Date of Hearing: April 21, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1970 (Harabedian) – As Amended March 24, 2026

SUBJECT: Health care coverage: mental health or substance use disorders.

SUMMARY: Prohibits a health plan or health insurer from imposing step therapy as a prerequisite to authorizing coverage of any prescription drug used for the treatment of a serious mental illness (SMI) or substance use disorder (SUD). Applies the provisions of this bill to Medi-Cal managed care plans only to the extent that the Department of Health Care Services (DHCS) obtains any necessary federal approvals, and federal financial participation under Medi-Cal is available and not otherwise jeopardized.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and California Department of Insurance (CDI) to regulate health insurers. [Health and Safety Code (HSC) § 1340, *et seq*., and Insurance Code (INS) § 106, *et seq*.]

2) Establishes California's Essential Health Benefits (EHBs) benchmark under the Patient Protection and Affordable Care Act (ACA) as the Kaiser Small Group Health Maintenance Organization. Establishes existing California health insurance mandates and the 10 ACA mandated benefits, including mental health (MH) and SUD coverage. [HSC § 1367.005 and INS § 10112.27]

3) Requires every disability insurance policy and health plan that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of MH and SUDs, under the same terms and conditions applied to other medical conditions, as specified. [HSC § 1374.72 and INS § 10144.5]

4) Defines medically necessary treatment of MH or SUD including that the service or product is in accordance with generally accepted standards of MH or SUD care, clinically appropriate in terms of type, frequency, extent, site, and duration. [HSC § 1374.72 and INS §10144.5]

5) Requires a health plan or insurer that provides hospital, medical, or surgical coverage to base any medical necessity determination or the utilization review (UR) criteria on current generally accepted standards of MH and SUD care, as specified. Requires medical necessity determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with MH and SUDs to be conducted in accordance with the requirements in 6) below. [HSC §1374.72 and INS §10144.5]

6) Requires a health plan or insurer that provides hospital, medical, or surgical coverage to base any medical necessity determination or the UR criteria that the plan, and any entity acting on the plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of MH and SUDs on current generally accepted standards of MH and SUD care, as specified. Requires a health plan or insurer to apply the criteria and guidelines set forth in the most recent versions of treatment criteria

developed by the nonprofit professional association for the relevant clinical specialty in conducting UR of all covered health care services and benefits for the diagnosis, prevention, and treatment of MH and SUDs in children, adolescents, and adults. [HSC § 1374.721 and INS § 10144.52]

7) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for UR or utilization management (UM) functions, to determine whether to authorize, modify, or deny health care services to:

   a) Be developed with involvement from actively practicing health care providers;

   b) Be consistent with sound clinical principles and processes;

   c) Be evaluated, and updated if necessary, at least annually;

   d) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee or insured in that specified case; and,

   e) Be available to the public upon request. [HSC § 1363.5 and INS § 10123.135]

8) Requires health plans to demonstrate that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. [HSC § 1367]

9) Requires health plans and disability insurers and any contracted entity that performs UR or UM functions, prospectively, retrospectively, or concurrently, based on medical necessity requests to comply with specified requirements. [HSC § 1367.01 and INS § 10123.135]

10) Prohibits any individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, from denying or modifying requests for authorization of health care services for an enrollee or insured for reasons of medical necessity. Requires the decision to be communicated to the provider within 24 hours of the decision, and the enrollee (in writing) within two business days of the decision. Prohibits, in the case of concurrent review, discontinuance of care until the treating provider has been notified and has agreed to a care plan that is appropriate for the medical needs of the patient. [HSC § 1367.01 and INS § 10123.135]

11) Establishes the Medi-Cal Program, administered by DHCS, to provide comprehensive health benefits to low-income individuals who meet specified eligibility criteria. [Welfare and Institutions Code (WIC) § 14000, *et seq.*]

12) Establishes a schedule of benefits under the Medi-Cal program, including inpatient services. [WIC § 14132]

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, people living with serious mental illness and substance use disorders should not have to "fail first" on medications that may not work before receiving the treatment their doctor recommends. The author continues that step therapy policies can delay access to effective care, putting patients at risk of relapse, hospitalization, homelessness, or involvement with the criminal justice system. The author notes that individuals already navigating instability, even short delays in treatment can have devastating consequences. The author argues that this bill puts doctors in charge of treatment, not insurers. The author concludes that this bill removes unnecessary barriers so patients can access the medications they need to stabilize, recover, and stay connected to care and their communities.

