

[First Reprint]
ASSEMBLY, No. 3

STATE OF NEW JERSEY
217th LEGISLATURE

INTRODUCED JANUARY 30, 2017

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District 33 (Hudson)

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District 35 (Bergen and Passaic)

Co-Sponsored by:

**Assemblyman Johnson, Assemblywoman McKnight, Assemblymen
Eustace, C.A.Brown, Wisniewski, Gusciora and Rooney**

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 reported by the Assembly Financial Institutions and Insurance Committee on January 30, 2017, with amendments.

(Sponsorship Updated As Of: 2/16/2017)

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 that
8 provides hospital or medical expense benefits and is delivered, issued,
9 executed or renewed in this State, or approved for issuance or renewal
10 in this State by the Commissioner of Banking and Insurance, on or
11 after the effective date of this act, shall provide unlimited benefits for
12 inpatient and outpatient treatment of substance use disorder at in-
13 network facilities. The services for the treatment of substance use
14 disorder shall be prescribed by a licensed physician, licensed
15 psychologist, or licensed psychiatrist and provided by licensed health
16 care professionals or licensed or certified substance use disorder
17 providers in licensed or otherwise State-approved facilities, as required
18 by the laws of the state in 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 any
23 prior authorization or other prospective utilization management
24 requirements. ¹The facility shall notify the hospital service
25 corporation of both the admission and the initial treatment plan within
26 48 hours of the admission or initiation of treatment.¹ If there is no in-
27 network facility immediately available for a covered person, a hospital
28 service corporation shall provide necessary exceptions to its network
29 to ensure 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 contract.

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 during
38 each plan year shall be provided without any retrospective review or
39 concurrent review of medical necessity and medical necessity shall be
40 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 28
45 day period. A request for approval of inpatient care beyond any period

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

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹Assembly AFI committee amendments adopted January 30, 2017.

1 that is approved under concurrent review shall be submitted within the
2 period that was previously approved. No hospital service corporation
3 shall initiate concurrent review more frequently than ¹**[three-week]**
4 two-week¹ intervals. If a hospital service corporation determines that
5 continued inpatient care in a facility is no longer medically necessary,
6 the hospital service corporation shall within 24 hours provide written
7 notice to the covered person and the covered person's physician of its
8 decision and the right to file an expedited internal appeal of the
9 determination pursuant to an expedited process pursuant to sections 11
10 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and
11 N.J.AC.11:24A-3.5, as applicable. The hospital service corporation
12 shall review and make a determination with respect to the internal
13 appeal within 24 hours and communicate such determination to the
14 covered person and the covered person's physician. If the
15 determination is to uphold the denial, the covered person and the
16 covered person's physician have the right to file an expedited external
17 appeal with the Independent Health Care Appeals Program in the
18 Department of Banking and Insurance pursuant to sections 11 through
19 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and
20 N.J.A.C.11:24A-3.6, as applicable. An independent utilization review
21 organization shall make a determination within 24 hours. If the
22 hospital service corporation's determination is upheld and it is
23 determined continued inpatient care is not medically necessary, the
24 hospital service corporation shall remain responsible to provide
25 benefits for 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 from
30 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 day
33 of discharge, the covered person shall only be responsible for any
34 applicable cost-sharing, and any additional charges shall be paid by the
35 facility or provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

38 (2) The benefits for days 29 and thereafter of inpatient care shall
39 be subject to concurrent review as defined in this section. A request
40 for approval of inpatient care beyond the first 28 days shall be
41 submitted for concurrent review before the expiration of the initial 28
42 day period. A request for approval of inpatient care beyond any period
43 that is approved under concurrent review shall be submitted within the
44 period that was previously approved. No medical service corporation
45 shall initiate concurrent review more frequently than ¹**three-week**
46 two-week¹ intervals. If a medical service corporation determines that
47 continued inpatient ¹**confinement**care¹ in a facility is no longer
48 medically necessary, the medical service corporation shall within 24

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

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

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

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

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

46 i. The benefits for medication-assisted treatments for substance
47 use disorder shall be provided when determined medically necessary
48 by the covered person's physician, psychologist or psychiatrist without

1 the imposition of any prior authorization or other prospective
2 utilization management requirements.

