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 Rxs," 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)***

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

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

1. (New section) a. A hospital service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. The benefits for the first 180 days per plan year of inpatient 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:
[1]Senate SHH committee amendments adopted January 30, 2017.

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. [1]The facility shall notify the hospital service corporation of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.[1] If there is no in-network facility immediately available for a covered person, a hospital service corporation shall provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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 hospital service corporation and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

2. (New section) a. A medical service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. [1]The facility shall notify the medical service corporation of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.[1] If there is no in-network facility immediately available for a covered person, a medical service corporation shall provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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 medical service corporation and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for medication-assisted treatments for 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.

j. 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 provided in this subsection.

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

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

3. (New section) a. A health service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. [1]The facility shall notify the health service corporation of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.[1] If there is no in-network facility immediately available for a covered person, a health service corporation shall provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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 health service corporation and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

4. (New section) a. An individual health insurance policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. [1]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.[1] 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.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

5. (New section) a. A group health insurance policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. [1]<u>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.</u>[1] If there is no in-network facility immediately available for a covered person, an insurer shall

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

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

6. (New section) a. An individual health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. [1]<u>The facility shall notify the carrier of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.</u>[1] If there is no in-network facility immediately available for a covered person, a carrier shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

f. (1) 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.

(2) 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.

g. 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 [1]**[**insurer**]** carrier[1] and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

7. (New section) a. A small employer health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. [1]<u>The facility shall notify the carrier of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.</u>[1] If there is no in-network facility immediately available for a covered person, a carrier shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

f. (1) 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.

(2) 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.

g. 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 carrier and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

o. As used in this section:

"Concurrent review" means 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.

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

8. (New section) a. A health maintenance organization contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. [1]The facility shall notify the health maintenance organization of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.[1] If there is no in-network facility immediately available for a covered person, a health maintenance organization shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. No health maintenance organization shall initiate concurrent review more frequently than [1]**[**three-week**]** two-week[1] intervals. If a health maintenance organization determines that continued inpatient [1]**[**confinement**]** care[1] in a facility is no longer medically necessary,

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

f. (1) 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.

(2) 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.

g. 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 health maintenance organization and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

9. (New section) a. The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act provides unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. [1]The facility shall notify the benefit payer of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.[1] If there is no in-network facility immediately available for a covered person, the contract shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

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

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

m. As used in this section:

"Concurrent review" means 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.

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

10. (New section) a. The School Employees' Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act provides unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. [1]<u>The facility shall notify the benefit payer of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.</u>[1] If there is no in-network facility immediately available for a covered person, the contract shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. The contract shall not initiate concurrent review more frequently than **[1]**[three-week]**[1]** two-week intervals. If it is determined that continued inpatient care in a facility is no longer medically necessary, the contract shall provide that within 24 hours, written notice shall be provided to the covered person and the covered person's physician of its decision and the right to file an expedited internal appeal of the determination pursuant to an expedited process pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as applicable. A determination shall be made with respect to the internal appeal within 24 hours and shall be communicated to the covered person and the covered person's physician. If the determination is to uphold the denial, the covered person and the covered person's physician have the right to file an expedited external appeal with the Independent Health Care Appeals Program in the Department of Banking and Insurance pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An independent utilization review organization shall make a determination within 24 hours. If the determination is upheld and it is determined continued inpatient care is not medically necessary, the contract shall state that benefits are provided for the inpatient care through the day following the date the determination is made and the covered person shall only be responsible for any applicable co-payment, deductible and co-insurance for the stay through that date as applicable under the contract. The covered person shall not be discharged or released from the inpatient facility until all internal appeals and independent utilization review organization appeals are exhausted. For any costs incurred after the day following the date of determination until the day of discharge, the covered person shall only be responsible for any applicable cost-sharing, and any additional charges shall be paid by the facility or provider.

f. (1) 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.

(2) 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.

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

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

m. As used in this section:

"Concurrent review" means 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.

