An act to add Section 1374.78 to the Health and Safety Code, and to add Section 10144.42 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL’S DIGEST

SB 854, as introduced, Beall. Health care coverage: Substance use disorders.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires specified health insurance policies that provide coverage for outpatient prescription drugs to cover medically necessary prescription drugs and subjects those policies to certain limitations on cost sharing and the placement of drugs on formularies. Existing law authorizes a health care service plan and a health insurer to utilize formularies, prior authorization, step therapy, or other reasonable medical management practices in the provision of outpatient prescription drug coverage.

This bill would require health care service plans and health insurers that provide prescription drug benefits for the treatment of substance use disorders to place prescription medications approved by the United
States Food and Drug Administration (FDA) on the lowest cost-sharing tier of the plan or insurer’s prescription drug formulary. The bill would impose various prohibitions on those plans and insurers, including a prohibition on prior authorization requirements on, or any step therapy requirements before authorizing coverage for, a prescription medication approved by the FDA for the treatment of substance use disorders. The bill would require those plans and insurers to make specified disclosures online and in printed provider directories, including which providers provide medication-assisted treatment services, and would state that these provisions do not apply to health care service plan contracts or health insurance policies for health care services or coverage provided in the Medi-Cal program.

Because a willful violation of the bill’s provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.


The people of the State of California do enact as follows:

1. SECTION 1. Section 1374.78 is added to the Health and Safety Code, to read:

   1374.78. (a) Notwithstanding any other law, a health care service plan that provides prescription drug benefits for the treatment of substance use disorders shall place all prescription medications approved by the United States Food and Drug Administration (FDA) on the lowest cost-sharing tier of the drug formulary developed and maintained by the health care service plan or the pharmacy benefit management company, and shall not do any of the following:

   (1) Impose any prior authorization requirements on any prescription medication approved by FDA for the treatment of substance use disorders, or on any behavioral, cognitive, or mental health services prescribed in conjunction with or supplementary
to that medication for the purpose of treating a substance use disorder.

(2) Impose any requirement that the enrollee receives coverage at an outpatient facility that exceeds allowable time and distance standards for network adequacy, a specific number of visits, days of coverage, scope, or duration of treatment, or other similar limitations.

(3) Impose any requirement related to an enrollee’s prior success or failure with substance use disorder treatment.

(4) Impose any step therapy requirements before authorizing coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

(5) Exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services on the grounds that those medications and services were court ordered.

(b) A health care service plan shall disclose which providers in each network provide medication-assisted treatment services, and the level of care that those providers render pursuant to the current edition of the ASAM Criteria. The disclosure shall be made in a prominent location in the online and printed provider directories.

(c) This section does not apply to a health care service plan contract issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(d) For purposes of this section, the following definitions apply:

(1) “ASAM Criteria” means the national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction, and includes a comprehensive set of guidelines for placement, continued stay, and transfer and discharge of patients with addiction and cooccurring conditions, as published by the American Society of Addiction Medicine.

(2) “Pharmacy benefit management company” means a company that administers a prescription drug plan for a health care service plan.

(3) “Prior authorization” means the process by which a health care service plan or pharmacy benefit management company determines the medical necessity of otherwise covered health care services before those services are rendered. “Prior authorization”
includes any health care service plan’s or utilization review entity’s requirement that an enrollee or health care provider notify the health care service plan or utilization review entity before those services are provided.

(4) “Step therapy” means a protocol or program that establishes the specific sequence that prescription drugs for a medical condition, and which drugs are medically appropriate for a patient, are authorized by a health care service plan or prescription drug management company.

SEC. 2. Section 10144.42 is added to the Insurance Code, to read:

10144.42. (a) Notwithstanding any other law, a health insurer that provides prescription drug benefits for the treatment of substance use disorders shall place all prescription medications approved by the United States Food and Drug Administration (FDA) on the lowest cost-sharing tier of the drug formulary developed and maintained by the health insurer, and shall not do any of the following:

(1) Impose any prior authorization requirements on any prescription medication approved by FDA for the treatment of substance use disorders, or on any behavioral, cognitive, or mental health services prescribed in conjunction with or supplementary to that medication for the purpose of treating a substance use disorder.

(2) Impose any requirement that the insured receives coverage at an outpatient facility that exceeds allowable time and distance standards for network adequacy, a specific number of visits, days of coverage, scope, or duration of treatment, or other similar limitations.

(3) Impose any requirement related to an insured’s prior success or failure with substance use disorder treatment.

(4) Impose any step therapy requirements before authorizing coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

(5) Exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services on the grounds that those medications and services were court ordered.

(b) A health insurer shall disclose which providers in each network provide medication-assisted treatment services, and the
level of care that those providers render pursuant to the current
edition of the ASAM Criteria. The disclosure shall be made in a
prominent location in the online and printed provider directories.
(c) This section does not apply to a health insurance policy
issued, sold, renewed, or offered for health care services or
coverage provided in the Medi-Cal program (Chapter 7
(commencing with Section 14000) of Part 3 of Division 9 of the
Welfare and Institutions Code).
(d) For purposes of this section, the following definitions apply:
(1) “ASAM Criteria” means the national set of criteria for
providing outcome-oriented and results-based care in the treatment
of addiction, and includes a comprehensive set of guidelines for
placement, continued stay, and transfer and discharge of patients
with addiction and cooccurring conditions, as published by the
American Society of Addiction Medicine.
(2) “Pharmacy benefit management company” means a company
that administers a prescription drug plan for a health insurer.
(3) “Prior authorization” means the process by which a health
insurer or pharmacy benefit management company determines the
medical necessity of otherwise covered health care services before
those services are rendered. “Prior authorization” includes any
health insurer’s or utilization review entity’s requirement that an
insured or health care provider notify the health insurer or
utilization review entity before those services are provided.
(4) “Step therapy” means a protocol or program that establishes
the specific sequence that prescription drugs for a medical
condition, and which drugs are medically appropriate for a patient,
are authorized by a health insurer or prescription drug management
company.
SEC. 3. No reimbursement is required by this act pursuant to
Section 6 of Article XIII B of the California Constitution because
the only costs that may be incurred by a local agency or school
district will be incurred because this act creates a new crime or
infraction, eliminates a crime or infraction, or changes the penalty
for a crime or infraction, within the meaning of Section 17556 of
the Government Code, or changes the definition of a crime within
the meaning of Section 6 of Article XIII B of the California
Constitution.