3 j. The first 180 days per plan year of benefits shall be computed
4 based on inpatient days. One or more unused inpatient days may be
5 exchanged for two outpatient visits. All extended outpatient services
6 such as partial hospitalization and intensive outpatient, shall be
7 deemed inpatient days for the purpose of the visit to day exchange
8 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 covered
11 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 medical service
17 corporation contracts in which the medical service corporation has
18 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. (C.)
21 (pending before the Legislature as this bill), including fraud, abuse,
22 waste, and mistreatment of covered persons. The Attorney General's
23 office is authorized to adopt, pursuant to the "Administrative
24 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et eq.), rules and
25 regulations to implement any of the provisions of P.L. , c. (C.)
26 (pending before the Legislature as this bill).

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

35 p. As used in this section:

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

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

44

45 3. (New section) a. A health service corporation contract that
46 provides hospital or medical expense benefits and is delivered, issued,
47 executed or renewed in this State, or approved for issuance or renewal
48 in this State by the Commissioner of Banking and Insurance, on or

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

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

20 c. Providers of treatment for substance use disorder to persons
21 covered under a covered contract 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 contract.

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 during
28 each plan year shall be provided without any retrospective review or
29 concurrent review of medical necessity and medical necessity shall be
30 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 28
35 day period. A request for approval of inpatient care beyond any period
36 that is approved under concurrent review shall be submitted within the
37 period that was previously approved. No health service corporation
38 shall initiate concurrent review more frequently than ¹**[three-week]**
39 two-week¹ intervals. If a health service corporation determines that
40 continued inpatient care in a facility is no longer medically necessary,
41 the health service corporation shall within 24 hours provide written
42 notice to the covered person and the covered person's physician of its
43 decision and the right to file an expedited internal appeal of the
44 determination pursuant to an expedited process pursuant to sections 11
45 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and
46 N.J.A.C.11:24A-3.5, as applicable. The health service corporation
47 shall review and make a determination with respect to the internal
48 appeal within 24 hours and communicate such determination to the

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

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

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

29 g. Benefits for inpatient and outpatient treatment of substance use
30 disorder after the first 180 days per plan year shall be subject to the
31 medical necessity determination of the health service corporation and
32 may be 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 consultation
37 with the Department of Health.

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

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

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

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

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

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

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

27 p. As used in this section:

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

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

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

1 b. The benefits for the first 180 days per plan year of inpatient
2 and outpatient treatment of substance use disorder shall be provided
3 when determined medically necessary by the covered person's
4 physician, psychologist or psychiatrist without the imposition of any
5 prior authorization or other prospective utilization management
6 requirements. ¹The facility shall notify the insurer of both the
7 admission and the initial treatment plan within 48 hours of the
8 admission or initiation of treatment.¹ If there is no in-network facility
9 immediately available for a covered person, an insurer shall provide
10 necessary exceptions to their network to ensure admission in a
11 treatment facility within 24 hours.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 p. As used in this section:

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

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

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

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

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

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

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

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

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

1 of discharge, the covered person shall only be responsible for any
2 applicable cost-sharing, and any additional charges shall be paid by the
3 facility or provider.

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

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

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

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

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

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

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

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

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

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

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

9 p. As used in this section:

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

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

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

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

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

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

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

4 g. Benefits for inpatient and outpatient treatment of substance use
5 disorder after the first 180 days per plan year shall be subject to the
6 medical necessity determination of the ¹ ~~insurer~~ carrier¹ and may be
7 subject to prior authorization or, retrospective review and other
8 utilization 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 consultation
12 with the Department of Health.

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

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

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

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

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

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

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

1 by the Division of Medical Assistance and Health Services in the
2 Department of Human Services.