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

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

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

b. Prior to issuing an initial prescription of a [1]**[**course of treatment that includes a**]**[1] Schedule II controlled dangerous substance or any other opioid drug which is a prescription drug as defined in section 2 of P.L.2003, c.280 (C.45:14-41) [1]in a course of treatment[1] 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 pursuant to section 8 of P.L.2015, c.74 (C. 45:1-46.1); 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.

c. No less than four days after issuing the initial prescription [1]pursuant to subsection a. of this subsection[1], 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.

d. Prior to issuing the initial prescription of [1]**[**a course of treatment that includes**]**[1] a Schedule II controlled dangerous substance or any other opioid drug which is a prescription drug as defined in section 2 of P.L.2003, c.280 (C.45:14-41) [1]in a course of treatment for acute or chronic pain[1] 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:

(1) 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;

(2) the reasons why the prescription is necessary;

(3) alternative treatments that may be available; and

(4) 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 [1]**[**obtain a written acknowledgement, on a form developed and made available by the Division of Consumer Affairs,**]** include a note in the patient's medical record[1] 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 this subsection.

e. 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.

f. 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.

g. As used in this section:

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

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

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

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

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

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

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

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

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

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

(4) identify the specific medications and other modes of treatment, including physical therapy or exercise, relaxation, or psychological counseling, that are included [1]as[1] a part of the pain management plan;

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

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

"Practitioner" means a medical doctor, doctor of osteopathy, dentist, optometrist, podiatrist, physician assistant, certified nurse midwife, or advanced practice nurse [1], acting within the scope of practice of their professional license pursuant to Title 45 of the Revised Statutes[1].

h. This section shall not apply to a prescription for 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, or to any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

[1]i. Every policy, contract or plan delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, and every contract purchased by the School Employees' Health Benefits Commission or State Health Benefits Commission, on or after the effective date of this act, 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.[1]

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

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

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

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

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

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

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

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

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

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

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

3. To qualify to prescribe drugs pursuant to section 2 of **[**this act**]** P.L.1991, c.97 (C.45:10-18), a certified nurse midwife shall have completed 30 contact hours, as defined by the National Task Force on the Continuing Education Unit, in pharmacology or a pharmacology course, acceptable to the board, in an accredited institution of higher education approved by the Department of Higher Education or the board. Such contact hours shall include one credit of educational programs or topics on 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.

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

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

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

(1) initiating laboratory and other diagnostic tests;

(2) prescribing or ordering medications and devices, as authorized by subsections b. and c. of this section; and

(3) prescribing or ordering treatments, including referrals to other licensed health care professionals, and performing specific procedures in accordance with the provisions of this subsection.

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

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

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

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

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

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

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

(7) the advanced practice nurse has completed six contact hours of continuing professional education in pharmacology related to controlled substances, including pharmacologic therapy **[**and**]**, addiction prevention and management, and 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, in accordance with regulations adopted by the New Jersey Board of Nursing. The six contact hours shall be in addition to New Jersey Board of Nursing pharmacology education requirements for advanced practice nurses related to initial certification and recertification of an advanced practice nurse as set forth in N.J.A.C.13:37-7.2.

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

(1) the collaborating physician and advanced practice nurse shall address in the joint protocols whether prior consultation with

the collaborating physician is required to initiate a prescription for a controlled dangerous substance;

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

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

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

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

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

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

(8) the advanced practice nurse has completed six contact hours of continuing professional education in pharmacology related to controlled substances, including pharmacologic therapy **[**and**]**, addiction prevention and management, and 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, in accordance with regulations adopted by the New Jersey Board of Nursing. The six contact hours shall be in addition to New Jersey Board of Nursing pharmacology education requirements for advanced practice nurses related to initial certification and recertification of an advanced practice nurse as set forth in N.J.A.C.13:37-7.2.

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

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

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

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

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

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

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

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

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

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

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

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

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

18. (New section) a. The New Jersey State Board of Dentistry shall require that the number of credits of continuing dental education required of each person licensed as a dentist, as a condition of biennial registration pursuant to R.S.45:6-10 and section 1 of P.L.1972, c.108 (C.45:1-7), include one credit of educational programs or topics 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. The continuing dental education requirement in this subsection shall be subject to the provisions of P.L.1991, c.490 (C.45:6-10.1 et seq.), including, but not limited to, the authority of the board to waive the provisions of this section for a specific individual if the board deems it is appropriate to do so.

