Chapter 28, P.L. 2017

(Approved February 15, 2017)

[First Reprint]

SENATE, No. 3

STATE OF NEW JERSEY

217th LEGISLATURE

INTRODUCED JANUARY 30, 2017

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Senators Addiego, Gordon, Madden, Turner, Greenstein, B.Smith, 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

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

As reported by the Senate Health, Human Services and Senior Citizens Committee on January 30, 2017, with amendments.

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

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

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

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

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

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

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

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

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be

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

Matter underlined <u>thus</u> is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Senate SHH committee amendments adopted January 30, 2017.

submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. No hospital service corporation shall initiate concurrent review more frequently than ¹[three-week] two-week¹ intervals. If a hospital service corporation determines that continued inpatient care in a facility is no longer medically necessary, the hospital service corporation shall within 24 hours provide written notice to the covered person and the covered person's physician of its decision and the right to file an expedited internal appeal of the determination pursuant to an expedited process pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as applicable. The hospital service corporation shall review and make a determination with respect to the internal appeal within 24 hours and communicate such determination to the covered person and the covered person's physician. If the determination is to uphold the denial, the covered person and the covered person's physician have the right to file an expedited external appeal with the Independent Health Care Appeals Program in the Department of Banking and Insurance pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An independent utilization review organization shall make a determination within 24 hours. If the hospital service corporation's determination is upheld and it is determined continued inpatient care is not medically necessary, the hospital service corporation shall remain responsible to provide benefits for the inpatient care through the day following the date the determination is made and the covered person shall only be responsible for any applicable co-payment, deductible and co-insurance for the stay through that date as applicable under the contract. The covered person shall not be discharged or released from the inpatient facility until all internal appeals and independent utilization review organization appeals are exhausted. For any costs incurred after the day following the date of determination until the day of discharge, the covered person shall only be responsible for any applicable cost-sharing, and any additional charges shall be paid by the facility or provider.

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

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

g. Benefits for inpatient and outpatient treatment of substance use disorder after the first 180 days per plan year shall be subject to the medical necessity determination of the hospital service

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

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

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

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

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

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

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

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

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

p. As used in this section:

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

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

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

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

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

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

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

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be

submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. No medical service corporation shall initiate concurrent review more frequently than 1[three-week] two-week1 intervals. If a medical service corporation determines that continued inpatient 1[confinement] care1 in a facility is no longer medically necessary, the medical service corporation shall within 24 hours provide written notice to the covered person and the covered person's physician of its decision and the right to file an expedited internal appeal of the determination pursuant to an expedited process pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as applicable. The medical service corporation shall review and make a determination with respect to the internal appeal within 24 hours and communicate such determination to the covered person and the covered person's physician. If the determination is to uphold the denial, the covered person and the covered person's physician have the right to file an expedited external appeal with the Independent Health Care Appeals Program in the Department of Banking and Insurance pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.6, as applicable. An independent utilization review organization shall make a determination within 24 hours. If the medical service corporation's determination is upheld and it is determined continued inpatient care is not medically necessary, the medical service corporation shall remain responsible to provide benefits for the inpatient care through the day following the date the determination is made and the covered person shall only be responsible for any applicable co-payment, deductible and co-insurance for the stay through that date as applicable under the contract. The covered person shall not be discharged or released from the inpatient facility until all internal appeals and independent utilization review organization appeals are exhausted. For any costs incurred after the day following the date of determination until the day of discharge, the covered person shall only be responsible for any applicable cost-sharing, and any additional charges shall be paid by the facility or provider.

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

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

g. Benefits for inpatient and outpatient treatment of substance use disorder after the first 180 days per plan year shall be subject to the medical necessity determination of the medical service

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

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

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

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

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

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

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

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

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

p. As used in this section:

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

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

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

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

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

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

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

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be

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

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

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

g. Benefits for inpatient and outpatient treatment of substance use disorder after the first 180 days per plan year shall be subject to the medical necessity determination of the health service

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

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

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

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

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

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

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

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

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

p. As used in this section:

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

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

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

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

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

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

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

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial

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

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

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

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

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

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

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

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

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

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

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

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

p. As used in this section:

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

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

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

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

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

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

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

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

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. No insurer shall initiate concurrent review more frequently than [1]**[**three-week**]** <u>two-week</u>[1] intervals. If an insurer determines that continued inpatient

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

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

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

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

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

i. The benefits for outpatient prescription drugs to treat substance use disorder shall be provided when determined

medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements.

