16 (2) The benefits for days 29 and thereafter of inpatient care shall
17 be subject to concurrent review as defined in this section. A request
18 for approval of inpatient care beyond the first 28 days shall be
19 submitted for concurrent review before the expiration of the initial
20 28 day period. A request for approval of inpatient care beyond any
21 period that is approved under concurrent review shall be submitted
22 within the period that was previously approved. No carrier shall
23 initiate concurrent review more frequently than three-week
24 intervals. If a carrier determines that continued inpatient care in a
25 facility is no longer medically necessary, the carrier shall within 24
26 hours provide written notice to the covered person and the covered
27 person's physician of its decision and the right to file an expedited
28 internal appeal of the determination pursuant to an expedited
29 process pursuant to sections 11 through 13 of P.L.1997, c.192
30 (C.26:2S-11 through 26:2S-13) and N.J.AC.11:24A-3.5, as
31 applicable. The carrier shall review and make a determination with
32 respect to the internal appeal within 24 hours and communicate
33 such determination to the covered person and the covered person's
34 physician. If the determination is to uphold the denial, the covered
35 person and the covered person's physician have the right to file an
36 expedited external appeal with the Independent Health Care
37 Appeals Program in the Department of Banking and Insurance
38 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
39 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
40 independent utilization review organization shall make a
41 determination within 24 hours. If the carrier's determination is
42 upheld and it is determined continued inpatient care is not
43 medically necessary, the carrier shall remain responsible to provide
44 benefits for the inpatient care through the day following the date the
45 determination is made and the covered person shall only be
46 responsible for any applicable co-payment, deductible and co-
47 insurance for the stay through that date as applicable under the
48 policy. The covered person shall not be discharged or released

1 from the inpatient facility until all internal appeals and independent
2 utilization review organization appeals are exhausted. For any costs
3 incurred after the day following the date of determination until the
4 day of discharge, the covered person shall only be responsible for
5 any applicable cost-sharing, and any additional charges shall be
6 paid by the facility or provider.

7 f. (1) The benefits for the first 28 days of intensive outpatient
8 or partial hospitalization services shall be provided without any
9 retrospective review of medical necessity and medical necessity
10 shall be as determined by the covered person's physician.

11 (2) The benefits for days 29 and thereafter of intensive
12 outpatient or partial hospitalization services shall be subject to a
13 retrospective review of the medical necessity of the services.

14 g. Benefits for inpatient and outpatient treatment of substance
15 use disorder after the first 180 days per plan year shall be subject to
16 the medical necessity determination of the insurer and may be
17 subject to prior authorization or, retrospective review and other
18 utilization management requirements.

19 h. Medical necessity review shall utilize an evidence-based and
20 peer reviewed clinical review tool to be designated through
21 rulemaking by the Commissioner of Human Services in
22 consultation with the Department of Health.

23 i. The benefits for outpatient prescription drugs to treat
24 substance use disorder shall be provided when determined
25 medically necessary by the covered person's physician,
26 psychologist or psychiatrist without the imposition of any prior
27 authorization or other prospective utilization management
28 requirements.

29 j. The first 180 days per plan year of benefits shall be
30 computed based on inpatient days. One or more unused inpatient
31 days may be exchanged for two outpatient visits. All extended
32 outpatient services such as partial hospitalization and intensive
33 outpatient, shall be deemed inpatient days for the purpose of the
34 visit to day exchange provided in this subsection.

35 k. Except as stated above, the benefits and cost-sharing shall be
36 provided to the same extent as for any other medical condition
37 covered under the health benefits plan.

38 l. The benefits required by this section are to be provided to all
39 covered persons with a diagnosis of substance use disorder. The
40 presence of additional related or unrelated diagnoses shall not be a
41 basis to reduce or deny the benefits required by this section.

42 m. The provisions of this section shall apply to all individual
43 health benefits plans in which the carrier has reserved the right to
44 change the premium.

45 n. The Attorney General's Office shall be responsible for
46 overseeing any violations of law that may result from P.L. c.
47 (C.) (pending before the Legislature as this bill), including fraud,
48 abuse, waste, and mistreatment of covered persons. The Attorney

1 General's Office is authorized to adopt, pursuant to the
2 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
3 seq.), rules and regulations to implement any of the provisions of
4 P.L. , c. (C.) (pending before the Legislature as this bill).

5 o. The provisions of this section shall not apply to an
6 individual health benefits plan which, pursuant to a contract
7 between the carrier and the Department of Human Services,
8 provides benefits to persons who are eligible for medical assistance
9 under P.L.1968, c.413 (C.30:4D-1 et seq.), the "Family Health Care
10 Coverage Act," P.L.2005, c.156 (C.30:4J-8 et seq.), or any other
11 program administered by the Division of Medical Assistance and
12 Health Services in the Department of Human Services.

13 p. As used in this section:

14 "Concurrent review" means inpatient care is reviewed as it is
15 provided. Medically qualified reviewers monitor appropriateness of
16 the care, the setting, and patient progress, and as appropriate, the
17 discharge plans.

18 "Substance use disorder" is as defined by the American
19 Psychiatric Association in the Diagnostic and Statistical Manual of
20 Mental Disorders, Fifth Edition and any subsequent editions and
21 shall include substance use withdrawal.

22

23 7. (New section) a. A small employer health benefits plan that
24 provides hospital or medical expense benefits and is delivered,
25 issued, executed or renewed in this State, or approved for issuance
26 or renewal in this State by the Commissioner of Banking and
27 Insurance, on or after the effective date of this act, shall provide
28 unlimited benefits for inpatient and outpatient treatment of
29 substance use disorder at in-network facilities. The services for the
30 treatment of substance use disorder shall be prescribed by a licensed
31 physician, licensed psychologist, or licensed psychiatrist and
32 provided by licensed health care professionals or licensed or
33 certified substance use disorder providers in licensed or otherwise
34 State-approved facilities, as required by the laws of the state in
35 which the services are rendered.

36 b. The benefits for the first 180 days per plan year of inpatient
37 and outpatient treatment of substance use disorder shall be provided
38 when determined medically necessary by the covered person's
39 physician, psychologist or psychiatrist without the imposition of
40 any prior authorization or other prospective utilization management
41 requirements. If there is no in-network facility immediately
42 available for a covered person, a carrier shall provide necessary
43 exceptions to their network to ensure admission in a treatment
44 facility within 24 hours.

45 c. Providers of treatment for substance use disorder to persons
46 covered under a covered health benefits plan shall not require pre-
47 payment of medical expenses during this 180 days in excess of
48 applicable co-payment, deductible, or co-insurance under the plan.

1 d. The benefits for outpatient visits shall not be subject to
2 concurrent or retrospective review of medical necessity or any other
3 utilization management review.

4 e. (1) The benefits for the first 28 days of an inpatient stay
5 during each plan year shall be provided without any retrospective
6 review or concurrent review of medical necessity and medical
7 necessity shall be as determined by the covered person's physician.

8 (2) The benefits for days 29 and thereafter of inpatient care shall
9 be subject to concurrent review as defined in this section. A request
10 for approval of inpatient care beyond the first 28 days shall be
11 submitted for concurrent review before the expiration of the initial
12 28 day period. A request for approval of inpatient care beyond any
13 period that is approved under concurrent review shall be submitted
14 within the period that was previously approved. No carrier shall
15 initiate concurrent review more frequently than three-week
16 intervals. If a carrier determines that continued inpatient care in a
17 facility is no longer medically necessary, the carrier shall within 24
18 hours provide written notice to the covered person and the covered
19 person's physician of its decision and the right to file an expedited
20 internal appeal of the determination pursuant to an expedited
21 process pursuant to sections 11 through 13 of P.L.1997, c.192
22 (C.26:2S-11 through 26:2S-13) and N.J.AC.11:24A-3.5, as
23 applicable. The carrier shall review and make a determination with
24 respect to the internal appeal within 24 hours and communicate
25 such determination to the covered person and the covered person's
26 physician. If the determination is to uphold the denial, the covered
27 person and the covered person's physician have the right to file an
28 expedited external appeal with the Independent Health Care
29 Appeals Program in the Department of Banking and Insurance
30 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
31 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
32 independent utilization review organization shall make a
33 determination within 24 hours. If the carrier's determination is
34 upheld and it is determined continued inpatient care is not
35 medically necessary, the carrier shall remain responsible to provide
36 benefits for the inpatient care through the day following the date the
37 determination is made and the covered person shall only be
38 responsible for any applicable co-payment, deductible and co-
39 insurance for the stay through that date as applicable under the
40 policy. The covered person shall not be discharged or released
41 from the inpatient facility until all internal appeals and independent
42 utilization review organization appeals are exhausted. For any costs
43 incurred after the day following the date of determination until the
44 day of discharge, the covered person shall only be responsible for
45 any applicable cost-sharing, and any additional charges shall be
46 paid by the facility or provider.

47 f. (1) The benefits for the first 28 days of intensive outpatient
48 or partial hospitalization services shall be provided without any

- 1 retrospective review of medical necessity and medical necessity
2 shall be as determined by the covered person's physician.
- 3 (2) The benefits for days 29 and thereafter of intensive
4 outpatient or partial hospitalization services shall be subject to a
5 retrospective review of the medical necessity of the services.
- 6 g. Benefits for inpatient and outpatient treatment of substance
7 use disorder after the first 180 days per plan year shall be subject to
8 the medical necessity determination of the carrier and may be
9 subject to prior authorization or, retrospective review and other
10 utilization management requirements.
- 11 h. Medical necessity review shall utilize an evidence-based and
12 peer reviewed clinical review tool to be designated through
13 rulemaking by the Commissioner of Human Services in
14 consultation with the Department of Health.
- 15 i. The benefits for outpatient prescription drugs to treat
16 substance use disorder shall be provided when determined
17 medically necessary by the covered person's physician,
18 psychologist or psychiatrist without the imposition of any prior
19 authorization or other prospective utilization management
20 requirements.
- 21 j. The first 180 days per plan year of benefits shall be
22 computed based on inpatient days. One or more unused inpatient
23 days may be exchanged for two outpatient visits. All extended
24 outpatient services such as partial hospitalization and intensive
25 outpatient, shall be deemed inpatient days for the purpose of the
26 visit to day exchange provided in this subsection.
- 27 k. Except as stated above, the benefits and cost-sharing shall be
28 provided to the same extent as for any other medical condition
29 covered under the health benefits plan.
- 30 l. The benefits required by this section are to be provided to all
31 covered persons with a diagnosis of substance use disorder. The
32 presence of additional related or unrelated diagnoses shall not be a
33 basis to reduce or deny the benefits required by this section.
- 34 m. The provisions of this section shall apply to all small
35 employer health benefits plans in which the carrier has reserved the
36 right to change the premium.
- 37 n. The Attorney General's Office shall be responsible for
38 overseeing any violations of law that may result from P.L. , c.
39 (C.) (pending before the Legislature as this bill), including fraud,
40 abuse, waste, and mistreatment of covered persons. The Attorney
41 General's Office is authorized to adopt, pursuant to the
42 Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
43 seq.), rules and regulations to implement any of the provisions of
44 P.L. , c. (C.) (pending before the Legislature as this bill).
- 45 o. As used in this section:
- 46 "Concurrent review" means inpatient care is reviewed as it is
47 provided. Medically qualified reviewers monitor appropriateness of

1 the care, the setting, and patient progress, and as appropriate, the
2 discharge plans.