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

19. (New section) a. The State Board of Medical Examiners shall require that the number of credits of continuing medical education required of each person licensed as a physician, as a condition of biennial registration pursuant to section 1 of P.L.1971, c.236 (C.45:9-6.1), include one credit of educational programs or topics 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. The continuing medical education requirement in this subsection shall be subject to the provisions of section 10 of P.L.2001, c.307 (C.45:9-7.1), including, but not limited to, the authority of the board to waive the provisions of this section for a specific individual if the board deems it is appropriate to do so.

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

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

c.378 (C.45:9-27.13), include one credit of educational programs or topics 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. The continuing medical education requirement in this subsection shall be subject to the provisions of section 16 of P.L.1991, c.378 (C.45:9-27.25), including, but not limited to, the authority of the board to waive the provisions of this section for a specific individual if the board deems it is appropriate to do so.

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

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

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

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

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

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

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

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

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

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

24. The following sections are repealed:

P.L.1977, c.115 (C.17:48-6a);

P.L.1977, c.116 (C.17B:27-46.1);

P.L.1977, c.117 (C.17:48A-7a);

P.L.1977, c.118 (C.17B:26-2.1); and

Section 34 of P.L.1985, c.236 (C.17:48E-34).

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

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.

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)

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

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

1. (New section) a. A hospital service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. If there is no in-network facility immediately available for a covered person, a hospital service corporation shall provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any 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 <u>thus</u> is new matter.

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

f. (1) 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.

(2) 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.

g. 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 hospital service corporation and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

2. (New section) a. A medical service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. If there is no in-network facility immediately available for a covered person, a medical service corporation shall provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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 medical service corporation and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for medication-assisted treatments for 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.

j. 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 provided in this subsection.

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

3. (New section) a. A health service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. If there is no in-network facility immediately available for a covered person, a health service corporation shall provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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 health service corporation and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

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

or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. 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.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

5. (New section) a. A group health insurance policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. If there is no in-network facility immediately available for a covered person, an insurer shall provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

6. (New section) a. An individual health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

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

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

n. The Attorney General's Office shall be responsible for overseeing any violations of law that may result from P.L. , c. (C.) (pending before the Legislature as this bill), including fraud, abuse, waste, and mistreatment of covered persons. The

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

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

p. As used in this section:

"Concurrent review" means 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.

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

7. (New section) a. A small employer health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

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

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

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

e. (1) 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.

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

f. (1) 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.

(2) 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.

g. 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 carrier and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

o. As used in this section:

"Concurrent review" means 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.

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

8. (New section) a. A health maintenance organization contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. If there is no in-network facility immediately available for a covered person, a health maintenance organization shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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 health maintenance organization and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

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

9. (New section) a. The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act provides unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. If there is no in-network facility immediately available for a covered person, the contract shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

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

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

m. As used in this section:

"Concurrent review" means 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.

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

10. (New section) a. The School Employees' Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act provides unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. If there is no in-network facility immediately available for a covered person, the contract shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. The contract shall not initiate concurrent review more frequently than three-week intervals. If it is determined that continued inpatient care in a facility is no longer medically necessary, the contract shall provide that within 24 hours, written notice shall be provided to the covered person and the covered person's physician of its decision and the right to file an expedited internal appeal of the determination pursuant to an expedited process pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.AC.11:24A-3.5, as applicable. A determination shall be made with respect to the internal appeal within 24 hours and shall be communicated to the covered person and the covered person's physician. If the determination is to uphold the denial, the covered person and the covered person's physician have the right to file an expedited external appeal with the Independent Health Care Appeals Program in the Department of Banking and Insurance pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2s-13) and N.J.A.C.11:24A-3.6, as applicable. An independent utilization review organization shall make a determination within 24 hours. If the determination is upheld and it is determined continued inpatient care is not medically necessary, the contract shall state that benefits are provided for the inpatient care through the day following the date the determination is made and the covered person shall only be responsible for any applicable co-payment, deductible and co-insurance for the stay through that date as applicable under the contract. The covered person shall not be discharged or released from the inpatient facility until all internal appeals and independent utilization review organization appeals are exhausted. For any costs incurred after the day following the date of determination until the day of discharge, the covered person shall only be responsible for any applicable cost-sharing, and any additional charges shall be paid by the facility or provider.

f. (1) 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.

