ASSEMBLY BILL No. 1011

Introduced by Assembly Member Waldron
(Principal coauthor: Senator Wiener)

February 18, 2021

An act to add Section 1367.207 to the Health and Safety Code, and to add Section 10123.204 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1011, as introduced, Waldron. 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 plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2022, that provide outpatient prescription drug benefits to cover all medically necessary prescription drugs approved by the United States Food and Drug Administration (FDA) for treating substance use

disorders that are appropriate for the specific needs of an enrollee or insured, and would require those drugs to be placed on the lowest cost-sharing tier of the plan or insurer's prescription drug formulary, unless specified criteria are met. The bill would prohibit these contracts and policies from imposing prescribed requirements, including prior authorization or step therapy requirements on a prescription drug approved by the FDA for treating substance use disorders, unless specified criteria are met. Because a willful violation of these 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.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. Section 1367.207 is added to the Health and Safety Code, to read:

1367.207. (a) Notwithstanding any other law, a health care service plan contract issued, amended, or renewed on or after January 1, 2022, that provides outpatient prescription drug benefits shall do both of the following:

(1) Cover, under applicable pharmacy and medical benefits, all medically necessary prescription drugs approved by the United States Food and Drug Administration (FDA) for treating substance use disorders that are appropriate for the specific needs of an enrollee.

(2) Place all outpatient prescription drugs approved by the FDA for treating substance use disorders on the lowest cost-sharing tier of the drug formulary developed and maintained by the health care service plan or the health care service plan's pharmacy benefit manager, except as authorized in subdivision (c).

(b) Except as authorized in subdivision (c), a health care service plan contract issued, amended, or renewed on or after January 1, 2022, shall not impose any of the following:

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

(2) A requirement that the enrollee receives treatment at an outpatient facility that exceeds allowable time and distance standards for network adequacy.

(3) A limit on the number of visits, days of coverage, scope or duration of treatment, or other similar limitations on coverage of prescription drugs and benefits for treating substance use disorders.

(4) An exclusion or limitation on coverage of prescription drugs and benefits for treating substance use disorders based on an enrollee's prior success or failure with substance use disorder treatment.

(5) Step therapy requirements on a prescription drug approved by the FDA for treating substance use disorders.

(6) A requirement that the enrollee receives concurrent behavioral, cognitive, mental health, or other services as a condition of coverage for a prescription drug approved by the FDA for treating substance use disorders.

(7) An exclusion of coverage for a prescription drug approved by the FDA for treating substance use disorders and any associated counseling or wraparound services on the grounds that substance use disorder treatment was court ordered if the drugs and services were determined to be medically necessary, prescribed by a licensed health care provider, and provided in a community setting.

(c) If the FDA has approved one or more therapeutic equivalents of a prescription drug for treating substance use disorders, a health care service plan contract issued, amended, or renewed on or after January 1, 2022, may do both of the following:

(1) Place a therapeutic equivalent of the drug on any tier of a drug formulary if at least one therapeutic equivalent of the drug is covered on the lowest cost-sharing tier of the drug formulary.

(2) Require prior authorization or step therapy for a therapeutic equivalent of the drug if at least one therapeutic equivalent of the drug is covered without prior authorization or step therapy.

(d) A health care service plan shall disclose which providers in each network provide prescription drugs approved by the FDA for treating substance use disorders 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.

(e) 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) or to a specialized health care service plan contract that covers only vision or dental benefits.

(f) 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 treating 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 manager" has the same meaning as defined in Section 1385.001.

(3) "Prior authorization" means the process by which a health care service plan or pharmacy benefit manager determines the medical necessity of otherwise covered health care services before those services are rendered. "Prior authorization" includes any requirement of a health care service plan, or of any entities with which the plan contracts for services that include utilization review or utilization management functions, that an enrollee or health care provider notify the health care service plan or contracting entity before those services are provided.

(4) "Step therapy" means a type of protocol that specifies the sequence in which different prescription drugs for a medical condition and medically appropriate for a particular enrollee are to be prescribed.

SEC. 2. Section 10123.204 is added to the Insurance Code, to read:

10123.204. (a) Notwithstanding any other law, a health insurance policy issued, amended, or renewed on or after January 1, 2022, that provides outpatient prescription drug benefits shall do both of the following:

(1) Cover, under applicable pharmacy and medical benefits, all medically necessary prescription drugs approved by the United States Food and Drug Administration (FDA) for treating substance

use disorders that are appropriate for the specific needs of an insured.

(2) Place all outpatient prescription drugs approved by the FDA for treating substance use disorders on the lowest cost-sharing tier of the drug formulary developed and maintained by the health insurer or the health insurer's pharmacy benefit manager, except as authorized in subdivision (c).

(b) Except as authorized in subdivision (c), a health insurance policy issued, amended, or renewed on or after January 1, 2022, shall not impose any of the following:

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

(2) A requirement that the insured receives treatment at an outpatient facility that exceeds allowable time and distance standards for network adequacy.

(3) A limit on the number of visits, days of coverage, scope or duration of treatment, or other similar limitations on coverage of prescription drugs and benefits for treating substance use disorders.

(4) An exclusion or limitation on coverage of prescription drugs and benefits for treating substance use disorders based on an insured's prior success or failure with substance use disorder treatment.

(5) Step therapy requirements on a prescription drug approved by the FDA for treating substance use disorders.

(6) A requirement that the insured receives concurrent behavioral, cognitive, mental health, or other services as a condition of coverage for a prescription drug approved by the FDA for treating substance use disorders.

(7) An exclusion of coverage for a prescription drug approved by the FDA for treating substance use disorders and any associated counseling or wraparound services on the grounds that substance use disorder treatment was court ordered if the drugs and services were determined to be medically necessary, prescribed by a licensed health care provider, and provided in a community setting.

(c) If the FDA has approved one or more therapeutic equivalents of a prescription drug for treating substance use disorders, a health

insurance policy issued, amended, or renewed on or after January 1, 2022, may do both of the following:

(1) Place a therapeutic equivalent of the drug on any tier of a drug formulary if at least one therapeutic equivalent of the drug is covered on the lowest cost-sharing tier of the drug formulary.

(2) Require prior authorization or step therapy for a therapeutic equivalent of the drug if at least one therapeutic equivalent of the drug is covered without prior authorization or step therapy.

(d) A health insurer shall disclose which providers in each network provide prescription drugs approved by the FDA for treating substance use disorders 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.

(e) This section does not apply to a specialized health insurance policy that covers only vision or dental benefits or a Medicare supplement policy.

(f) 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 treating 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 manager" means a person, business, or other entity that, pursuant to a contract with a health insurer, manages the prescription drug coverage provided by the health insurer, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs.

(3) "Prior authorization" means the process by which a health insurer or pharmacy benefit manager determines the medical necessity of otherwise covered health care services before those services are rendered. "Prior authorization" includes any requirement of a health insurer, or of any entities with which the insurer contracts for services that include utilization review or utilization management functions, that an insured or health care

provider notify the health insurer or contracting entity before those services are provided.

(4) "Step therapy" has the same meaning as defined in Section 10123.201.

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.

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