2) **BACKGROUND.** SMI is defined as a diagnosable mental, behavioral, or emotional disorder (within the past year) in a person aged 18 years or older that substantially interferes with their life and ability to function. For the purpose of this bill, California code states that SMI includes but is not limited to diagnoses of schizophrenia, bipolar disorder, post-traumatic stress disorder, and major affective disorders or other severely disabling mental disorders. This bill defines SUD as a substance-related and addictive disorder (encompassing major sub-types of opioid use disorder, alcohol use disorder, and the residual substances) as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

   a) **SUD.** A 2022 publication from the California Health Care Foundation (CHCF), titled "Substance Use in California: Prevalence and Treatment" reported that substance use in California is widespread with over half of Californians over age 12 reporting using alcohol in the past month and 20% reporting using marijuana in the past year. According to the report, 9% of Californians have met the criteria for a SUD within the last year. Overdose deaths from both opioids and psychostimulants (such as amphetamines), are soaring. This issue, compounded by the increased availability of fentanyl, has resulted in a 10-fold increase in fentanyl related deaths between 2015 and 2019. This epidemic is disproportionately impacting American Indian and Alaskan Native Californians who have the highest rate of opioid overdose deaths, followed by white and Black Californians. According to the California Department of Public Health's Overdose Prevention Initiative, 7,847 opioid-related overdose deaths occurred in California in 2023. In the first two quarters of 2024, 2,975 opioid-related overdose deaths were recorded in California. In August 2024, Health Management Associates, with support of the CHCF published "Substance Use Disorder in California — a Focused Landscape Analysis" and found that a key barrier to accessing care for people with substance use disorders is the lack of access to housing and residential services.

   b) **MH Disorders.** A 2022 publication from CHCF, titled "Mental Health in California" reported that nearly 1 in 7 California adults experience a mental illness, and 1 in 26 has a serious MH condition that makes it difficult to carry out daily activities. One in 14 children has an emotional disturbance that limits functioning in family, school, or community activities. According to the report, the prevalence of serious mental illness varies by income, with the highest rates in adults and children in families with incomes below 100% of the federal poverty level.

A 2019 survey by the Substance Abuse and Mental Health Services Administration found nearly five million, or 16%, of Black Americans reported having a mental illness. However, only 1 in 3 Black adults who needs MH care receives it. Similarly, a 2021 study by the University of California Los Angeles Center for Health Policy Research found that almost half of Latino adults who had a perceived need for MH services experienced an unmet need for care.

c) **California Health Benefits Review Program (CHBRP).** CHBRP was created in response to AB 1996 (Thomson), Chapter 795, Statutes of 2002, which requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost-sharing, premiums, and other health insurance topics to CHBRP's purview. CHBRP reviewed this bill and included the following impact estimates in their analysis:

   i) **Premium & out-of-pocket increases.** CHBRP notes that the immediate utilization impact of this bill is projected to be a small shift from generic to branded SMI and SUD drugs among a narrow subset of affected enrollees. CHBRP estimates there would be no net change in the number of enrollees using SMI or SUD drugs, however, an estimated 300 enrollees accessing drugs currently subject to step therapy would shift from generic to branded drugs. An additional $2,440,000 in total annual premiums would be paid by employers and enrollees due to the use of higher-cost drugs to treat SMI and SUDs, ranging from $0-$0.017 per member per month. Of this, annual enrollee premiums — which include premiums for enrollees using and not using the benefit — would increase by a total of $859,000. Enrollee cost sharing would increase by a total of $158,000.

   ii) **Medical effectiveness.** CHBRP found some evidence that step therapy requirements for prescription drugs used to treat SMI decrease utilization of those drugs and increase hospitalizations. However, these findings should be interpreted with caution because some of the studies analyzed older atypical antipsychotic drugs that are no longer subject to step therapy. CHBRP did not identify any direct evidence on the effect of step therapy requirements for prescription drugs used to treat SMI on health outcomes.