3 “Substance use disorder” is as defined by the American
4 Psychiatric Association in the Diagnostic and Statistical Manual of
5 Mental Disorders, Fifth Edition and any subsequent editions and
6 shall include substance abuse withdrawal.

7
8 8. (New section) a. A health maintenance organization
9 contract that provides hospital or medical expense benefits and is
10 delivered, issued, executed or renewed in this State, or approved for
11 issuance or renewal in this State by the Commissioner of Banking
12 and Insurance, on or after the effective date of this act, shall provide
13 unlimited benefits for inpatient and outpatient treatment of
14 substance use disorder at in-network facilities. The services for the
15 treatment of substance use disorder shall be prescribed by a licensed
16 physician, licensed psychologist, or licensed psychiatrist and
17 provided by licensed health care professionals or licensed or
18 certified substance use disorder providers in licensed or otherwise
19 State-approved facilities, as required by the laws of the state in
20 which the services are rendered.

21 b. The benefits for the first 180 days per plan year of inpatient
22 and outpatient treatment of substance use disorder shall be provided
23 when determined medically necessary by the covered person’s
24 physician, psychologist or psychiatrist without the imposition of
25 any prior authorization or other prospective utilization management
26 requirements. If there is no in-network facility immediately
27 available for a covered person, a health maintenance organization
28 shall provide necessary exceptions to their network to ensure
29 admission in a treatment facility within 24 hours.

30 c. Providers of treatment for substance use disorder to persons
31 covered under a covered contract shall not require pre-payment of
32 medical expenses during this 180 days in excess of applicable co-
33 payment, deductible, or co-insurance under the policy.

34 d. The benefits for outpatient visits shall not be subject to
35 concurrent or retrospective review of medical necessity or any other
36 utilization management review.

37 e. (1) The benefits for the first 28 days of an inpatient stay
38 during each plan year shall be provided without any retrospective
39 review or concurrent review of medical necessity and medical
40 necessity shall be as determined by the covered person’s physician.

41 (2) The benefits for days 29 and thereafter of inpatient care shall
42 be subject to concurrent review as defined in this section. A request
43 for approval of inpatient care beyond the first 28 days shall be
44 submitted for concurrent review before the expiration of the initial
45 28 day period. A request for approval of inpatient care beyond any
46 period that is approved under concurrent review shall be submitted
47 within the period that was previously approved. No health
48 maintenance organization shall initiate concurrent review more

1 frequently than three-week intervals. If a health maintenance
2 organization determines that continued inpatient confinement in a
3 facility is no longer medically necessary, the health insurance
4 organization shall within 24 hours provide written notice to the
5 covered person and the covered person's physician of its decision
6 and the right to file an expedited internal appeal of the
7 determination pursuant to an expedited process pursuant to sections
8 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13)
9 and N.J.AC.11:24A-3.5, as applicable. The health maintenance
10 organization shall review and make a determination with respect to
11 the internal appeal within 24 hours and communicate such
12 determination to the covered person and the covered person's
13 physician. If the determination is to uphold the denial, the covered
14 person and the covered person's physician have the right to file an
15 expedited external appeal with the Independent Health Care
16 Appeals Program in the Department of Banking and Insurance
17 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
18 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An
19 independent utilization review organization shall make a
20 determination within 24 hours. If the health maintenance
21 organization's determination is upheld and it is determined
22 continued inpatient care is not medically necessary, the carrier shall
23 remain responsible to provide benefits for the inpatient care through
24 the day following the date the determination is made and the
25 covered person shall only be responsible for any applicable co-
26 payment, deductible and co-insurance for the stay through that date
27 as applicable under the policy. The covered person shall not be
28 discharged or released from the inpatient facility until all internal
29 appeals and independent utilization review organization appeals are
30 exhausted. For any costs incurred after the day following the date of
31 determination until the day of discharge, the covered person shall
32 only be responsible for any applicable cost-sharing, and any
33 additional charges shall be paid by the facility or provider.

34 f. (1) The benefits for the first 28 days of intensive outpatient
35 or partial hospitalization services shall be provided without any
36 retrospective review of medical necessity and medical necessity
37 shall be as determined by the covered person's physician.

38 (2) The benefits for days 29 and thereafter of intensive
39 outpatient or partial hospitalization services shall be subject to a
40 retrospective review of the medical necessity of the services.

41 g. Benefits for inpatient and outpatient treatment of substance
42 use disorder after the first 180 days per plan year shall be subject to
43 the medical necessity determination of the health maintenance
44 organization and may be subject to prior authorization or,
45 retrospective review and other utilization management
46 requirements.

47 h. Medical necessity review shall utilize an evidence-based and
48 peer reviewed clinical review tool to be designated through

1 rulemaking by the Commissioner of Human Services in
2 consultation with the Department of Health.

3 i. The benefits for outpatient prescription drugs to treat
4 substance use disorder shall be provided when determined
5 medically necessary by the covered person's physician,
6 psychologist or psychiatrist without the imposition of any prior
7 authorization or other prospective utilization management
8 requirements.

9 j. The first 180 days per plan year of benefits shall be
10 computed based on inpatient days. One or more unused inpatient
11 days may be exchanged for two outpatient visits. All extended
12 outpatient services such as partial hospitalization and intensive
13 outpatient, shall be deemed inpatient days for the purpose of the
14 visit to day exchange provided in this subsection.

15 k. Except as stated above, the benefits and cost-sharing shall be
16 provided to the same extent as for any other medical condition
17 covered under the contract.

18 l. The benefits required by this section are to be provided to all
19 covered persons with a diagnosis of substance use disorder. The
20 presence of additional related or unrelated diagnoses shall not be a
21 basis to reduce or deny the benefits required by this section.

22 m. The provisions of this section shall apply to those contracts
23 in which the health maintenance organization has reserved the right
24 to change the premium.

25 n. The Attorney General's Office shall be responsible for
26 overseeing any violations of law that may result from P.L. , c.
27 (C.) (pending before the Legislature as this bill), including fraud,
28 abuse, waste, and mistreatment of covered persons. The Attorney
29 General's Office is authorized to adopt, pursuant to the
30 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
31 seq.), rules and regulations to implement any of the provisions of
32 P.L. , c. (C.) (pending before the Legislature as this bill).

33 o. The provisions of this section shall not apply to a health
34 maintenance organization contract which, pursuant to a contract
35 between the health maintenance organization and the Department of
36 Human Services, provides benefits to persons who are eligible for
37 medical assistance under P.L.1968, c.413 (C.30:4D-1 et seq.), the
38 "Family Health Care Coverage Act," P.L.2005, c.156 (C.30:4J-8 et
39 seq.), or any other program administered by the Division of Medical
40 Assistance and Health Services in the Department of Human
41 Services.

42 p. As used in this section:

43 "Concurrent review" means inpatient care is reviewed as it is
44 provided. Medically qualified reviewers monitor appropriateness of
45 the care, the setting, and patient progress, and as appropriate, the
46 discharge plans.

47 "Substance use disorder" is as defined by the American
48 Psychiatric Association in the Diagnostic and Statistical Manual of

1 Mental Disorders, Fifth Edition and any subsequent editions and
2 shall include substance use withdrawal.

3
4 9. (New section) a. The State Health Benefits Commission
5 shall ensure that every contract purchased by the commission on or
6 after the effective date of this act provides unlimited benefits for
7 inpatient and outpatient treatment of substance use disorder at in-
8 network facilities. The services for the treatment of substance use
9 disorder shall be prescribed by a licensed physician, licensed
10 psychologist, or licensed psychiatrist and provided by licensed
11 health care professionals or licensed or certified substance use
12 disorder providers in licensed or otherwise State-approved facilities,
13 as required by the laws of the state in which the services are
14 rendered.

15 b. The benefits for the first 180 days per plan year of inpatient
16 and outpatient treatment of substance use disorder shall be provided
17 when determined medically necessary by the covered person's
18 physician, psychologist or psychiatrist without the imposition of
19 any prior authorization or other prospective utilization management
20 requirements. If there is no in-network facility immediately
21 available for a covered person, the contract shall provide necessary
22 exceptions to their network to ensure admission in a treatment
23 facility within 24 hours.

24 c. Providers of treatment for substance use disorder to persons
25 covered under a covered contract shall not require pre-payment of
26 medical expenses during this 180 days in excess of applicable co-
27 payment, deductible, or co-insurance under the policy.

28 d. The benefits for outpatient visits shall not be subject to
29 concurrent or retrospective review of medical necessity or any other
30 utilization management review.

31 e. (1) The benefits for the first 28 days of an inpatient stay
32 during each plan year shall be provided without any retrospective
33 review or concurrent review of medical necessity and medical
34 necessity shall be as determined by the covered person's physician.

35 (2) The benefits for days 29 and thereafter of inpatient care shall
36 be subject to concurrent review as defined in this section. A request
37 for approval of inpatient care beyond the first 28 days shall be
38 submitted for concurrent review before the expiration of the initial
39 28 day period. A request for approval of inpatient care beyond any
40 period that is approved under concurrent review shall be submitted
41 within the period that was previously approved. The contract shall
42 not initiate concurrent review more frequently than three-week
43 intervals. If it is determined that continued inpatient care in a
44 facility is no longer medically necessary, the contract shall provide
45 that within 24 hours, written notice shall be provided to the covered
46 person and the covered person's physician of its decision and the
47 right to file an expedited internal appeal of the determination
48 pursuant to an expedited process pursuant to sections 11 through 13

1 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and
2 N.J.AC.11:24A-3.5, as applicable. A determination shall be made
3 with respect to the internal appeal within 24 hours and shall be
4 communicated to the covered person and the covered person's
5 physician. If the determination is to uphold the denial, the covered
6 person and the covered person's physician have the right to file an
7 expedited external appeal with the Independent Health Care
8 Appeals Program in the Department of Banking and Insurance
9 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
10 through 26:2s-13) and N.J.A.C.11:24A-3.6, as applicable. An
11 independent utilization review organization shall make a
12 determination within 24 hours. If the determination is upheld and it
13 is determined continued inpatient care is not medically necessary,
14 the contract shall state that benefits are provided for the inpatient
15 care through the day following the date the determination is made
16 and the covered person shall only be responsible for any applicable
17 co-payment, deductible and co-insurance for the stay through that
18 date as applicable under the contract. The covered person shall not
19 be discharged or released from the inpatient facility until all internal
20 appeals and independent utilization review organization appeals are
21 exhausted. For any costs incurred after the day following the date of
22 determination until the day of discharge, the covered person shall
23 only be responsible for any applicable cost-sharing, and any
24 additional charges shall be paid by the facility or provider.