(2) 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.

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

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

m. As used in this section:

"Concurrent review" means 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.

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

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

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

defined in section 2 of P.L.2003, c.280 (C.45:14-41) 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 pursuant to section 8 of P.L.2015, c.74 (C. 45:1-46.1); 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.

c. No less than four days after issuing the initial prescription, 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.

d. Prior to issuing the initial prescription of a course of treatment that includes a Schedule II controlled dangerous substance or any other opioid drug which is a prescription drug as defined in section 2 of P.L.2003, c.280 (C.45:14-41) 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:

(1) 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;

(2) the reasons why the prescription is necessary;

(3) alternative treatments that may be available; and

(4) 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 obtain a written acknowledgement, on a form developed and made available by the Division of Consumer Affairs, 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 this subsection.

e. 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.

f. 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.

g. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

h. This section shall not apply to a prescription for 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, or to any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

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

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

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

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

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

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

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

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

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

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

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

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

3. To qualify to prescribe drugs pursuant to section 2 of [this act] P.L.1991, c.97 (C.45:10-18), a certified nurse midwife shall have completed 30 contact hours, as defined by the National Task Force on the Continuing Education Unit, in pharmacology or a pharmacology course, acceptable to the board, in an accredited institution of higher education approved by the Department of Higher Education or the board. Such contact hours shall include one credit of educational programs or topics on 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.
(cf: P.L.1991, c.97, s.3)

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

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

(1) initiating laboratory and other diagnostic tests;

(2) prescribing or ordering medications and devices, as authorized by subsections b. and c. of this section; and

(3) prescribing or ordering treatments, including referrals to other licensed health care professionals, and performing specific procedures in accordance with the provisions of this subsection.

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

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

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

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

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

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

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

(7) the advanced practice nurse has completed six contact hours of continuing professional education in pharmacology related to controlled substances, including pharmacologic therapy **[**and**]**, addiction prevention and management, and 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, in accordance with regulations adopted by the New Jersey Board of Nursing. The six contact hours shall be in addition to New Jersey Board of Nursing pharmacology education requirements for advanced practice nurses related to initial certification and recertification of an advanced practice nurse as set forth in N.J.A.C.13:37-7.2.

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

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

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

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

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

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

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

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

(8) the advanced practice nurse has completed six contact hours of continuing professional education in pharmacology related to controlled substances, including pharmacologic therapy **[**and**]**, addiction prevention and management, and 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, in accordance with regulations adopted by the New Jersey Board of Nursing. The six contact hours shall be in addition to New Jersey Board of Nursing pharmacology education requirements for advanced practice nurses related to initial certification and recertification of an advanced practice nurse as set forth in N.J.A.C.13:37-7.2.

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

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

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

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

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

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

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

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

measurement of the powers of vision or diagnose any ocular deficiency or deformity, visual or muscular anomaly of the human eye and adnexae or prescribe lenses, prisms or ocular exercise for the correction or the relief thereof, or who uses or prescribes pharmaceutical agents for the purposes of diagnosing and treating deficiencies, deformities, diseases or abnormalities of the human eye and adnexae or who holds himself out as qualified to practice optometry.
(cf: P.L.2004, c.115, s.1)