3 p. As used in this section:

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

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

12

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

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

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

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

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

47 (2) The benefits for days 29 and thereafter of inpatient care shall
48 be subject to concurrent review as defined in this section. A request

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

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

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

44 g. Benefits for inpatient and outpatient treatment of substance use
45 disorder after the first 180 days per plan year shall be subject to the
46 medical necessity determination of the carrier and may be subject to
47 prior authorization or, retrospective review and other utilization
48 management 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 consultation
4 with the Department of Health.

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

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

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

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

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

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

34 o. As used in this section:

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

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

43
44 8. (New section) a. A health maintenance organization contract
45 that provides hospital or medical expense benefits and is delivered,
46 issued, executed or renewed in this State, or approved for issuance or
47 renewal in this State by the Commissioner of Banking and Insurance,
48 on or after the effective date of this act, shall provide unlimited

1 benefits for inpatient and outpatient treatment of substance use
2 disorder at in-network facilities. The services for the treatment of
3 substance use disorder shall be prescribed by a licensed physician,
4 licensed psychologist, or licensed psychiatrist and provided by
5 licensed health care professionals or licensed or certified substance use
6 disorder providers in licensed or otherwise State-approved facilities, as
7 required by the laws of the state in which the services are rendered.

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

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

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

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

30 (2) The benefits for days 29 and thereafter of inpatient care shall
31 be subject to concurrent review as defined in this section. A request
32 for approval of inpatient care beyond the first 28 days shall be
33 submitted for concurrent review before the expiration of the initial 28
34 day period. A request for approval of inpatient care beyond any period
35 that is approved under concurrent review shall be submitted within the
36 period that was previously approved. No health maintenance
37 organization shall initiate concurrent review more frequently than
38 ¹~~three-week~~ two-week¹ intervals. If a health maintenance
39 organization determines that continued inpatient ¹~~confinement~~care¹
40 in a facility is no longer medically necessary, the health
41 ¹~~insurance~~maintenance¹ organization shall within 24 hours provide
42 written notice to the covered person and the covered person's
43 physician of its decision and the right to file an expedited internal
44 appeal of the determination pursuant to an expedited process pursuant
45 to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through
46 26:2S-13) and N.J.AC.11:24A-3.5, as applicable. The health
47 maintenance organization shall review and make a determination with
48 respect to the internal appeal within 24 hours and communicate such

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

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

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

29 g. Benefits for inpatient and outpatient treatment of substance use
30 disorder after the first 180 days per plan year shall be subject to the
31 medical necessity determination of the health maintenance
32 organization and may be subject to prior authorization or, retrospective
33 review and other 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 consultation
37 with the Department of Health.

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

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

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

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

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

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

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

27 p. As used in this section:

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

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

36
37 9. (New section) a. The State Health Benefits Commission shall
38 ensure that every contract purchased by the commission on or after the
39 effective date of this act provides unlimited benefits for inpatient and
40 outpatient treatment of substance use disorder at in-network facilities.
41 The services for the treatment of substance use disorder shall be
42 prescribed by a licensed physician, licensed psychologist, or licensed
43 psychiatrist and provided by licensed health care professionals or
44 licensed or certified substance use disorder providers in licensed or
45 otherwise State-approved facilities, as required by the laws of the state
46 in which the services are rendered.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

44 m. 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 Psychiatric
2 Association in the Diagnostic and Statistical Manual of Mental
3 Disorders, Fifth Edition and any subsequent editions and shall include
4 substance use withdrawal.