25 f. (1) The benefits for the first 28 days of intensive outpatient
26 or partial hospitalization services shall be provided without any
27 retrospective review of medical necessity and medical necessity
28 shall be as determined by the covered person's physician.

29 (2) The benefits for days 29 and thereafter of intensive
30 outpatient or partial hospitalization services shall be subject to a
31 retrospective review of the medical necessity of the services.

32 g. Benefits for inpatient and outpatient treatment of substance
33 use disorder after the first 180 days per plan year shall be subject to
34 medical necessity determination and may be subject to prior
35 authorization or, retrospective review and other utilization
36 management requirements.

37 h. Medical necessity review shall utilize an evidence-based and
38 peer reviewed clinical review tool to be designated through
39 rulemaking by the Commissioner of Human Services in
40 consultation with the Department of Health.

41 i. The benefits for outpatient prescription drugs to treat
42 substance use disorder shall be provided when determined
43 medically necessary by the covered person's physician,
44 psychologist or psychiatrist without the imposition of any prior
45 authorization or other prospective utilization management
46 requirements.

47 j. The first 180 days per plan year of benefits shall be
48 computed based on inpatient days. One or more unused inpatient

1 days may be exchanged for two outpatient visits. All extended
2 outpatient services such as partial hospitalization and intensive
3 outpatient, shall be deemed inpatient days for the purpose of the
4 visit to day exchange provided in this subsection.

5 k. Except as stated above, the benefits and cost-sharing shall be
6 provided to the same extent as for any other medical condition
7 covered under the contract.

8 l. The benefits required by this section are to be provided to all
9 covered persons with a diagnosis of substance use disorder. The
10 presence of additional related or unrelated diagnoses shall not be a
11 basis to reduce or deny the benefits required by this section.

12 m. As used in this section:

13 “Concurrent review” means inpatient care is reviewed as it is
14 provided. Medically qualified reviewers monitor appropriateness of
15 the care, the setting, and patient progress, and as appropriate, the
16 discharge plans.

17 “Substance use disorder” is as defined by the American
18 Psychiatric Association in the Diagnostic and Statistical Manual of
19 Mental Disorders, Fifth Edition and any subsequent editions and
20 shall include substance use withdrawal.

21

22 10. (New section) a. The School Employees’ Health Benefits
23 Commission shall ensure that every contract purchased by the
24 commission on or after the effective date of this act provides
25 unlimited benefits for inpatient and outpatient treatment of
26 substance use disorder at in-network facilities. The services for the
27 treatment of substance use disorder shall be prescribed by a licensed
28 physician, licensed psychologist, or licensed psychiatrist and
29 provided by licensed health care professionals or licensed or
30 certified substance use disorder providers in licensed or otherwise
31 State-approved facilities, as required by the laws of the state in
32 which the services are rendered.

33 b. The benefits for the first 180 days per plan year of inpatient
34 and outpatient treatment of substance use disorder shall be provided
35 when determined medically necessary by the covered person’s
36 physician, psychologist or psychiatrist without the imposition of
37 any prior authorization or other prospective utilization management
38 requirements. If there is no in-network facility immediately
39 available for a covered person, the contract shall provide necessary
40 exceptions to their network to ensure admission in a treatment
41 facility within 24 hours.

42 c. Providers of treatment for substance use disorder to persons
43 covered under a covered contract shall not require pre-payment of
44 medical expenses during this 180 days in excess of applicable co-
45 payment, deductible, or co-insurance under the policy.

46 d. The benefits for outpatient visits shall not be subject to
47 concurrent or retrospective review of medical necessity or any other
48 utilization management review.

- 1 e. (1) The benefits for the first 28 days of an inpatient stay
2 during each plan year shall be provided without any retrospective
3 review or concurrent review of medical necessity and medical
4 necessity shall be as determined by the covered person's physician.
- 5 (2) The benefits for days 29 and thereafter of inpatient care shall
6 be subject to concurrent review as defined in this section. A request
7 for approval of inpatient care beyond the first 28 days shall be
8 submitted for concurrent review before the expiration of the initial
9 28 day period. A request for approval of inpatient care beyond any
10 period that is approved under concurrent review shall be submitted
11 within the period that was previously approved. The contract shall
12 not initiate concurrent review more frequently than three-week
13 intervals. If it is determined that continued inpatient care in a
14 facility is no longer medically necessary, the contract shall provide
15 that within 24 hours, written notice shall be provided to the covered
16 person and the covered person's physician of its decision and the
17 right to file an expedited internal appeal of the determination
18 pursuant to an expedited process pursuant to sections 11 through 13
19 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and
20 N.J.AC.11:24A-3.5, as applicable. A determination shall be made
21 with respect to the internal appeal within 24 hours and shall be
22 communicated to the covered person and the covered person's
23 physician. If the determination is to uphold the denial, the covered
24 person and the covered person's physician have the right to file an
25 expedited external appeal with the Independent Health Care
26 Appeals Program in the Department of Banking and Insurance
27 pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11
28 through 26:2s-13) and N.J.A.C.11:24A-3.6, as applicable. An
29 independent utilization review organization shall make a
30 determination within 24 hours. If the determination is upheld and it
31 is determined continued inpatient care is not medically necessary,
32 the contract shall state that benefits are provided for the inpatient
33 care through the day following the date the determination is made
34 and the covered person shall only be responsible for any applicable
35 co-payment, deductible and co-insurance for the stay through that
36 date as applicable under the contract. The covered person shall not
37 be discharged or released from the inpatient facility until all internal
38 appeals and independent utilization review organization appeals are
39 exhausted. For any costs incurred after the day following the date of
40 determination until the day of discharge, the covered person shall
41 only be responsible for any applicable cost-sharing, and any
42 additional charges shall be paid by the facility or provider.
- 43 f. (1) The benefits for the first 28 days of intensive outpatient
44 or partial hospitalization services shall be provided without any
45 retrospective review of medical necessity and medical necessity
46 shall be as determined by the covered person's physician.

1 (2) The benefits for days 29 and thereafter of intensive
2 outpatient or partial hospitalization services shall be subject to a
3 retrospective review of the medical necessity of the services.

4 g. Benefits for inpatient and outpatient treatment of substance
5 use disorder after the first 180 days per plan year shall be subject to
6 medical necessity determination and may be subject to prior
7 authorization or, retrospective review and other utilization
8 management requirements.

9 h. Medical necessity review shall utilize an evidence-based and
10 peer reviewed clinical review tool to be designated through
11 rulemaking by the Commissioner of Human Services in
12 consultation with the Department of Health.

13 i. The benefits for outpatient prescription drugs to treat
14 substance use disorder shall be provided when determined
15 medically necessary by the covered person's physician,
16 psychologist or psychiatrist without the imposition of any prior
17 authorization or other prospective utilization management
18 requirements.

19 j. The first 180 days per plan year of benefits shall be
20 computed based on inpatient days. One or more unused inpatient
21 days may be exchanged for two outpatient visits. All extended
22 outpatient services such as partial hospitalization and intensive
23 outpatient, shall be deemed inpatient days for the purpose of the
24 visit to day exchange provided in this subsection.

25 k. Except as stated above, the benefits and cost-sharing shall be
26 provided to the same extent as for any other medical condition
27 covered under the contract.

28 l. The benefits required by this section are to be provided to all
29 covered persons with a diagnosis of substance use disorder. The
30 presence of additional related or unrelated diagnoses shall not be a
31 basis to reduce or deny the benefits required by this section.

32 m. As used in this section:

33 "Concurrent review" means inpatient care is reviewed as it is
34 provided. Medically qualified reviewers monitor appropriateness of
35 the care, the setting, and patient progress, and as appropriate, the
36 discharge plans.

37 "Substance use disorder" is as defined by the American
38 Psychiatric Association in the Diagnostic and Statistical Manual of
39 Mental Disorders, Fifth Edition and any subsequent editions and
40 shall include substance use withdrawal.

41

42 11. (New section) a. A practitioner shall not issue an initial
43 prescription for an opioid drug which is a prescription drug as
44 defined in section 2 of P.L.2003, c.280 (C.45:14-41) in a quantity
45 exceeding a five-day supply for treatment of acute pain.

46 b. Prior to issuing an initial prescription of a course of
47 treatment that includes a Schedule II controlled dangerous
48 substance or any other opioid drug which is a prescription drug as

1 defined in section 2 of P.L.2003, c.280 (C.45:14-41) for acute or
2 chronic pain, a practitioner shall:

3 (1) take and document the results of a thorough medical history,
4 including the patient's experience with non-opioid medication and
5 non-pharmacological pain management approaches and substance
6 abuse history;

7 (2) conduct, as appropriate, and document the results of a
8 physical examination;

9 (3) develop a treatment plan, with particular attention focused
10 on determining the cause of the patient's pain;

11 (4) access relevant prescription monitoring information under
12 the Prescription Monitoring Program pursuant to section 8 of
13 P.L.2015, c.74 (C. 45:1-46.1); and

14 (5) limit the supply of any opioid drug prescribed for acute pain
15 to a duration of no more than five days as determined by the
16 directed dosage and frequency of dosage.

17 c. No less than four days after issuing the initial prescription,
18 the practitioner, after consultation with the patient, may issue a
19 subsequent prescription for the drug to the patient in any quantity
20 that complies with applicable State and federal laws, provided that:

21 (1) the subsequent prescription would not be deemed an initial
22 prescription under this section;

23 (2) the practitioner determines the prescription is necessary and
24 appropriate to the patient's treatment needs and documents the
25 rationale for the issuance of the subsequent prescription; and

26 (3) the practitioner determines that issuance of the subsequent
27 prescription does not present an undue risk of abuse, addiction, or
28 diversion and documents that determination.

29 d. Prior to issuing the initial prescription of a course of
30 treatment that includes a Schedule II controlled dangerous
31 substance or any other opioid drug which is a prescription drug as
32 defined in section 2 of P.L.2003, c.280 (C.45:14-41) and again prior
33 to issuing the third prescription of the course of treatment, a
34 practitioner shall discuss with the patient, or the patient's parent or
35 guardian if the patient is under 18 years of age and is not an
36 emancipated minor, the risks associated with the drugs being
37 prescribed, including but not limited to:

38 (1) the risks of addiction and overdose associated with opioid
39 drugs and the dangers of taking opioid drugs with alcohol,
40 benzodiazepines and other central nervous system depressants;

41 (2) the reasons why the prescription is necessary;

42 (3) alternative treatments that may be available; and

43 (4) risks associated with the use of the drugs being prescribed,
44 specifically that opioids are highly addictive, even when taken as
45 prescribed, that there is a risk of developing a physical or
46 psychological dependence on the controlled dangerous substance,
47 and that the risks of taking more opioids than prescribed, or mixing

1 sedatives, benzodiazepines or alcohol with opioids, can result in
2 fatal respiratory depression.

