

SENATE HEALTH, HUMAN SERVICES AND SENIOR  
CITIZENS COMMITTEE

STATEMENT TO

**SENATE, No. 3**

with committee amendments

**STATE OF NEW JERSEY**

DATED: JANUARY 30, 2017

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- the reasons why the prescription is necessary;

- alternative treatments that may be available; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The committee amendments to the bill:

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

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