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

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

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

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

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

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

p. As used in this section:

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

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

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

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

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

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

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

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

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. No carrier shall initiate concurrent review more frequently than ¹[three-week] two-week¹ intervals. If a carrier determines that continued inpatient care in a facility is no longer medically necessary, the carrier shall within 24 hours provide written notice to the covered person and the covered person's physician of its decision and the right to file an expedited internal appeal of the determination pursuant to an expedited process pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as applicable. The carrier shall review and make a determination with

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

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

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

g. Benefits for inpatient and outpatient treatment of substance use disorder after the first 180 days per plan year shall be subject to the medical necessity determination of the [1]**[**insurer**]** carrier[1] and may be subject to prior authorization or, retrospective review and other utilization management requirements.

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

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

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

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

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

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

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

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

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

p. As used in this section:

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

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

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

provided by licensed health care professionals or licensed or certified substance use disorder providers in licensed or otherwise State-approved facilities, as required by the laws of the state in which the services are rendered.

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

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

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

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

(2) The benefits for days 29 and thereafter of inpatient care shall be subject to concurrent review as defined in this section. A request for approval of inpatient care beyond the first 28 days shall be submitted for concurrent review before the expiration of the initial 28 day period. A request for approval of inpatient care beyond any period that is approved under concurrent review shall be submitted within the period that was previously approved. No carrier shall initiate concurrent review more frequently than ¹[three-week] two-week¹ intervals. If a carrier determines that continued inpatient care in a facility is no longer medically necessary, the carrier shall within 24 hours provide written notice to the covered person and the covered person's physician of its decision and the right to file an expedited internal appeal of the determination pursuant to an expedited process pursuant to sections 11 through 13 of P.L.1997, c.192 (C.26:2S-11 through 26:2S-13) and N.J.A.C.11:24A-3.5, as applicable. The carrier shall review and make a determination with respect to the internal appeal within 24 hours and communicate such determination to the covered person and the covered person's physician. If the determination is to uphold the denial, the covered person and the covered person's physician have the right to file an expedited external appeal with the Independent Health Care Appeals Program in the Department of Banking and Insurance

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

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

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

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

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

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

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

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

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

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

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

o. As used in this section:

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

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

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

b. The benefits for the first 180 days per plan year of inpatient and outpatient treatment of substance use disorder shall be provided when determined medically necessary by the covered person's physician, psychologist or psychiatrist without the imposition of any prior authorization or other prospective utilization management requirements. [1]<u>The facility shall notify the health maintenance organization of both the admission and the initial treatment plan within 48 hours of the admission or initiation of treatment.</u>[1] If there is no in-network facility immediately available for a covered person, a health maintenance organization shall provide necessary

exceptions to their network to ensure admission in a treatment facility within 24 hours.

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

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

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

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

person shall not be discharged or released from the inpatient facility until all internal appeals and independent utilization review organization appeals are exhausted. For any costs incurred after the day following the date of determination until the day of discharge, the covered person shall only be responsible for any applicable cost-sharing, and any additional charges shall be paid by the facility or provider.

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

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

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

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

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

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

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

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

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

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

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

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

p. As used in this section:

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

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

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

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

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

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

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

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

only be responsible for any applicable cost-sharing, and any additional charges shall be paid by the facility or provider.

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

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

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

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

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

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

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

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

m. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

m. As used in this section:

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

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

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

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

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

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

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

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

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

c. No less than four days after issuing the initial prescription [1]pursuant to subsection a. of this subsection[1], the practitioner, after consultation with the patient, may issue a subsequent prescription

for the drug to the patient in any quantity that complies with applicable State and federal laws, provided that:

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

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

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

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

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

(2) the reasons why the prescription is necessary;

(3) alternative treatments that may be available; and

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

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

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

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

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

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

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

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

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

g. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) initiating laboratory and other diagnostic tests;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

another, whether under the personal supervision of his employer or perceptor or not, or to use testing appliances for the purposes of measurement of the powers of vision or diagnose any ocular deficiency or deformity, visual or muscular anomaly of the human eye and adnexae or prescribe lenses, prisms or ocular exercise for the correction or the relief thereof, or who uses or prescribes pharmaceutical agents for the purposes of diagnosing and treating deficiencies, deformities, diseases or abnormalities of the human eye and adnexae or who holds himself out as qualified to practice optometry.
(cf: P.L.2004, c.115, s.1)

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

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

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

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

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

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

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

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

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

b. The board may, in its discretion, waive the continuing education requirement in subsection a. of this section on an individual basis for reasons of hardship, such as illness or disability,

retirement of the license, or other good cause. A waiver shall apply only to the current biennial renewal period at the time of board issuance.

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

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

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

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

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

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

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

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