3 The practitioner shall obtain a written acknowledgement, on a
4 form developed and made available by the Division of Consumer
5 Affairs, that the patient or the patient's parent or guardian, as
6 applicable, has discussed with the practitioner the risks of
7 developing a physical or psychological dependence on the
8 controlled dangerous substance and alternative treatments that may
9 be available. The Division of Consumer Affairs shall develop and
10 make available to practitioners guidelines for the discussion
11 required pursuant to this subsection.

12 e. At the time of the issuance of the third prescription for a
13 prescription opioid drug, the practitioner shall enter into a pain
14 management agreement with the patient.

15 f. When a Schedule II controlled dangerous substance or any
16 other prescription opioid drug is continuously prescribed for three
17 months or more for chronic pain, the practitioner shall:

18 (1) review, at a minimum of every three months, the course of
19 treatment, any new information about the etiology of the pain, and
20 the patient's progress toward treatment objectives and document the
21 results of that review;

22 (2) assess the patient prior to every renewal to determine
23 whether the patient is experiencing problems associated with
24 physical and psychological dependence and document the results of
25 that assessment;

26 (3) periodically make reasonable efforts, unless clinically
27 contraindicated, to either stop the use of the controlled substance,
28 decrease the dosage, try other drugs or treatment modalities in an
29 effort to reduce the potential for abuse or the development of
30 physical or psychological dependence and document with
31 specificity the efforts undertaken;

32 (4) review the Prescription Drug Monitoring information in
33 accordance with section 8 of P.L.2015, c.74 (C. 45:1-46.1); and

34 (5) monitor compliance with the pain management agreement
35 and any recommendations that the patient seek a referral.

36 g. As used in this section:

37 "Acute pain" means pain, whether resulting from disease,
38 accidental or intentional trauma, or other cause, that the practitioner
39 reasonably expects to last only a short period of time. "Acute pain"
40 does not include chronic pain, pain being treated as part of cancer
41 care, hospice or other end of life care, or pain being treated as part
42 of palliative care.

43 "Initial prescription" means a prescription issued to a patient
44 who:

45 (1) has never previously been issued a prescription for the drug
46 or its pharmaceutical equivalent; or

47 (2) was previously issued a prescription for the drug or its
48 pharmaceutical equivalent, but the date on which the current

1 prescription is being issued is more than one year after the date the
2 patient last used or was administered the drug or its equivalent.

3 When determining whether a patient was previously issued a
4 prescription for a drug or its pharmaceutical equivalent, the
5 practitioner shall consult with the patient and review the patient's
6 medical record and prescription monitoring information.

7 "Pain management agreement" means a written contract or
8 agreement that is executed between a practitioner and a patient,
9 prior to the commencement of treatment for chronic pain using a
10 Schedule II controlled dangerous substance or any other opioid
11 drug which is a prescription drug as defined in section 2 of P.L.
12 2003, c. 280 (C.45:14-41), as a means to:

13 (1) prevent the possible development of physical or
14 psychological dependence in the patient;

15 (2) document the understanding of both the practitioner and the
16 patient regarding the patient's pain management plan;

17 (3) establish the patient's rights in association with treatment,
18 and the patient's obligations in relation to the responsible use,
19 discontinuation of use, and storage of Schedule II controlled
20 dangerous substances, including any restrictions on the refill of
21 prescriptions or the acceptance of Schedule II prescriptions from
22 practitioners;

23 (4) identify the specific medications and other modes of
24 treatment, including physical therapy or exercise, relaxation, or
25 psychological counseling, that are included a part of the pain
26 management plan;

27 (5) specify the measures the practitioner may employ to monitor
28 the patient's compliance, including but not limited to random
29 specimen screens and pill counts; and

30 (6) delineate the process for terminating the agreement,
31 including the consequences if the practitioner has reason to believe
32 that the patient is not complying with the terms of the agreement.

33 "Practitioner" means a medical doctor, doctor of osteopathy,
34 dentist, optometrist, podiatrist, physician assistant, certified nurse
35 midwife, or advanced practice nurse.

36 h. This section shall not apply to a prescription for a patient
37 who is currently in active treatment for cancer, receiving hospice
38 care from a licensed hospice or palliative care, or is a resident of a
39 long term care facility, or to any medications that are being
40 prescribed for use in the treatment of substance abuse or opioid
41 dependence.

42

43 12. Section 1 of P.L.1997, c.249 (C.45:9-22.19) is amended to
44 read as follows:

45 1. a. **[A]** Except in the case of an initial prescription issued
46 pursuant to section 11 of P.L. , c. (C.)(pending before the
47 Legislature as this bill), a physician licensed pursuant to chapter 9
48 of Title 45 of the Revised Statutes may prescribe a Schedule II

1 controlled dangerous substance for the use of a patient in any
2 quantity which does not exceed a 30-day supply, as defined by
3 regulations adopted by the State Board of Medical Examiners in
4 consultation with the Department of Health **and Senior Services**.
5 The physician shall document the diagnosis and the medical need
6 for the prescription in the patient's medical record, in accordance
7 with guidelines established by the State Board of Medical
8 Examiners.

9 b. **[A]** Except in the case of an initial prescription issued
10 pursuant to section 11 of P.L. , c. (C.)(pending before the
11 Legislature as this bill), a physician may issue multiple
12 prescriptions authorizing the patient to receive a total of up to a 90-
13 day supply of a Schedule II controlled dangerous substance,
14 provided that the following conditions are met:

15 (1) each separate prescription is issued for a legitimate medical
16 purpose by the physician acting in the usual course of professional
17 practice;

18 (2) the physician provides written instructions on each
19 prescription, other than the first prescription if it is to be filled
20 immediately, indicating the earliest date on which a pharmacy may
21 fill each prescription;

22 (3) the physician determines that providing the patient with
23 multiple prescriptions in this manner does not create an undue risk
24 of diversion or abuse; and

25 (4) the physician complies with all other applicable State and
26 federal laws and regulations.

27 (cf: P.L.2009, c.165, s.1)

28

29 13. (New section) a. The Director of the Division of Consumer
30 Affairs, pursuant to the "Administrative Procedure Act," P.L.1968,
31 c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to
32 effectuate the purposes of sections 11 and 12 of P.L. , c. (C.)
33 (pending before the Legislature as this bill).

34 b. Notwithstanding the provision of the "Administrative
35 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to the
36 contrary, the Director of the Division of Consumer Affairs may
37 adopt, immediately upon filing with the Office of Administrative
38 Law, and no later than the 90th day after the effective date of this
39 act, such regulations as the director deems necessary to implement
40 any of the provisions of P.L. , c. (C.) (pending before the
41 Legislature as this bill). Regulations adopted pursuant to this
42 subsection shall be effective until the adoption of rules and
43 regulations pursuant to subsection a. of this section, and may be
44 amended, adopted, or readopted by the director in accordance with
45 the requirements of P.L.1968, c.410 (C.52:14B-1 et seq.).

46

47 14. Section 3 of P.L.1991, c.97 (C.45:10-19) is amended to read
48 as follows:

1 3. To qualify to prescribe drugs pursuant to section 2 of **[this**
2 **act]** P.L.1991, c.97 (C.45:10-18), a certified nurse midwife shall
3 have completed 30 contact hours, as defined by the National Task
4 Force on the Continuing Education Unit, in pharmacology or a
5 pharmacology course, acceptable to the board, in an accredited
6 institution of higher education approved by the Department of
7 Higher Education or the board. Such contact hours shall include
8 one credit of educational programs or topics on issues concerning
9 prescription opioid drugs, including responsible prescribing
10 practices, alternatives to opioids for managing and treating pain,
11 and the risks and signs of opioid abuse, addiction, and diversion.
12 (cf: P.L.1991, c.97, s.3)
13

14 15. Section 10 of P.L.1991, c.377 (C.45:11-49) is amended to
15 read as follows:

16 10. a. In addition to all other tasks which a registered
17 professional nurse may, by law, perform, an advanced practice
18 nurse may manage preventive care services and diagnose and
19 manage deviations from wellness and long-term illnesses, consistent
20 with the needs of the patient and within the scope of practice of the
21 advanced practice nurse, by:

- 22 (1) initiating laboratory and other diagnostic tests;
23 (2) prescribing or ordering medications and devices, as
24 authorized by subsections b. and c. of this section; and
25 (3) prescribing or ordering treatments, including referrals to
26 other licensed health care professionals, and performing specific
27 procedures in accordance with the provisions of this subsection.

28 b. An advanced practice nurse may order medications and
29 devices in the inpatient setting, subject to the following conditions:

- 30 (1) the collaborating physician and advanced practice nurse
31 shall address in the joint protocols whether prior consultation with
32 the collaborating physician is required to initiate an order for a
33 controlled dangerous substance;

- 34 (2) the order is written in accordance with standing orders or
35 joint protocols developed in agreement between a collaborating
36 physician and the advanced practice nurse, or pursuant to the
37 specific direction of a physician;

- 38 (3) the advanced practice nurse authorizes the order by signing
39 the nurse's own name, printing the name and certification number,
40 and printing the collaborating physician's name;

- 41 (4) the physician is present or readily available through
42 electronic communications;

- 43 (5) the charts and records of the patients treated by the advanced
44 practice nurse are reviewed by the collaborating physician and the
45 advanced practice nurse within the period of time specified by rule
46 adopted by the Commissioner of Health pursuant to section 13 of
47 P.L.1991, c.377 (C.45:11-52);

1 (6) the joint protocols developed by the collaborating physician
2 and the advanced practice nurse are reviewed, updated, and signed
3 at least annually by both parties; and

4 (7) the advanced practice nurse has completed six contact hours
5 of continuing professional education in pharmacology related to
6 controlled substances, including pharmacologic therapy **[and]** ,
7 addiction prevention and management, and issues concerning
8 prescription opioid drugs, including responsible prescribing
9 practices, alternatives to opioids for managing and treating pain,
10 and the risks and signs of opioid abuse, addiction, and diversion, in
11 accordance with regulations adopted by the New Jersey Board of
12 Nursing. The six contact hours shall be in addition to New Jersey
13 Board of Nursing pharmacology education requirements for
14 advanced practice nurses related to initial certification and
15 recertification of an advanced practice nurse as set forth in
16 N.J.A.C.13:37-7.2.

17 c. An advanced practice nurse may prescribe medications and
18 devices in all other medically appropriate settings, subject to the
19 following conditions:

20 (1) the collaborating physician and advanced practice nurse
21 shall address in the joint protocols whether prior consultation with
22 the collaborating physician is required to initiate a prescription for a
23 controlled dangerous substance;

24 (2) the prescription is written in accordance with standing orders
25 or joint protocols developed in agreement between a collaborating
26 physician and the advanced practice nurse, or pursuant to the
27 specific direction of a physician;

28 (3) the advanced practice nurse writes the prescription on a New
29 Jersey Prescription Blank pursuant to P.L.2003, c.280 (C.45:14-40
30 et seq.), signs the nurse's own name to the prescription and prints
31 the nurse's name and certification number;

32 (4) the prescription is dated and includes the name of the patient
33 and the name, address, and telephone number of the collaborating
34 physician;

35 (5) the physician is present or readily available through
36 electronic communications;

37 (6) the charts and records of the patients treated by the advanced
38 practice nurse are periodically reviewed by the collaborating
39 physician and the advanced practice nurse;

40 (7) the joint protocols developed by the collaborating physician
41 and the advanced practice nurse are reviewed, updated, and signed
42 at least annually by both parties; and

43 (8) the advanced practice nurse has completed six contact hours
44 of continuing professional education in pharmacology related to
45 controlled substances, including pharmacologic therapy **[and]** ,
46 addiction prevention and management, and issues concerning
47 prescription opioid drugs, including responsible prescribing
48 practices, alternatives to opioids for managing and treating pain,

1 and the risks and signs of opioid abuse, addiction, and diversion, in
2 accordance with regulations adopted by the New Jersey Board of
3 Nursing. The six contact hours shall be in addition to New Jersey
4 Board of Nursing pharmacology education requirements for
5 advanced practice nurses related to initial certification and
6 recertification of an advanced practice nurse as set forth in
7 N.J.A.C.13:37-7.2.

