

# ASSEMBLY, No. 3

## STATE OF NEW JERSEY 217th LEGISLATURE

INTRODUCED JANUARY 30, 2017

**Sponsored by:**

**Assemblyman VINCENT PRIETO**

**District 32 (Bergen and Hudson)**

**Assemblyman JON M. BRAMNICK**

**District 21 (Morris, Somerset and Union)**

**Assemblyman HERB CONAWAY, JR.**

**District 7 (Burlington)**

**Assemblyman DAVID P. RIBLE**

**District 30 (Monmouth and Ocean)**

**Assemblyman JOSEPH A. LAGANA**

**District 38 (Bergen and Passaic)**

**Assemblyman JOHN F. MCKEON**

**District 27 (Essex and Morris)**

**Assemblywoman SHAVONDA E. SUMTER**

**District 35 (Bergen and Passaic)**

**Assemblyman DANIEL R. BENSON**

**District 14 (Mercer and Middlesex)**

**Assemblywoman VALERIE VAINIERI HUTTLE**

**District 37 (Bergen)**

**Assemblyman DECLAN J. O'SCANLON, JR.**

**District 13 (Monmouth)**

**Co-Sponsored by:**

**Assemblyman Johnson**

**SYNOPSIS**

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

**CURRENT VERSION OF TEXT**

As introduced.

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

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

3

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

6

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

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

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

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

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

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

**EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.**

**Matter underlined thus is new matter.**

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

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

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

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

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

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

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

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

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

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

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

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

44 p. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

40 p. As used in this section:

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

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

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

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

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

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

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

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



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

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

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

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

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

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

1 authorization or other prospective utilization management  
2 requirements.

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

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

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

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

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

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

36 p. As used in this section:

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

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

45

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28 p. As used in this section:

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

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

37

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 p. As used in this section:

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

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

30

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 p. As used in this section:

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

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

22

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42 p. As used in this section:

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 m. As used in this section:

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

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

21

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

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

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

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

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

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

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

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

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

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

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

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

32 m. As used in this section:

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

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

41

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

36 g. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42

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

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



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

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

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

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

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

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

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

28

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

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

46

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

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

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

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

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

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

- 30       (1) the collaborating physician and advanced practice nurse  
31 shall address in the joint protocols whether prior consultation with  
32 the collaborating physician is required to initiate an order for a  
33 controlled dangerous substance;  
34       (2) the order is written in accordance with standing orders or  
35 joint protocols developed in agreement between a collaborating  
36 physician and the advanced practice nurse, or pursuant to the  
37 specific direction of a physician;  
38       (3) the advanced practice nurse authorizes the order by signing  
39 the nurse's own name, printing the name and certification number,  
40 and printing the collaborating physician's name;  
41       (4) the physician is present or readily available through  
42 electronic communications;  
43       (5) the charts and records of the patients treated by the advanced  
44 practice nurse are reviewed by the collaborating physician and the  
45 advanced practice nurse within the period of time specified by rule  
46 adopted by the Commissioner of Health pursuant to section 13 of  
47 P.L.1991, c.377 (C.45:11-52);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20

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

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

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

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

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

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

10

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

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

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

28

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

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

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

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

18

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

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

36

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

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

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

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

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

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

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

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

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

47  
48 24. The following sections are repealed:

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

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

9  
10

11 STATEMENT

12

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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