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

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

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

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

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

38 (2) The benefits for days 29 and thereafter of inpatient care shall
39 be subject to concurrent review as defined in this section. A request
40 for approval of inpatient care beyond the first 28 days shall be
41 submitted for concurrent review before the expiration of the initial 28
42 day period. A request for approval of inpatient care beyond any period
43 that is approved under concurrent review shall be submitted within the
44 period that was previously approved. The contract shall not initiate
45 concurrent review more frequently than ¹~~three-week~~ two-week¹
46 intervals. If it is determined that continued inpatient care in a facility
47 is no longer medically necessary, the contract shall provide that within
48 24 hours, written notice shall be provided to the covered person and

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

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

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

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

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

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

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

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

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

14 m. As used in this section:

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

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

23

24 11. (New section) a. A practitioner shall not issue an initial
25 prescription for an opioid drug which is a prescription drug as defined
26 in section 2 of P.L.2003, c.280 (C.45:14-41) in a quantity exceeding a
27 five-day supply for treatment of acute pain. ¹Any prescription for
28 acute pain pursuant to this subsection shall be for the lowest effective
29 dose of immediate-release opioid drug.¹

30 b. Prior to issuing an initial prescription of a ¹course of
31 treatment that includes a¹ Schedule II controlled dangerous substance
32 or any other opioid drug which is a prescription drug as defined in
33 section 2 of P.L.2003, c.280 (C.45:14-41) ¹in a course of treatment¹
34 for acute or chronic pain, a practitioner shall:

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

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

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

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

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

4 c. No less than four days after issuing the initial prescription
5 1pursuant to subsection a. of this subsection¹, the practitioner, after
6 consultation with the patient, may issue a subsequent prescription for
7 the drug to the patient in any quantity that complies with applicable
8 State and federal laws, provided that:

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

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

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

17 d. Prior to issuing the initial prescription of ¹**[a course of**
18 **treatment that includes]**¹ a Schedule II controlled dangerous substance
19 or any other opioid drug which is a prescription drug as defined in
20 section 2 of P.L.2003, c.280 (C.45:14-41) ¹in a course of treatment for
21 acute or chronic pain¹ and again prior to issuing the third prescription
22 of the course of treatment, a practitioner shall discuss with the patient,
23 or the patient's parent or guardian if the patient is under 18 years of
24 age and is not an emancipated minor, the risks associated with the
25 drugs being prescribed, including but not limited to:

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

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

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

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

38 The practitioner shall ¹**[obtain a written acknowledgement, on a**
39 **form developed and made available by the Division of Consumer**
40 **Affairs,]** include a note in the patient's medical record¹ that the patient
41 or the patient's parent or guardian, as applicable, has discussed with
42 the practitioner the risks of developing a physical or psychological
43 dependence on the controlled dangerous substance and alternative
44 treatments that may be available. The Division of Consumer Affairs
45 shall develop and make available to practitioners guidelines for the
46 discussion required pursuant to this subsection.

1 e. At the time of the issuance of the third prescription for a
2 prescription opioid drug, the practitioner shall enter into a pain
3 management agreement with the patient.

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

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

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

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

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

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

25 g. As used in this section:

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

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

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

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

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

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

- 1 (1) prevent the possible development of physical or psychological
2 dependence in the patient;
- 3 (2) document the understanding of both the practitioner and the
4 patient regarding the patient's pain management plan;
- 5 (3) establish the patient's rights in association with treatment, and
6 the patient's obligations in relation to the responsible use,
7 discontinuation of use, and storage of Schedule II controlled dangerous
8 substances, including any restrictions on the refill of prescriptions or
9 the acceptance of Schedule II prescriptions from practitioners;
- 10 (4) identify the specific medications and other modes of treatment,
11 including physical therapy or exercise, relaxation, or psychological
12 counseling, that are included ¹as¹ a part of the pain management plan;
- 13 (5) specify the measures the practitioner may employ to monitor
14 the patient's compliance, including but not limited to random
15 specimen screens and pill counts; and
- 16 (6) delineate the process for terminating the agreement, including
17 the consequences if the practitioner has reason to believe that the
18 patient is not complying with the terms of the agreement.

19 "Practitioner" means a medical doctor, doctor of osteopathy,
20 dentist, optometrist, podiatrist, physician assistant, certified nurse
21 midwife, or advanced practice nurse ¹, acting within the scope of
22 practice of their professional license pursuant to Title 45 of the
23 Revised Statutes¹.