8 d. The joint protocols employed pursuant to subsections b. and
9 c. of this section shall conform with standards adopted by the
10 Director of the Division of Consumer Affairs pursuant to section 12
11 of P.L.1991, c.377 (C.45:11-51) or section 10 of P.L.1999, c.85
12 (C.45:11-49.2), as applicable.

13 e. (Deleted by amendment, P.L.2004, c.122.)

14 f. An attending advanced practice nurse may determine and
15 certify the cause of death of the nurse's patient and execute the
16 death certification pursuant to R.S.26:6-8 if no collaborating
17 physician is available to do so and the nurse is the patient's primary
18 caregiver.

19 (cf: P.L.2015, c.38, s.3)

20

21 16. R.S.45:12-1 is amended to read as follows:

22 45:12-1. Optometry is hereby declared to be a profession, and
23 the practice of optometry is defined to be the employment of
24 objective or subjective means, or both, for the examination of the
25 human eye and adnexae for the purposes of ascertaining any
26 departure from the normal, measuring its powers of vision and
27 adapting lenses or prisms for the aid thereof, or the use and
28 prescription of pharmaceutical agents, excluding injections, except
29 for injections to counter anaphylactic reaction **[.]**; and excluding
30 controlled dangerous substances as provided in sections 5 and 6 of
31 P.L.1970, c.226 (C.24:21-5 and C.24:21-6), except as otherwise
32 authorized by section 9 of P.L.1991, c.385 (C.45:12-9.11), for the
33 purposes of treating deficiencies, deformities, diseases, or
34 abnormalities of the human eye and adnexae, including the removal
35 of superficial foreign bodies from the eye and adnexae.

36 An optometrist utilizing pharmaceutical agents for the purposes
37 of treatment of ocular conditions and diseases shall be held to a
38 standard of patient care in the use of such agents commensurate to
39 that of a physician utilizing pharmaceutical agents for treatment
40 purposes.

41 A person shall be deemed to be practicing optometry within the
42 meaning of this chapter who in any way advertises himself as an
43 optometrist, or who shall employ any means for the measurement of
44 the powers of vision or the adaptation of lenses or prisms for the aid
45 thereof, practice, offer or attempt to practice optometry as herein
46 defined, either on his own behalf or as an employee or student of
47 another, whether under the personal supervision of his employer or
48 perceptor or not, or to use testing appliances for the purposes of

1 measurement of the powers of vision or diagnose any ocular
2 deficiency or deformity, visual or muscular anomaly of the human
3 eye and adnexae or prescribe lenses, prisms or ocular exercise for
4 the correction or the relief thereof, or who uses or prescribes
5 pharmaceutical agents for the purposes of diagnosing and treating
6 deficiencies, deformities, diseases or abnormalities of the human
7 eye and adnexae or who holds himself out as qualified to practice
8 optometry.

9 (cf: P.L.2004, c.115, s.1)

10

11 17. Section 3 of P.L.1975, c.24 (C.45:12-9.3) is amended to read
12 as follows:

13 3. Fifty credits of continuing professional optometric education
14 shall be required biennially of each New Jersey optometrist holding
15 an active license during the period preceding the established license
16 renewal date. Each credit shall represent or be equivalent to one
17 hour of actual course attendance or in the case of those electing an
18 alternative method of satisfying the requirements of this act shall be
19 approved by the board and certified to the board on forms to be
20 provided for that purpose. Of the 50 credits biennially required
21 under this section, at least one credit shall be for educational
22 programs or topics that concern the prescription of hydrocodone, or
23 the prescription of opioid drugs in general, including responsible
24 prescribing practices, the alternatives to the use of opioids for the
25 management and treatment of pain, and the risks and signs of opioid
26 abuse, addiction, and diversion.

27 (cf: P.L.1975, c.24, s.3)

28

29 18. (New section) a. The New Jersey State Board of Dentistry
30 shall require that the number of credits of continuing dental
31 education required of each person licensed as a dentist, as a
32 condition of biennial registration pursuant to R.S.45:6-10 and
33 section 1 of P.L.1972, c.108 (C.45:1-7), include one credit of
34 educational programs or topics concerning prescription opioid
35 drugs, including responsible prescribing practices, alternatives to
36 opioids for managing and treating pain, and the risks and signs of
37 opioid abuse, addiction, and diversion. The continuing dental
38 education requirement in this subsection shall be subject to the
39 provisions of P.L.1991, c.490 (C.45:6-10.1 et seq.), including, but
40 not limited to, the authority of the board to waive the provisions of
41 this section for a specific individual if the board deems it is
42 appropriate to do so.

43 b. The New Jersey State Board of Dentistry, pursuant to the
44 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
45 seq.), shall adopt such rules and regulations as are necessary to
46 effectuate the purposes of this section.

1 19. (New section) a. The State Board of Medical Examiners
2 shall require that the number of credits of continuing medical
3 education required of each person licensed as a physician, as a
4 condition of biennial registration pursuant to section 1 of P.L.1971,
5 c.236 (C.45:9-6.1), include one credit of educational programs or
6 topics concerning prescription opioid drugs, including responsible
7 prescribing practices, alternatives to opioids for managing and
8 treating pain, and the risks and signs of opioid abuse, addiction, and
9 diversion. The continuing medical education requirement in this
10 subsection shall be subject to the provisions of section 10 of
11 P.L.2001, c.307 (C.45:9-7.1), including, but not limited to, the
12 authority of the board to waive the provisions of this section for a
13 specific individual if the board deems it is appropriate to do so.

14 b. The State Board of Medical Examiners, pursuant to the
15 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
16 seq.), shall adopt such rules and regulations as are necessary to
17 effectuate the purposes of this section.

18

19 20. (New section) a. The State Board of Medical Examiners
20 shall require that the number of credits of continuing medical
21 education required of each person licensed as a physician assistant,
22 as a condition of biennial renewal pursuant to section 4 of P.L.1991,
23 c.378 (C.45:9-27.13), include one credit of educational programs or
24 topics concerning prescription opioid drugs, including responsible
25 prescribing practices, alternatives to opioids for managing and
26 treating pain, and the risks and signs of opioid abuse, addiction, and
27 diversion. The continuing medical education requirement in this
28 subsection shall be subject to the provisions of section 16 of
29 P.L.1991, c.378 (C.45:9-27.25), including, but not limited to, the
30 authority of the board to waive the provisions of this section for a
31 specific individual if the board deems it is appropriate to do so.

32 b. The State Board of Medical Examiners, pursuant to the
33 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
34 seq.), shall adopt such rules and regulations as are necessary to
35 effectuate the purposes of this section.

36

37 21. (New section) a. The New Jersey Board of Nursing shall
38 require that the number of credits of continuing education required
39 of each person licensed as a professional nurse or a practical nurse,
40 as a condition of biennial license renewal, include one credit of
41 educational programs or topics concerning prescription opioid
42 drugs, including alternatives to opioids for managing and treating
43 pain and the risks and signs of opioid abuse, addiction, and
44 diversion.

45 b. The board may, in its discretion, waive the continuing
46 education requirement in subsection a. of this section on an
47 individual basis for reasons of hardship, such as illness or disability,
48 retirement of the license, or other good cause. A waiver shall apply

1 only to the current biennial renewal period at the time of board
2 issuance.

3 c. The New Jersey Board of Nursing, pursuant to the
4 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
5 seq.), shall adopt such rules and regulations as are necessary to
6 effectuate the purposes of this section.

7
8 22. (New section) a. The New Jersey State Board of Pharmacy
9 shall require that the number of credits of continuing pharmacy
10 education required of each person registered as a pharmacist, as a
11 condition of biennial renewal certification, include one credit of
12 educational programs or topics concerning prescription opioid
13 drugs, including alternatives to opioids for managing and treating
14 pain and the risks and signs of opioid abuse, addiction, and
15 diversion. The continuing pharmacy education requirement in this
16 subsection shall be subject to the provisions of section 15 of
17 P.L.2003, c.280 (C.45:14-54), including, but not limited to, the
18 authority of the board to waive the provisions of this section for a
19 specific individual if the board deems it is appropriate to do so.

20 b. The New Jersey State Board of Pharmacy, pursuant to the
21 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
22 seq.), shall adopt such rules and regulations as are necessary to
23 effectuate the purposes of this section.

24
25 23. (New section) The Commissioner of Health, in consultation
26 with the Commissioner of Banking and Insurance, shall submit
27 reports at two intervals to the Legislature, pursuant to section 2 of
28 P.L.1991, c.164 (C.52:14-19.1), and the Governor. The first report
29 shall be submitted six months, and the second report shall be
30 submitted 12 months, after the date of enactment of this act. The
31 reports shall evaluate the implementation and impact of the act’s
32 provisions and make recommendations regarding revisions to the
33 statutes that may be appropriate. The report shall include, but not
34 be limited to, an evaluation of the following:

35 a. The effects of the five-day supply limitation on
36 prescriptions, and other requirements concerning the prescribing of
37 opioids and other drugs pursuant to section 11 of the act, including
38 the impact of these provisions on patients with chronic pain and the
39 impact on patient cost sharing; and

40 b. The effects of the provisions of the bill providing that if
41 there is no in-network facility immediately available for a covered
42 person to receive treatment, a carrier shall provide necessary
43 exceptions to their network to ensure admission in a treatment
44 facility within 24 hours, including the impact of these provisions on
45 the availability of treatment beds for patients, the impact on
46 facilities in the State, and the costs associated with these provisions.

47
48 24. The following sections are repealed:

1 P.L.1977, c.115 (C.17:48-6a);
2 P.L.1977, c.116 (C.17B:27-46.1);
3 P.L.1977, c.117 (C.17:48A-7a);
4 P.L.1977, c.118 (C.17B:26-2.1); and
5 Section 34 of P.L.1985, c.236 (C.17:48E-34).

6
7 25. This bill shall take effect on the 90th day next after
8 enactment.