   iii) **Public health impacts.** CHRBP determined that the shift from utilization of generic to branded drugs for SMI and SUD as a result of this bill would not have an impact on public health outcomes.

d) **Office of Health Care Affordability (OHCA) cost targets.** OHCA was established in 2022 in response to widespread cost-related access challenges across California. According to the California Health Care Foundation (CHCF), over half of Californians say they skip or delay health care due to costs. OHCA collects, analyzes, and publicly reports data on total health care expenditures and enforces spending targets. OHCA's spending targets are intended to reduce excess spending and slow health care spending growth. In April of 2024, OHCA approved a statewide cost growth target of 3.5% starting in 2025 and phasing down to 3% by 2029. Health care entities, including health

plans and insurers, are subject to the statewide spending target and are subject to progressive enforcement if the entity's costs exceed the target. Some entities have raised concerns that new legislative insurance mandates will make it difficult for them to meet the established cost growth target.

Current law does not explicitly require OHCA to adjust the cost growth targets based on changes to state policy, such as insurance mandates, that may increase spending. However, it does require OHCA to consider state benefit mandates in its development and enforcement of cost growth targets. Specifically, when establishing cost growth target methodology, OHCA is required to review relevant state policy changes impacting covered benefits, provider reimbursement, and costs, among other factors. In addition, in enforcing cost growth targets, OHCA is required to consider factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target.

3) **SUPPORT.** The California Behavioral Health Association (CBHA) is sponsoring this bill, stating that it addresses a significant barrier to timely behavioral health treatment. CBHA continues that step therapy, or "fail-first," forces patients to try insurer-preferred medications before accessing the medication their provider has determined is clinically appropriate. For individuals living with SMI or SUD, these delays can have negative and sometimes dangerous effects. CBHA states that delayed access to the right medication can worsen symptoms, increase relapse risk, disrupt care, and drive avoidable psychiatric crises, emergency department use, hospitalization, and readmission. CBHA continues that the burden falls heavily on the patients least able to manage a delay. CBHA argues that vulnerable populations, including unhoused and transient patients, often lack stable housing, transportation, communication access, or pharmacy access. CBHA continues that step therapy assumes repeated follow-up and ongoing administrative navigation that many patients cannot sustain. CBHA notes that when medication is delayed, providers may lose contact with patients, leading to missed treatment windows that result in no treatment at all. CBHA concludes that the Legislature has already recognized that step therapy can create dangerous delays in other clinical contexts and this bill applies that same principle to behavioral health, where treatment timing, stabilization, and continuity directly impact the outcome.

4) **OPPOSITION.** The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) are opposed to this bill, stating that step therapy is a narrowly used, clinically grounded UM tool designed to ensure patients receive safe and appropriate treatment based on their medical needs. CAHP and ACLHIC note that it is also used to promote affordability, such as trying a therapeutically equivalent generic medication before a significantly more expensive branded drug. CAHP and ACLHIC continue that the number of drugs subject to step therapy is limited and generally applies only where multiple therapeutic alternatives exist to treat the same condition. CAHP and ACLHIC note that for SMI and SUD specifically, UM protocols are driven by safety considerations and cost control strategies. CAHP and ACLHIC share the example that some medications used in these settings are subject to FDA Risk Evaluation and Mitigation Strategies due to serious safety risks. CAHP and ACLHIC continue that Spravato, a drug used for severe, treatment-resistant depression, carries significant risks including sedation, dissociation, addiction, and high abuse potential – it also requires specialized provider training, registry participation, and strict administration protocols. CAHP and ACLHIC note

that step therapy helps ensure that patients can first try clinically appropriate alternatives with fewer risks before progressing to high-risk treatments. CAHP and ACLHIC state that some medications for SMI and SUD also have more affordable therapeutically equivalent versions available. CAHP and ACLHIC provide another example, Rexulti, an add-on therapy to antidepressants for the treatment of major depressive disorder and for the treatment of schizophrenia, has the approximate cost of $1,400/prescription. However, CAHP and ACLHIC note that there are multiple therapeutically equivalent alternatives available for $15-$20/prescription, and Rexulti has not been found to offer any clinically significant advantages over these alternatives in the same class.