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

3. Fifty credits of continuing professional optometric education shall be required biennially of each New Jersey optometrist holding an active license during the period preceding the established license renewal date. Each credit shall represent or be equivalent to one hour of actual course attendance or in the case of those electing an alternative method of satisfying the requirements of this act shall be approved by the board and certified to the board on forms to be provided for that purpose. Of the 50 credits biennially required under this section, at least one credit shall be for educational programs or topics that concern the prescription of hydrocodone, or the prescription of opioid drugs in general, including responsible prescribing practices, the alternatives to the use of opioids for the management and treatment of pain, and the risks and signs of opioid abuse, addiction, and diversion.
(cf: P.L.1975, c.24, s.3)

18. (New section) a. The New Jersey State Board of Dentistry shall require that the number of credits of continuing dental education required of each person licensed as a dentist, as a condition of biennial registration pursuant to R.S.45:6-10 and section 1 of P.L.1972, c.108 (C.45:1-7), include one credit of educational programs or topics 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. The continuing dental education requirement in this subsection shall be subject to the provisions of P.L.1991, c.490 (C.45:6-10.1 et seq.), including, but not limited to, the authority of the board to waive the provisions of this section for a specific individual if the board deems it is appropriate to do so.

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

19. (New section) a. The State Board of Medical Examiners shall require that the number of credits of continuing medical education required of each person licensed as a physician, as a condition of biennial registration pursuant to section 1 of P.L.1971, c.236 (C.45:9-6.1), include one credit of educational programs or topics 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. The continuing medical education requirement in this subsection shall be subject to the provisions of section 10 of P.L.2001, c.307 (C.45:9-7.1), including, but not limited to, the authority of the board to waive the provisions of this section for a specific individual if the board deems it is appropriate to do so.

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

20. (New section) a. The State Board of Medical Examiners shall require that the number of credits of continuing medical education required of each person licensed as a physician assistant, as a condition of biennial renewal pursuant to section 4 of P.L.1991, c.378 (C.45:9-27.13), include one credit of educational programs or topics 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. The continuing medical education requirement in this subsection shall be subject to the provisions of section 16 of P.L.1991, c.378 (C.45:9-27.25), including, but not limited to, the authority of the board to waive the provisions of this section for a specific individual if the board deems it is appropriate to do so.

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

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

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

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

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

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

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

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

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

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

24. The following sections are repealed:

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

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

STATEMENT

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. If there is no in-network facility immediately available for a covered person, a carrier 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 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. 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, 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 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 obtain a written acknowledgement, on a form developed and made available by the Division of Consumer Affairs, 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 N.J.S.A.45:1-46; and

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

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 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.

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 of 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	FY 2017	FY 2018	FY 2019
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)

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

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

1. (New section) a. A hospital service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. If there is no in-network facility immediately available for a covered person, a hospital service corporation shall provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any 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 <u>thus</u> is new matter.

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

f. (1) 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.

(2) 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.

g. 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 hospital service corporation and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

2. (New section) a. A medical service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. If there is no in-network facility immediately available for a covered person, a medical service corporation shall provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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 medical service corporation and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for medication-assisted treatments for 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.

j. 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 provided in this subsection.

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

3. (New section) a. A health service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. If there is no in-network facility immediately available for a covered person, a health service corporation shall provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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 health service corporation and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

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

or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. 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.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

5. (New section) a. A group health insurance policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. If there is no in-network facility immediately available for a covered person, an insurer shall provide necessary exceptions to its network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

6. (New section) a. An individual health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

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

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

n. The Attorney General's Office shall be responsible for overseeing any violations of law that may result from P.L. c. (C.) (pending before the Legislature as this bill), including fraud, abuse, waste, and mistreatment of covered persons. The Attorney

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

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

p. As used in this section:

"Concurrent review" means 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.

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

7. (New section) a. A small employer health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

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

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

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

e. (1) 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.

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

f. (1) 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.

(2) 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.

g. 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 carrier and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

o. As used in this section:

"Concurrent review" means 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.

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

8. (New section) a. A health maintenance organization contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. If there is no in-network facility immediately available for a covered person, a health maintenance organization shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

g. 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 health maintenance organization and may be subject to prior authorization or, retrospective review and other utilization management requirements.

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

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

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

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

p. As used in this section:

"Concurrent review" means 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.