9
10

11 STATEMENT

12

13 This bill requires health insurance coverage for substance use
14 disorders and regulates opioids and certain other prescription drugs
15 in several ways. The bill requires health insurance carriers, the State
16 Health Benefits Program, and the School Employees' Health
17 Benefits Program, to adhere to certain coverage requirements for
18 treatment of substance use disorders. The bill also places certain
19 restrictions on the prescription of opioids, and requires certain
20 notifications when prescribing Schedule II controlled dangerous
21 substances used to treat chronic or acute pain. The bill also requires
22 certain health care professionals to receive training on topics related
23 to prescription opioid drugs. Finally, the bill repeals certain
24 sections of law that are obviated by the bill's provisions.

25 Specifically, the bill requires insurers to provide unlimited
26 benefits for inpatient and outpatient treatment of substance use
27 disorders at in-network facilities. The bill further specifies that the
28 services for the treatment of substance use disorders shall be
29 prescribed by a licensed physician, licensed psychologist, or
30 licensed psychiatrist and provided by licensed health care
31 professionals or licensed or certified substance use disorder
32 providers in licensed or otherwise State-approved facilities, as
33 required by the laws of the state in which the services are rendered.

34 The bill provides that the benefits, for the first 180 days per plan
35 year of inpatient and outpatient treatment of substance use disorder,
36 shall be provided when determined medically necessary by the
37 covered person's physician, psychologist or psychiatrist without the
38 imposition of any prior authorization or other prospective utilization
39 management requirements. If there is no in-network facility
40 immediately available for a covered person, a carrier shall provide
41 necessary exceptions to their network to ensure admission in a
42 treatment facility within 24 hours.

43 Under the bill, providers of treatment for substance use disorders
44 to persons covered under a covered insurance policy shall not
45 require pre-payment of medical expenses during the 180 days in
46 excess of applicable co-payment, deductible, or co-insurance under
47 the policy. The benefits for outpatient visits shall not be subject to

1 concurrent or retrospective review of medical necessity or any other
2 utilization management review.

3 The benefits for the first 28 days of an inpatient stay during each
4 plan year shall be provided without any retrospective review or
5 concurrent review of medical necessity and medical necessity shall
6 be as determined by the covered person's physician. The benefits
7 for days 29 and thereafter of inpatient care shall be subject to
8 concurrent review as defined in the bill. The bill establishes a
9 process for concurrent review and an appeals process pursuant to
10 the Independent Health Care Appeals Program in the Department of
11 Banking and Insurance.

12 The benefits for the first 28 days of intensive outpatient or partial
13 hospitalization services shall be provided without any retrospective
14 review of medical necessity and medical necessity shall be as
15 determined by the covered person's physician. The benefits for
16 days 29 and thereafter of intensive outpatient or partial
17 hospitalization services shall be subject to a retrospective review of
18 the medical necessity of the services.

19 The bill specifies that benefits for inpatient and outpatient
20 treatment of substance use disorder after the first 180 days per plan
21 year shall be subject to the medical necessity determination of the
22 insurer and may be subject to prior authorization or, retrospective
23 review and other utilization management requirements.

24 The medical necessity review shall utilize an evidence-based and
25 peer reviewed clinical review tool to be designated through
26 rulemaking by the Commissioner of Human Services in
27 consultation with the Department of Health.

28 The benefits for outpatient prescription drugs used to treat
29 substance abuse disorder shall be provided when determined
30 medically necessary by the covered person's physician,
31 psychologist or psychiatrist without the imposition of any prior
32 authorization or other prospective utilization management
33 requirements.

34 The bill defines a "substance use disorder" as defined by the
35 American Psychiatric Association in the Diagnostic and Statistical
36 Manual of Mental Disorders, Fifth Edition and any subsequent
37 editions and includes substance use withdrawal. "Concurrent
38 review" is defined to mean inpatient care is reviewed as it is
39 provided. Medically qualified reviewers monitor appropriateness of
40 the care, the setting, and patient progress, and as appropriate, the
41 discharge plans.

42 The bill provides that the first 180 days per plan year of benefits
43 shall be computed based on inpatient days. One or more unused
44 inpatient days may be exchanged for two outpatient visits. All
45 extended outpatient services such as partial hospitalization and
46 intensive outpatient, shall be deemed inpatient days for the purpose
47 of the visit to day exchange as provided in the bill.

1 The bill stipulates that the Attorney General's Office shall be
2 responsible for overseeing any violations of law that may result
3 from the bill, including fraud, abuse, waste, and mistreatment of
4 covered persons. The bill also makes clear that the provisions
5 requiring health insurance coverage do not apply to plans
6 administered by the Department of Human Services.

7 The bill also places certain restrictions on how opioids and other
8 Schedule II controlled substances may be prescribed. In cases of
9 acute pain, the bill provides that a practitioner shall not issue an
10 initial prescription for an opioid drug in a quantity exceeding a five-
11 day supply. In cases of acute or chronic pain, prior to issuing an
12 initial prescription of a course of treatment that includes a Schedule
13 II controlled dangerous substance or any other opioid drug, a
14 practitioner shall:

15 (1) take and document the results of a thorough medical history,
16 including the patient's experience with non-opioid medication and
17 non-pharmacological pain management approaches and substance
18 abuse history;

19 (2) conduct, as appropriate, and document the results of a
20 physical examination;

21 (3) develop a treatment plan, with particular attention focused
22 on determining the cause of the patient's pain;

23 (4) access relevant prescription monitoring information under the
24 Prescription Monitoring Program; and

25 (5) limit the supply of any opioid drug prescribed for acute pain
26 to a duration of no more than five days as determined by the
27 directed dosage and frequency of dosage.

28 No less than four days after issuing the initial prescription, the
29 practitioner, after consultation with the patient, may issue a
30 subsequent prescription for the drug to the patient in any quantity
31 that complies with applicable State and federal laws, provided that:

32 (1) the subsequent prescription would not be deemed an initial
33 prescription under this section;

34 (2) the practitioner determines the prescription is necessary and
35 appropriate to the patient's treatment needs and documents the
36 rationale for the issuance of the subsequent prescription; and

37 (3) the practitioner determines that issuance of the subsequent
38 prescription does not present an undue risk of abuse, addiction, or
39 diversion and documents that determination.

40 The bill also requires, prior to issuing the initial prescription of a
41 course of treatment that includes a Schedule II controlled dangerous
42 substance or any other opioid drug and again prior to issuing the
43 third prescription of the course of treatment, a practitioner shall
44 discuss with the patient, or the patient's parent or guardian if the
45 patient is under 18 years of age and is not an emancipated minor,
46 the risks associated with the drugs being prescribed, including but
47 not limited to:

1 - the risks of addiction and overdose associated with opioid
2 drugs and the dangers of taking opioid drugs with alcohol,
3 benzodiazepines and other central nervous system depressants;
4 - the reasons why the prescription is necessary;
5 - alternative treatments that may be available; and
6 - risks associated with the use of the drugs being prescribed,
7 specifically that opioids are highly addictive, even when taken as
8 prescribed, that there is a risk of developing a physical or
9 psychological dependence on the controlled dangerous substance,
10 and that the risks of taking more opioids than prescribed, or mixing
11 sedatives, benzodiazepines or alcohol with opioids, can result in
12 fatal respiratory depression.

13 The practitioner shall obtain a written acknowledgement, on a
14 form developed and made available by the Division of Consumer
15 Affairs, that the patient or the patient's parent or guardian, as
16 applicable, has discussed with the practitioner the risks of
17 developing a physical or psychological dependence on the
18 controlled dangerous substance and alternative treatments that may
19 be available. The Division of Consumer Affairs shall develop and
20 make available to practitioners guidelines for the discussion
21 required pursuant to the bill.

22 At the time of the issuance of the third prescription for a
23 prescription opioid drug, the practitioner shall enter into a pain
24 management agreement with the patient. When a Schedule II
25 controlled dangerous substance or any other prescription opioid
26 drug is continuously prescribed for three months or more for
27 chronic pain, the practitioner shall:

28 (1) review, at a minimum of every three months, the course of
29 treatment, any new information about the etiology of the pain, and
30 the patient's progress toward treatment objectives and document the
31 results of that review;

32 (2) assess the patient prior to every renewal to determine whether
33 the patient is experiencing problems associated with physical and
34 psychological dependence and document the results of that
35 assessment;

36 (3) periodically make reasonable efforts, unless clinically
37 contraindicated, to either stop the use of the controlled substance,
38 decrease the dosage, try other drugs or treatment modalities in an
39 effort to reduce the potential for abuse or the development of
40 physical or psychological dependence and document with
41 specificity the efforts undertaken;

42 (4) review the Prescription Drug Monitoring information in
43 accordance with N.J.S.A.45:1-46; and

44 (5) monitor compliance with the pain management agreement
45 and any recommendations that the patient seek a referral.

46 The bill exempts from the prescription limitations above the
47 following: a patient who is currently in active treatment for cancer,
48 receiving hospice care from a licensed hospice or palliative care, or

1 is a resident of a long term care facility, and any medications that
2 are being prescribed for use in the treatment of substance abuse or
3 opioid dependence.

4 The bill also would require certain health care professionals to
5 receive training on topics related to prescription opioid drugs.
6 Health care professionals who have the authority to prescribe opioid
7 medications, including physicians, physician assistants, dentists,
8 and optometrists (who have limited authority to prescribe only
9 hydrocodone), will be required to complete one continuing
10 education credit on topics that include responsible prescribing
11 practices, alternatives to opioids for managing and treating pain,
12 and the risks and signs of opioid abuse, addiction, and diversion.
13 For advance practice nurses, who also have prescribing authority,
14 their required six contact hours of continuing professional education
15 in pharmacology related to controlled substances will include issues
16 concerning prescription opioid drugs, including responsible
17 prescribing practices, alternatives to opioids for managing and
18 treating pain, and the risks and signs of opioid abuse, addiction, and
19 diversion.

20 Health care professionals who do not have prescribing authority
21 but who frequently interact with patients who may be prescribed
22 opioids, including pharmacists, professional nurses, and practical
23 nurses, would also be required to complete one continuing
24 education credit on topics that include alternatives to opioids for
25 managing and treating pain and the risks and signs of opioid abuse,
26 addiction, and diversion. The continuing education credits required
27 under the bill will be part of a professional's regular continuing
28 education credits and will not increase the total number of
29 continuing education credits required.

30 The bill additionally provides that certified nurse midwives will
31 be required to complete one credit of educational programs or
32 topics related to prescription opioid drugs as part of the 30 contact
33 hours in pharmacology training that is required for them to be
34 authorized to prescribe drugs.

35 The bill also requires the Commissioner of Health, in
36 consultation with the Commissioner of Banking and Insurance, to
37 submit reports to the Legislature and the Governor concerning
38 implementation of the bill. One report is to be submitted six
39 months, and the second report is to be submitted 12 months, after
40 the date of enactment of the bill.

41 Finally the bill repeals several statutes, initially enacted in 1977
42 and 1985, which required coverage for the treatment of alcoholism.
43 Because the bill expands that coverage to include treatment for all
44 types of substance use disorder, including alcohol abuse, those
45 sections of law specific to alcoholism are no longer required.