5) PREVIOUS LEGISLATION.

a) AB 384 (Connolly) of 2025, would have prohibited a health plan, health insurer, or Medi-Cal from requiring prior authorization for an individual to be admitted to medically necessary 24-hour inpatient settings for mental health and SUDs and for any medically necessary health care services provided to an individual while admitted for that care. AB 384 was held on the Assembly Appropriations Committee suspense file.

b) AB 669 (Haney) of 2025, would have prohibited concurrent or retrospective review of medical necessity for the first 28 days of in-network inpatient SUD stay. Would have prohibited concurrent or retrospective review of medical necessity of in-network outpatient SUD visits. Would have prohibited retrospective review of medical necessity for the first 28 days of in-network intensive outpatient or partial hospitalization SUD services, as specified. Would have prohibited PA for in-network coverage of medically necessary outpatient prescription drugs to treat SUD. AB 669 was held on the Senate Appropriations Committee suspense file.

c) AB 1451 (Jackson) of 2023, would have required a health plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for treatment of urgent and emergency MH and SUD without preauthorization. AB 1451 was vetoed by Governor Newsom who stated in part:

"I share the author's concern regarding the importance of accessible behavioral health services statewide, as evidenced by the billions of dollars we have invested to enhance access to timely and necessary behavioral health care, as well as the programs and reforms implemented to improve our delivery system. Existing law already prohibits prior authorization for emergency care, and requires mental health and substance use disorder services to meet timely access standards. The requirements in this bill would result in significant costs in the tens of millions of dollars, to the state General Fund and to consumers through health plan premium increases. These impacts should be considered as part of the annual budget process."

d) SB 238 (Wiener) of 2023, would have required a health plan or a disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the independent medical review system, as specified, if the decision is to deny, modify, or delay specified services relating to MH or SUD conditions for an enrollee or insured up to 26 years of age. SB 238 was held on the Assembly Appropriations suspense file.

e) SB 855 (Wiener), Chapter 151, Statutes of 2020, revises and recasts California's MH Parity provisions, and requires a health plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of MH and SUD, as defined, under the same terms and conditions applied to other medical conditions and prohibits a health plan or disability insurer from limiting benefits or coverage for MH and SUD to short-term or acute treatment. Specifies that if services for the medically necessary treatment of a MH and SUD are not available in network within the geographic and timely access standards in existing law, the health plan or insurer is required to arrange coverage to ensure the delivery of medically necessary out of network services and any medically necessary follow up services, as specified.

REGISTERED SUPPORT / OPPOSITION:

Support

California Behavioral Health Association (sponsor)
Alliance for Patient Access
Association of Community Human Service Agencies
Biocom
California Access Coalition
California Chronic Care Coalition
California Community Foundation
California Consortium of Addiction Programs and Professionals
California Federation of Labor Unions, Afl-cio
California Hospital Association
California Institute for Behavioral Health Solutions
California Life Sciences Association
California Medical Association
California Peer Watch
California Psychological Association
California State Association of Psychiatrists
Children's Institute, INC.
Chronic Disease Coalition
Drug Policy Alliance
Hillsides Pasadena
Kings View
Mental Health America of California
NASW California
National Alliance on Mental Illness
Pacific Clinics
Pathpoint
Portia Bell Hume Behavioral Health and Training Center
Safe Passages
Shields for Families
Sistahfriends
Southern California Health & Rehabilitation Program
Stars Behavioral Health Group
Steinberg Institute

Sycamores
Tarzana Treatment Centers, INC.
The Kennedy Forum
Turning Point Community Programs
Turning Point of Central California, INC.
U.S. Pain Foundation
Unite Here International Union, Afl-cio
Wellspace Health
Western Center on Law & Poverty

Opposition

Association of California Life and Health Insurance Companies
California Association of Health Plans
California Small Business Association

Analysis Prepared by: Riana King / HEALTH / (916) 319-2097