ASSEMBLY BILL No. 669

Introduced by Assembly Member Haney

February 14, 2025

An act to add Sections 1367.047, 1367.048, and 1367.049 to the Health and Safety Code, and to add Sections 10123.1937, 10123.1938, and 10123.1939 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 669, as introduced, Haney. Substance use disorder coverage.

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 generally authorizes a health care service plan or health insurer to use prior authorization and other utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage and are issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions, as specified.

On and after January 1, 2027, this bill would prohibit concurrent or retrospective review of medical necessity for the first 28 days of an inpatient substance use disorder stay during each plan or policy year,

and would prohibit retrospective review of medical necessity for the first 28 days of intensive outpatient or partial hospitalization services for substance use disorder, but would require specified review for day 29 and days thereafter of that stay or service. On and after January 1, 2027, the bill would prohibit the imposition of prior authorization or other prospective utilization management requirements for outpatient prescription drugs to treat substance use disorder that are determined medically necessary by the enrollee's or insured's physician, psychologist, or psychiatrist. Because a willful violation of the bill's requirements 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 1367.047 is added to the Health and Safety Code, to read:

1367.047. (a) On and after January 1, 2027:

(1) The covered benefits for the first 28 days of an inpatient substance use disorder stay during each plan year shall not be subject to concurrent or retrospective review of medical necessity. Medical necessity shall be as determined by the enrollee's physician.

(2) The covered benefits for day 29 and days thereafter of inpatient substance use disorder care shall be subject to concurrent review. 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 a period that is approved under concurrent review shall be submitted within the period that was previously approved.

(3) After 28 days, a health care service plan shall not initiate concurrent review more frequently than at two-week intervals. If a health care service plan determines that continued inpatient

substance use disorder care in a facility is no longer medically necessary, the health care service plan shall, within 24 hours, provide written notice to the enrollee and the enrollee's physician of its decision and the right to file an expedited internal appeal of the determination.

(4) A health care service plan shall review and make a determination with respect to the internal appeal within 24 hours and communicate the determination to the enrollee and the enrollee's physician. If the determination is to uphold the denial, the enrollee and the enrollee's physician have the right to file an expedited external appeal with the department pursuant to Article 5.55 (commencing with Section 1374.30) of the Health and Safety Code. Notwithstanding any other law, the department shall make a determination within 24 hours. If the health care service plan's determination is upheld and it is determined continued inpatient substance use disorder care is not medically necessary, the health care service plan shall remain responsible to provide benefits for the inpatient care through the day following the date the determination is made and the enrollee shall only be responsible for any applicable copayment, deductible, and coinsurance for the stay through that date, as applicable under the contract. The enrollee shall not be discharged or released from the inpatient facility until all internal and department appeals are exhausted. For any costs incurred after the day following the date of determination until the day of discharge, the enrollee shall only be responsible for any applicable cost sharing, and any additional charges shall be paid by the facility or provider.

(b) For purposes of this section, "concurrent review" means inpatient care is reviewed as it is provided by medically qualified reviewers monitoring appropriateness of the care, the setting, and patient progress, and, as appropriate, the discharge plans.

SEC. 2. Section 1367.048 is added to the Health and Safety Code, to read:

1367.048. On and after January 1, 2027:

(a) The covered benefits for outpatient substance use disorder visits shall not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

(b) The covered benefits for the first 28 days of intensive outpatient or partial hospitalization services for substance use disorder shall not be subject to retrospective review of medical

necessity. Medical necessity shall be as determined by the enrollee's physician.

(c) The covered benefits for day 29 and days thereafter of intensive outpatient or partial hospitalization services for substance use disorder shall be subject to a retrospective review of the medical necessity of the services. Medical necessity review shall utilize the American Society of Addiction Medicine guidelines. The benefits for outpatient prescription drugs to treat substance use disorder shall be provided when determined medically necessary by the enrollee's physician, psychologist, or psychiatrist, without the imposition of prior authorization or other prospective utilization management requirements.

(d) The covered benefits required by this section shall be provided to all enrollees 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.

SEC. 3. Section 1367.049 is added to the Health and Safety Code, to read:

1367.049. On and after January 1, 2027:

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

(b) The covered benefits required by this section shall be provided to all enrollees 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.

SEC. 4. Section 10123.1937 is added to the Insurance Code, to read:

10123.1937. (a) On and after January 1, 2027:

(1) The covered benefits for the first 28 days of an inpatient substance use disorder stay during each policy year shall not be subject to concurrent or retrospective review of medical necessity. Medical necessity shall be as determined by the insured's physician.

(2) The covered benefits for day 29 and days thereafter of inpatient substance use disorder care shall be subject to concurrent review. 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 a period that is approved under concurrent review shall be submitted within the period that was previously approved.

(3) After 28 days, a health insurer shall not initiate concurrent review more frequently than at two-week intervals. If a health insurer determines that continued inpatient substance use disorder care in a facility is no longer medically necessary, the health insurer shall, within 24 hours, provide written notice to the insured and the insured's physician of its decision and the right to file an expedited internal appeal of the determination.

(4) A health insurer shall review and make a determination with respect to the internal appeal within 24 hours and communicate the determination to the insured and the insured's physician. If the determination is to uphold the denial, the insured and the insured's physician have the right to file an expedited external appeal with the department pursuant to Article 5.55 (commencing with Section 1374.30). Notwithstanding any other law, the department shall make a determination within 24 hours. If the health insurer's determination is upheld and it is determined continued inpatient substance use disorder care is not medically necessary, the health insurer shall remain responsible to provide benefits for the inpatient care through the day following the date the determination is made and the insured shall only be responsible for any applicable copayment, deductible, and coinsurance for the stay through that date, as applicable under the policy. The insured shall not be discharged or released from the inpatient facility until all internal and department appeals are exhausted. For any costs incurred after the day following the date of determination until the day of discharge, the insured shall only be responsible for any applicable cost sharing, and any additional charges shall be paid by the facility or provider.

(b) For purposes of this section, "concurrent review" means inpatient care is reviewed as it is provided by medically qualified reviewers monitoring appropriateness of the care, the setting, and patient progress, and, as appropriate, the discharge plans.

SEC. 5. Section 10123.1938 is added to the Insurance Code, to read:

10123.1938. On and after January 1, 2027:

(a) The covered benefits for outpatient substance use disorder visits shall not be subject to concurrent or retrospective review of medical necessity or any other utilization management review.

(b) The covered benefits for the first 28 days of intensive outpatient or partial hospitalization services for substance use disorder shall not be subject to retrospective review of medical necessity. Medical necessity shall be as determined by the insured's physician.

(c) The covered benefits for day 29 and days thereafter of intensive outpatient or partial hospitalization services for substance use disorder shall be subject to a retrospective review of the medical necessity of the services. Medical necessity review shall utilize the American Society of Addiction Medicine guidelines. The benefits for outpatient prescription drugs to treat substance use disorder shall be provided when determined medically necessary by the insured's physician, psychologist, or psychiatrist, without the imposition of prior authorization or other prospective utilization management requirements.

(d) The covered benefits required by this section shall be provided to all insureds 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.

SEC. 6. Section 10123.1939 is added to the Insurance Code, to read:

10123.1939. On and after January 1, 2027:

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

(b) The covered benefits required by this section shall be provided to all insureds 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.

SEC. 7. 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.

O