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE
COMMITTEE

STATEMENT TO
ASSEMBLY, No. 3

with committee amendments

STATE OF NEW JERSEY

DATED: JANUARY 30, 2017

The Assembly Financial Institutions and Insurance Committee reports favorably and with committee amendments Assembly Bill No. 3.

As amended, this bill requires health insurance coverage for substance use disorders and regulates opioids and certain other prescription drugs in several ways. The bill requires health insurance carriers, the State Health Benefits Program, and the School Employees' Health Benefits Program, to adhere to certain coverage requirements for treatment of substance use disorders. The bill also places certain restrictions on the prescription of opioids, and requires certain notifications when prescribing Schedule II controlled dangerous substances used to treat chronic or acute pain. The bill also requires certain health care professionals to receive training on topics related to prescription opioid drugs. Finally, the bill repeals certain sections of law that are obviated by the bill's provisions.

Specifically, the bill requires insurers to provide unlimited benefits for inpatient and outpatient treatment of substance use disorders at in-network facilities. The bill further specifies that the services for the treatment of substance use disorders shall be prescribed by a licensed physician, licensed psychologist, or licensed psychiatrist and provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise State-approved facilities, as required by the laws of the state in which the services are rendered.

The bill provides that the benefits, for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder, shall be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements. The facility shall notify the insurer of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment. If there is no in-network facility immediately available for a covered person, an insurer shall

provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

Under the bill, providers of treatment for substance use disorders to persons covered under a covered insurance policy shall not require pre-payment of medical expenses during the 180 days in excess of applicable co-payment, deductible, or co-insurance under the policy. The benefits for outpatient visits shall not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

The benefits for the first 28 days of an inpatient stay during each plan year shall be provided without any retrospective review or concurrent review of medical necessity and medical necessity shall be as determined by the covered person's physician. The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in the bill. The insurer shall not initiate concurrent review more frequently than two-week intervals. The bill establishes a process for concurrent review and an appeals process pursuant to the Independent Health Care Appeals Program in the Department of Banking and Insurance.

The benefits for the first 28 days of intensive outpatient or partial hospitalization services shall be provided without any retrospective review of medical necessity and medical necessity shall be as determined by the covered person's physician. The benefits for days 29 and thereafter of intensive outpatient or partial hospitalization services shall be subject to a retrospective review of the medical necessity of the services.

The bill specifies that benefits for inpatient and outpatient treatment of substance use disorder after the first 180 days per plan year shall be subject to the medical necessity determination of the insurer and may be subject to prior authorization or, retrospective review and other utilization management requirements.

The medical necessity review shall utilize an evidence-based and peer reviewed clinical review tool to be designated through rulemaking by the Commissioner of Human Services in consultation with the Department of Health.

The benefits for outpatient prescription drugs used to treat substance abuse disorder shall be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements.

The bill defines a "substance use disorder" as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition and any subsequent editions and includes substance use withdrawal. "Concurrent review" is defined to mean inpatient care is reviewed as it is provided. Medically qualified reviewers monitor appropriateness of

the care, the setting, and patient progress, and as appropriate, the discharge plans.

The bill provides that the first 180 days per plan year of benefits shall be computed based on inpatient days. One or more unused inpatient days may be exchanged for two outpatient visits. All extended outpatient services such as partial hospitalization and intensive outpatient, shall be deemed inpatient days for the purpose of the visit to day exchange as provided in the bill.

The bill stipulates that the Attorney General's Office shall be responsible for overseeing any violations of law that may result from the bill, including fraud, abuse, waste, and mistreatment of covered persons. The bill also makes clear that the provisions requiring health insurance coverage do not apply to plans administered by the Department of Human Services.

The bill also places certain restrictions on how opioids and other Schedule II controlled substances may be prescribed. In cases of acute pain, the bill provides that a practitioner shall not issue an initial prescription for an opioid drug in a quantity exceeding a five-day supply. Any prescription for acute pain shall be for the lowest effective dose of immediate-release opioid drug. In cases of acute or chronic pain, prior to issuing an initial prescription of a course of treatment that includes a Schedule II controlled dangerous substance or any other opioid drug, a practitioner shall:

- (1) take and document the results of a thorough medical history, including the patient's experience with non-opioid medication and non-pharmacological pain management approaches and substance abuse history;

- (2) conduct, as appropriate, and document the results of a physical examination;

- (3) develop a treatment plan, with particular attention focused on determining the cause of the patient's pain;

- (4) access relevant prescription monitoring information under the Prescription Monitoring Program; and

- (5) limit the supply of any opioid drug prescribed for acute pain to a duration of no more than five days as determined by the directed dosage and frequency of dosage.

No less than four days after issuing the initial prescription of an opioid drug in a course of treatment for acute pain that is subject to the 5-day limit, the practitioner, after consultation with the patient, may issue a subsequent prescription for the drug to the patient in any quantity that complies with applicable State and federal laws, provided that:

- (1) the subsequent prescription would not be deemed an initial prescription under this section;

- (2) the practitioner determines the prescription is necessary and appropriate to the patient's treatment needs and documents the rationale for the issuance of the subsequent prescription; and

(3) the practitioner determines that issuance of the subsequent prescription does not present an undue risk of abuse, addiction, or diversion and documents that determination.

The bill also requires, prior to issuing the initial prescription of a course of treatment that includes a Schedule II controlled dangerous substance or any other opioid drug in a course of treatment for acute or chronic pain and again prior to issuing the third prescription of the course of treatment, a practitioner shall discuss with the patient, or the patient's parent or guardian if the patient is under 18 years of age and is not an emancipated minor, the risks associated with the drugs being prescribed, including but not limited to:

- the risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants;

- the reasons why the prescription is necessary;

- alternative treatments that may be available; and

- risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed, or mixing sedatives, benzodiazepines or alcohol with opioids, can result in fatal respiratory depression.

The practitioner shall include a note in the patient's medical record that the patient or the patient's parent or guardian, as applicable, has discussed with the practitioner the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available. The Division of Consumer Affairs shall develop and make available to practitioners guidelines for the discussion required pursuant to the bill.

At the time of the issuance of the third prescription for a prescription opioid drug, the practitioner shall enter into a pain management agreement with the patient. When a Schedule II controlled dangerous substance or any other prescription opioid drug is continuously prescribed for three months or more for chronic pain, the practitioner shall:

- (1) review, at a minimum of every three months, the course of treatment, any new information about the etiology of the pain, and the patient's progress toward treatment objectives and document the results of that review;

- (2) assess the patient prior to every renewal to determine whether the patient is experiencing problems associated with physical and psychological dependence and document the results of that assessment;

- (3) periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance,

decrease the dosage, try other drugs or treatment modalities in an effort to reduce the potential for abuse or the development of physical or psychological dependence and document with specificity the efforts undertaken;

(4) review the Prescription Drug Monitoring information in accordance with section 8 of P.L.2015, c.74(c.45:1-46.1); and

(5) monitor compliance with the pain management agreement and any recommendations that the patient seek a referral.

The bill clarifies in the definition of practitioner that the bill is not intended to expand the scope of practice of any practitioner.

The bill exempts from the prescription limitations above the following: a patient who is currently in active treatment for cancer, receiving hospice care from a licensed hospice or palliative care, or is a resident of a long term care facility, and any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

The bill requires that every policy or contract that provides coverage for prescription drugs subject to a co-payment, coinsurance or deductible shall charge a co-payment, coinsurance or deductible for an initial prescription of an opioid drug that is either:

(1) proportional between the cost sharing for a 30-day supply and the amount of drugs the patient was prescribed; or

(2) equivalent to the cost sharing for a full 30-day supply of the opioid drug, provided that no additional cost sharing may be charged for any additional prescriptions for the remainder of the 30-day supply.

The bill also would require certain health care professionals to receive training on topics related to prescription opioid drugs. Health care professionals who have the authority to prescribe opioid medications, including physicians, physician assistants, dentists, and optometrists (who have limited authority to prescribe only hydrocodone), will be required to complete one continuing education credit on topics that include responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion. For advance practice nurses, who also have prescribing authority, their required six contact hours of continuing professional education in pharmacology related to controlled substances will include issues concerning prescription opioid drugs, including responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion.

Health care professionals who do not have prescribing authority but who frequently interact with patients who may be prescribed opioids, including pharmacists, professional nurses, and practical nurses, would also be required to complete one continuing education credit on topics that include alternatives to opioids for

managing and treating pain and the risks and signs of opioid abuse, addiction, and diversion. The continuing education credits required under the bill will be part of a professional's regular continuing education credits and will not increase the total number of continuing education credits required.

The bill additionally provides that certified nurse midwives will be required to complete one credit of educational programs or topics related to prescription opioid drugs as part of the 30 contact hours in pharmacology training that is required for them to be authorized to prescribe drugs.

The bill also requires the Commissioner of Health, in consultation with the Commissioner of Banking and Insurance, to submit reports to the Legislature and the Governor concerning implementation of the bill. One report is to be submitted six months, and the second report is to be submitted 12 months, after the date of enactment of the bill.

Finally the bill repeals several statutes, initially enacted in 1977 and 1985, which required coverage for the treatment of alcoholism. Because the bill expands that coverage to include treatment for all types of substance use disorder, including alcohol abuse, those sections of law specific to alcoholism are no longer required.

COMMITTEE AMENDMENTS

The committee amended the bill to provide:

- That, in the case of the bill's prohibition on prior authorization or prospective utilization management for benefits for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder, the facility shall notify the insurer of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.
- The insurer shall not initiate concurrent review more frequently than, instead of three-week, two-week intervals, after the first 28 days of treatment.
- The initial prescription for acute pain must be for the lowest effective dose of immediate-release opioid drug.
- Certain clarifications in section 11 regarding whether the subsections apply to acute or chronic pain, or both.
- Instead of requiring a written acknowledgement, the practitioner is required to include a note in the patient's medical record that the patient or the patient's parent or guardian, as applicable, has discussed with the practitioner the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available.
- A clarification in the definition of "practitioner," so that the bill is not intended to expand the scope of practice of any practitioner.

- That contracts, policies, and plans that provide coverage for prescription drugs subject to a co-payment, coinsurance or deductible shall charge a co-payment, coinsurance or deductible for an initial prescription of an opioid drug that is either: (1) proportional between the cost of sharing for a 30-day supply and the amount of drugs the patient was prescribed; or (2) equivalent to the cost sharing for a full 30-day supply of the opioid drug, provided that no additional cost sharing may be charged for any additional prescriptions for the remainder of the 30-day supply.

LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

ASSEMBLY, No. 3

STATE OF NEW JERSEY 217th LEGISLATURE

DATED: FEBRUARY 10, 2017

SUMMARY

- Synopsis:** Requires health insurance coverage for treatment of substance use disorders; places certain restrictions on the prescription of opioid and certain other drugs; concerns continuing education related thereto.
- Type of Impact:** Expenditure increase to the State and to local governments (including school districts).
- Agencies Affected:** Division of Pensions and Benefits in the Department of the Treasury; local government entities (including school districts).