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

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

9. (New section) a. The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act provides unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. If there is no in-network facility immediately available for a covered person, the contract shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

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

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

f. (1) 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.

(2) 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.

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

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

m. As used in this section:

"Concurrent review" means 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.

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

10. (New section) a. The School Employees' Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act provides unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities. The services for the treatment of substance use disorder 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.

b. 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. If there is no in-network facility immediately available for a covered person, the contract shall provide necessary exceptions to their network to ensure admission in a treatment facility within 24 hours.

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

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

e. (1) 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.

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. The contract shall not initiate concurrent review more frequently than three-week intervals. If it is determined that continued inpatient care in a facility is no longer medically necessary, the contract shall provide that within 24 hours, written notice shall be provided to the covered person and the covered person's physician of its decision and the right to file an expedited internal appeal of the determination pursuant to an expedited process pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.AC.11:24A-3.5, as applicable. A determination shall be made with respect to the internal appeal within 24 hours and shall be communicated to the covered person and the covered person's physician. If the determination is to uphold the denial, the covered person and the covered person's physician have the right to file an expedited external appeal with the Independent Health Care Appeals Program in the Department of Banking and Insurance pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2s-13) and N.J.A.C.11:24A-3.6, as applicable. An independent utilization review organization shall make a determination within 24 hours. If the determination is upheld and it is determined continued inpatient care is not medically necessary, the contract shall state that benefits are provided for the inpatient care through the day following the date the determination is made and the covered person shall only be responsible for any applicable co-payment, deductible and co-insurance for the stay through that date as applicable under the contract. The covered person shall not be discharged or released from the inpatient facility until all internal appeals and independent utilization review organization appeals are exhausted. For any costs incurred after the day following the date of determination until the day of discharge, the covered person shall only be responsible for any applicable cost-sharing, and any additional charges shall be paid by the facility or provider.

f. (1) 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.

(2) 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.

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

h. 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.

i. The benefits for outpatient prescription drugs to treat 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.

j. 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 provided in this subsection.

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

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

m. As used in this section:

"Concurrent review" means 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.

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

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

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

defined in section 2 of P.L.2003, c.280 (C.45:14-41) 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 pursuant to section 8 of P.L.2015, c.74 (C. 45:1-46.1); 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.

c. No less than four days after issuing the initial prescription, 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.

d. Prior to issuing the initial prescription of a course of treatment that includes a Schedule II controlled dangerous substance or any other opioid drug which is a prescription drug as defined in section 2 of P.L.2003, c.280 (C.45:14-41) 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:

(1) 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;

(2) the reasons why the prescription is necessary;

(3) alternative treatments that may be available; and

(4) 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 obtain a written acknowledgement, on a form developed and made available by the Division of Consumer Affairs, 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 this subsection.

e. 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.

f. 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.

g. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

h. This section shall not apply to a prescription for 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, or to any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

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

1. a. 【A】 <u>Except in the case of an initial prescription issued pursuant to section 11 of P.L. , c. (C.)(pending before the Legislature as this bill), a</u> physician licensed pursuant to chapter 9 of Title 45 of the Revised Statutes may prescribe a Schedule II

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

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

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

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

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

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

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

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

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

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

3. To qualify to prescribe drugs pursuant to section 2 of [this act] P.L.1991, c.97 (C.45:10-18), a certified nurse midwife shall have completed 30 contact hours, as defined by the National Task Force on the Continuing Education Unit, in pharmacology or a pharmacology course, acceptable to the board, in an accredited institution of higher education approved by the Department of Higher Education or the board. Such contact hours shall include one credit of educational programs or topics on 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.

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

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

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

(1) initiating laboratory and other diagnostic tests;

(2) prescribing or ordering medications and devices, as authorized by subsections b. and c. of this section; and

(3) prescribing or ordering treatments, including referrals to other licensed health care professionals, and performing specific procedures in accordance with the provisions of this subsection.