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

29 ¹i. Every policy, contract or plan delivered, issued, executed or
30 renewed in this State, or approved for issuance or renewal in this State
31 by the Commissioner of Banking and Insurance, and every contract
32 purchased by the School Employees' Health Benefits Commission or
33 State Health Benefits Commission, on or after the effective date of
34 this act, that provides coverage for prescription drugs subject to a co-
35 payment, coinsurance or deductible shall charge a co-payment,
36 coinsurance or deductible for an initial prescription of an opioid drug
37 prescribed pursuant to this section that is either:

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

40 (2) equivalent to the cost sharing for a full 30-day supply of the
41 opioid drug, provided that no additional cost sharing may be charged
42 for any additional prescriptions for the remainder of the 30-day
43 supply.¹

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

47 1. a. **[A]** Except in the case of an initial prescription issued
48 pursuant to section 11 of P.L. , c. (C.)(pending before the

1 Legislature as this bill), a physician licensed pursuant to chapter 9
2 of Title 45 of the Revised Statutes may prescribe a Schedule II
3 controlled dangerous substance for the use of a patient in any
4 quantity which does not exceed a 30-day supply, as defined by
5 regulations adopted by the State Board of Medical Examiners in
6 consultation with the Department of Health **【and Senior Services】**.
7 The physician shall document the diagnosis and the medical need
8 for the prescription in the patient's medical record, in accordance
9 with guidelines established by the State Board of Medical
10 Examiners.

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

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

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

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

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

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

30

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

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

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

3 3. To qualify to prescribe drugs pursuant to section 2 of **【this**
4 **act】** P.L.1991, c.97 (C.45:10-18), a certified nurse midwife shall
5 have completed 30 contact hours, as defined by the National Task
6 Force on the Continuing Education Unit, in pharmacology or a
7 pharmacology course, acceptable to the board, in an accredited
8 institution of higher education approved by the Department of
9 Higher Education or the board. Such contact hours shall include
10 one credit of educational programs or topics on issues concerning
11 prescription opioid drugs, including responsible prescribing
12 practices, alternatives to opioids for managing and treating pain,
13 and the risks and signs of opioid abuse, addiction, and diversion.
14 (cf: P.L.1991, c.97, s.3)
15

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

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

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

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

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

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

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

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

45 (5) the charts and records of the patients treated by the advanced
46 practice nurse are reviewed by the collaborating physician and the
47 advanced practice nurse within the period of time specified by rule

1 adopted by the Commissioner of Health pursuant to section 13 of
2 P.L.1991, c.377 (C.45:11-52);

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

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

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

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

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

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

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

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

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

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

45 (8) the advanced practice nurse has completed six contact hours
46 of continuing professional education in pharmacology related to
47 controlled substances, including pharmacologic therapy **[and]** ,
48 addiction prevention and management, and issues concerning

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

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

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

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

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

22

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

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

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

43 A person shall be deemed to be practicing optometry within the
44 meaning of this chapter who in any way advertises himself as an
45 optometrist, or who shall employ any means for the measurement of
46 the powers of vision or the adaptation of lenses or prisms for the aid
47 thereof, practice, offer or attempt to practice optometry as herein
48 defined, either on his own behalf or as an employee or student of

1 another, whether under the personal supervision of his employer or
2 perceptor or not, or to use testing appliances for the purposes of
3 measurement of the powers of vision or diagnose any ocular
4 deficiency or deformity, visual or muscular anomaly of the human
5 eye and adnexae or prescribe lenses, prisms or ocular exercise for
6 the correction or the relief thereof, or who uses or prescribes
7 pharmaceutical agents for the purposes of diagnosing and treating
8 deficiencies, deformities, diseases or abnormalities of the human
9 eye and adnexae or who holds himself out as qualified to practice
10 optometry.

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

12

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

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

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

30

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

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

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

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

18

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

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

36

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

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

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

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

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

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

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

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

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

47
48 24. The following sections are repealed:

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

6

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