Office of Legislative Services Estimate

Fiscal Impact	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>
State Cost	Indeterminate Increase – See comments below		
Local Cost	Indeterminate Increase – See comments below		

- The Office of Legislative Services (OLS) concludes that State and local expenditures for employee health benefits may increase by indeterminate amounts. To the extent that inpatient and outpatient treatment of substance use disorders at in-network facilities is provided without prior authorization or other prospective utilization management requirements, costs to the State Health Benefits Program (SHBP) and the School Employees' Health Benefits Program (SEHBP) will likely increase. It has been shown that prior authorization and utilization management reduces health care costs by curtailing unnecessary and inappropriate treatment.
- Local governments and school districts that do not participate in the SHBP and the SEHBP may experience significant expenditure increases if their plans do not cover treatment of substance abuse disorder to the extent mandated by the bill.
- The fiscal impact of the provisions restricting and regulating prescriptions for opioids is indeterminate, given that it depends on the price of the opioids; the volume of opioids being prescribed; and how restrictions that would be imposed would affect either the price or the volume.

- The cost to the State and local governments of prescription drugs also includes pharmacy dispensing fees. The bill will increase the number of prescriptions for the same opioid dosage, thereby increasing dispensing fees. However, if shorter-duration prescriptions actually reduce total dosages prescribed, savings may be realized.
- To the extent that physicians charge patients for a return consultation (follow-up visit) after the first five days of prescribing an opioid, or each additional time a prescription is needed, the SHBP/SEHBP could incur additional office visit costs.
- This bill would require health insurance plans to provide unlimited benefits for inpatient and outpatient treatment of substance use disorders at in-network facilities for treatment of substance use disorders; would place certain restrictions on the prescription of opioid and certain other drugs; and would require health care providers to attend related continuing education classes.

BILL DESCRIPTION

Assembly Bill No. 3 (1R) of 2017 requires health insurance coverage for substance use disorders and regulates opioids and certain other prescription drugs in several ways. The bill requires health insurance carriers, and the State Health Benefits Program and the School Employees' Health Benefits Program, to adhere to certain coverage requirements for treatment of substance use disorders. The bill also places certain restrictions on the prescription of opioids, and requires certain notifications when prescribing Schedule II controlled dangerous substances used to treat chronic or acute pain. The bill also requires certain health care professionals to receive training on topics related to prescription opioid drugs.

Specifically, the bill requires insurers to provide unlimited benefits for inpatient and outpatient treatment of substance use disorders at in-network facilities. The bill specifies that the services for the treatment of substance use disorders must be prescribed by a licensed physician, licensed psychologist, or licensed psychiatrist and provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise State-approved facilities, as required by the laws of the state in which the services are rendered.

The bill provides that the benefits, for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder, would be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements. If there is no in-network facility immediately available for a covered person, insurers must provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

The benefits for the first 28 days of an inpatient stay during each plan year must be provided without any retrospective review or concurrent review of medical necessity and medical necessity as determined by the covered person's physician. The benefits for days 29 and thereafter of inpatient care would be subject to concurrent review as defined in the bill. The insurer cannot initiate concurrent review more frequently than two-week intervals.

The benefits for the first 28 days of intensive outpatient or partial hospitalization services must be provided without any retrospective review of medical necessity and medical necessity as determined by the covered person's physician. The benefits for days 29 and thereafter of intensive outpatient or partial hospitalization services would be subject to a retrospective review of the medical necessity of the services.

The bill specifies that benefits for inpatient and outpatient treatment of substance use disorder after the first 180 days per plan year would be subject to the medical necessity determination of the insurer and may be subject to prior authorization or retrospective review and other utilization management requirements.

Under the bill, the benefits for outpatient visits would not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

The benefits for outpatient prescription drugs used to treat substance abuse disorder must be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements.

The bill also places certain restrictions on how opioids and other Schedule II controlled substances may be prescribed. In cases of acute pain, the bill provides that a practitioner cannot issue an initial prescription for an opioid drug in a quantity exceeding a five-day supply. Any prescription for acute pain must be for the lowest effective dose of immediate-release opioid drug. In cases of acute or chronic pain, prior to issuing an initial prescription of a course of treatment that includes a Schedule II controlled dangerous substance or any other opioid drug, a practitioner must document the patient's medical history, develop a treatment plan, conform with a monitoring requirement, limit the supply of opioid drug prescriptions, and comply with State and federal laws.

The bill also would require certain health care professionals to receive training on topics related to prescription opioid drugs.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

Assembly Bill No. 3 (1R) of 2017 would require the SHBP and the SEHBP and other insurance plans to provide the first 180 days of inpatient and outpatient treatment of substance abuse disorder, when determined medically necessary by the covered person's physician, psychologist, or psychiatrist, without prior authorization or other initial utilization management (UM) requirements. If there is no in-network facility immediately available, the contract must provide exceptions to the network to ensure admission to a treatment center within 24 hours.

This bill would also limit concurrent or retrospective review of medical necessity or any utilization management review for substance use disorder services. Prior authorization and utilization management are used by the SHBP and the SEHBP to contain costs. Currently, some specialty outpatient services require pre-approval and all inpatient substance use disorder services require pre-approval, whether or not the provider is in-network or out-of-network.

The OLS does not have information regarding how much the State pays Aetna and Horizon to provide utilization management services and the total cost for substance use disorder services. Therefore, the OLS is not able to determine the potential costs to the SHBP and the SEHBP of limiting utilization management for substance use disorder services.

According to the Centers for Medicare and Medicaid Services in the United States Department of Health and Human Services, "the components of UM that relate to certifying the necessity of the health care services provided includes, precertification, concurrent review, and

discharge planning to ensure that care is both medically necessary and covered for payment.” In a 2001 State of New Jersey, State Health Benefits Program and Consultant Review, commissioned by the State and conducted by Mercer Human Resource Consulting, the reported Horizon Utilization Management Return on Investment (ROI) was 3.6:1. This means that for every dollar the SHBP/SEHBP spends on UM, the SHBP/SEHBP saves \$3.60 in program costs. A June 2016 study by Accenture Consulting (formerly Anderson Consulting and a division of Arthur Anderson) and entitled, Risk Based. Data Driven. The New Face of Utilization Management, concluded that health care organizations that employ network-centric utilization management can save in administrative and medical cost savings combined, with a 60 percent to 80 percent annual reduction in the number of billing codes requiring review, and a 17 percent to 40 percent reduction in administrative costs resulting from fewer billing codes.

The OLS notes that it is reasonable to assume that limiting UM practices would increase health care benefit costs accordingly.

The fiscal impact of the provisions regulating prescriptions for opioids depends on the price of the opioids, the volume of opioids being prescribed, and how restrictions that would be imposed would affect either the price or the volume. If opioid prescriptions are restricted, prescription drug costs to the SHBP/SEHBP would be reduced accordingly due to fewer prescriptions. If the number of people who need opioid prescriptions increases, even under the restrictions, opioid prescription costs to the SHBP/SEHBP could increase due to the increased new volume prescribed, although to a lesser degree because of the restrictions. Additionally, if the usage is restricted, prices may be increased by manufacturers to make up for the volume lost under the restrictions. Finally, if the prices do not change under the restrictions and the same number of opioids are prescribed after the restrictions are imposed, the bill could be cost neutral.

The cost to the State of prescription drugs also includes pharmacy dispensing fees. The bill will increase the number of prescriptions for the same opioid dosage, therefor increasing dispensing fees. However, if shorter-duration prescriptions actually reduce total dosages prescribed, savings may be realized.

To the extent that physicians charge patients for a return consultation after the first five days, or each additional time a prescription is needed, the SHBP/SEHBP could incur additional office visit costs.

Local governments that participate in the SHBP and SEHBP will experience indeterminate expenditure increases, due to the same factors affecting State costs as discussed above. Local governments that do not participate in the SHBP and SEHBP will not only be affected by these factors, but may also experience increased expenditures if their health insurance plans do not provide the level of coverage for substance use disorders mandated by the bill. The OLS does not have information on which to base an estimate of potential cost increases for these local governments.

Section: State Government

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This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

Governor Christie Signs Life-Saving Drug Addiction Reform, Ensuring Immediate Covered Treatment

Wednesday, February 15, 2017 Tags: [Addiction Taskforce](#)



Trenton, NJ – Governor Chris Christie signed into law today his life-saving healthcare reform to guarantee insurance coverage for people to access immediate drug addiction treatment and to limit initial opioid prescriptions. Governor Christie announced America’s strongest addiction recovery reform during his 2017 State of the State address, and it was passed in a month by the legislature.

“Everyone in New Jersey is impacted by America’s growing drug addiction crisis, and so I am proud bipartisan legislative leaders expedited the passage of this life-saving healthcare reform that will serve as a national model,” Governor Christie said. “Lives will no longer be put at risk by layers of needless bureaucracy or due to an overabundance of prescribed opioid pills that get into the hands of children and the vulnerable. This is no doubt the strongest law in the country that will provide critical prevention and treatment measures to combat the rampant, deadly disease of addiction.”

This new law, S-3/A-3, makes New Jersey the only state in which people with insurance are guaranteed coverage and cannot be retroactively charged for six months of necessary addiction treatment, and it establishes in New Jersey the country’s strongest maximum limit of five days’ worth of prescribed opioid pills to keep them out of the hands of children and the vulnerable.

This new law ensures:

- No one will be turned away from treatment for insurance reasons, if a licensed provider prescribes substance abuse disorder treatment;
- Insurance coverage for treatment of a substance abuse disorder will be required and any waiting period that could derail a person’s recovery will be eliminated;
- People diagnosed with a substance abuse disorder will have covered treatment for 180 days, starting the day they need it, including long-term out-patient treatment with no interference from their carrier;
- Covered medication-assisted treatments must be provided without the imposition of prior approval from a carrier;
- Onerous pre-payment obligations imposed by providers will be prohibited, and instead, patients will only be required to pay their copayment, deductible or co-insurance for their treatment;
- Treatment for substance abuse disorders must be covered by the carrier to the same extent as any other covered medical condition without increased copayments, deductibles or co-insurance;
- The Office of Attorney General will be tasked with monitoring this system to prevent waste, fraud or abuse, and to ensure providers are not improperly treating patients or filling beds that could be used by others in need of treatment; and
- A five-day limit on initial opioid prescriptions, lowered from 30 days, to avoid deadly and habit-forming gateway drugs from getting into the hands of children and the vulnerable.

Earlier this month, Governor Christie signed legislation to help fulfill another anti-addiction reform announced in his 2017 State of the State that will raise awareness and education to prevent deadly opioid issues from impacting children and teenagers.

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[Governor’s Statement Upon Signing Assembly Bill No. 333 \[pdf 30KB\]](#)

The Governor encourages people to call 844-ReachNJ or visit www.reachnj.gov for instant, 24-hour per day, cost-free drug addiction related help for themselves and others. That website also lists a comprehensive menu of Governor Christie's pending and enacted life-saving prevention, treatment and recovery reforms.

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