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

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

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

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

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

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

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

(7) the advanced practice nurse has completed six contact hours of continuing professional education in pharmacology related to controlled substances, including pharmacologic therapy **[**and**]** , addiction prevention and management, and 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, in accordance with regulations adopted by the New Jersey Board of Nursing. The six contact hours shall be in addition to New Jersey Board of Nursing pharmacology education requirements for advanced practice nurses related to initial certification and recertification of an advanced practice nurse as set forth in N.J.A.C.13:37-7.2.

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

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

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

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

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

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

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

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

(8) the advanced practice nurse has completed six contact hours of continuing professional education in pharmacology related to controlled substances, including pharmacologic therapy **[**and**]** , addiction prevention and management, and 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, in accordance with regulations adopted by the New Jersey Board of Nursing. The six contact hours shall be in addition to New Jersey Board of Nursing pharmacology education requirements for advanced practice nurses related to initial certification and recertification of an advanced practice nurse as set forth in N.J.A.C.13:37-7.2.

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

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

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

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

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

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

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

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

measurement of the powers of vision or diagnose any ocular deficiency or deformity, visual or muscular anomaly of the human eye and adnexae or prescribe lenses, prisms or ocular exercise for the correction or the relief thereof, or who uses or prescribes pharmaceutical agents for the purposes of diagnosing and treating deficiencies, deformities, diseases or abnormalities of the human eye and adnexae or who holds himself out as qualified to practice optometry.
(cf: P.L.2004, c.115, s.1)

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

3. Fifty credits of continuing professional optometric education shall be required biennially of each New Jersey optometrist holding an active license during the period preceding the established license renewal date. Each credit shall represent or be equivalent to one hour of actual course attendance or in the case of those electing an alternative method of satisfying the requirements of this act shall be approved by the board and certified to the board on forms to be provided for that purpose. Of the 50 credits biennially required under this section, at least one credit shall be for educational programs or topics that concern the prescription of hydrocodone, or the prescription of opioid drugs in general, including responsible prescribing practices, the alternatives to the use of opioids for the management and treatment of pain, and the risks and signs of opioid abuse, addiction, and diversion.
(cf: P.L.1975, c.24, s.3)

18. (New section) a. The New Jersey State Board of Dentistry shall require that the number of credits of continuing dental education required of each person licensed as a dentist, as a condition of biennial registration pursuant to R.S.45:6-10 and section 1 of P.L.1972, c.108 (C.45:1-7), include one credit of educational programs or topics 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. The continuing dental education requirement in this subsection shall be subject to the provisions of P.L.1991, c.490 (C.45:6-10.1 et seq.), including, but not limited to, the authority of the board to waive the provisions of this section for a specific individual if the board deems it is appropriate to do so.

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

19. (New section) a. The State Board of Medical Examiners shall require that the number of credits of continuing medical education required of each person licensed as a physician, as a condition of biennial registration pursuant to section 1 of P.L.1971, c.236 (C.45:9-6.1), include one credit of educational programs or topics 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. The continuing medical education requirement in this subsection shall be subject to the provisions of section 10 of P.L.2001, c.307 (C.45:9-7.1), including, but not limited to, the authority of the board to waive the provisions of this section for a specific individual if the board deems it is appropriate to do so.

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

20. (New section) a. The State Board of Medical Examiners shall require that the number of credits of continuing medical education required of each person licensed as a physician assistant, as a condition of biennial renewal pursuant to section 4 of P.L.1991, c.378 (C.45:9-27.13), include one credit of educational programs or topics 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. The continuing medical education requirement in this subsection shall be subject to the provisions of section 16 of P.L.1991, c.378 (C.45:9-27.25), including, but not limited to, the authority of the board to waive the provisions of this section for a specific individual if the board deems it is appropriate to do so.

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

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

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

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

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

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

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

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

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

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

24. The following sections are repealed:

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

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

STATEMENT

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. If there is no in-network facility immediately available for a covered person, a carrier 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 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. 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, 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 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 obtain a written acknowledgement, on a form developed and made available by the Division of Consumer Affairs, 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 N.J.S.A.45:1-46; and

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

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 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.

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	FY 2017	FY 2018	FY 2019
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.

Related Links

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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