STATE OF NEW YORK

7704--A

Cal. No. 270

2021-2022 Regular Sessions

IN ASSEMBLY

May 20, 2021

Introduced by M. of A. FERNANDEZ, ABBATE, DAVILA -- read once and referred to the Committee on Insurance -- ordered to a third reading, amended and ordered reprinted, retaining its place on the order of third reading

AN ACT to amend the insurance law, in relation to providing behavioral health parity (Part A); and to amend the insurance law, in relation to the authorization for certain drugs for the detoxification or maintenance of a substance use disorder (Part B)

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. This act enacts into law components of legislation which are necessary to effectuate provisions relating to mental health and substance use disorder parity. Each component is wholly contained within a Part identified as Parts A through B. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

Section 1. Subparagraph (D) of paragraph 30 of subsection (i) of section 3216 of the insurance law, as amended by section 5 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(D) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of [~~alcoholism and substance abuse services~~] **addiction services and supports** that are

EXPLANATION--Matter in ***italics*** (underscored) is new; matter in brackets [-] is old law to be omitted.

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participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall also not be subject to concurrent utilization review during the first twenty-eight days of the inpatient admission provided that the facility notifies the insurer of both the admission and the initial treatment plan within two business days of the admission **on a standardized form developed by the department in consultation with the department of health and the office of addiction services and supports**. The facility shall perform daily clinical review of the patient[~~, including periodic~~] **and consult periodically with the insurer regarding the patient's progress, course of treatment, and discharge plan. Periodic** consultation with the insurer [~~at or just prior to~~] **shall occur no later than** the fourteenth day of treatment [~~to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient~~]. Prior to discharge, the facility shall provide the patient and the insurer with a written discharge plan which shall describe arrangements for additional services needed following discharge from the inpatient facility as determined using the evidence-based and peer-reviewed clinical review tool utilized by the insurer which is designated by the office of [~~alcoholism and substance abuse services~~] **addiction services and supports**. Prior to discharge, the facility shall indicate to the insurer whether services included in the discharge plan are secured or determined to be reasonably available. [~~Any~~] **Insurers shall actively participate in facility-initiated periodic consultations prior to the patient's discharge and except where the insurer fails to do so, any** utilization review of treatment provided under this subparagraph may include a review of all services provided during such inpatient treatment, including all services provided during the first twenty-eight days of such inpatient treatment. Provided, however, the insurer **shall be required to process claims for the provision of such services within the timeframes established in subsection (a) of section three thousand two hundred twenty-four-a of this article and** shall only deny coverage for any portion of the initial twenty-eight day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of [~~alcoholism and substance abuse services~~] **addiction services and supports**. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

§ 2. Subparagraph (E) of paragraph 31 of subsection (i) of section 3216 of the insurance law, as amended by section 6 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(E) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of [~~alcoholism and substance abuse services~~] **addiction services and supports** for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall not be subject to concurrent review for the first four weeks of continuous treatment, not to exceed twenty-eight visits, provided the facility

notifies the insurer of both the start of treatment and the initial treatment plan within two business days **on a standardized form developed by the department in consultation with the department of health and the office of addiction services and supports**. The facility shall perform clinical assessment of the patient at each visit[~~, including periodic~~] **and consult periodically with the insurer regarding the patient's progress, course of treatment, and discharge plan. Periodic** consultation with the insurer [~~at or just prior to~~] **shall occur no later than** the fourteenth day of treatment [~~to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient~~]. [~~Any~~] **Insurers shall actively participate in facility-initiated periodic consultations prior to the patient's discharge and except where the insurer fails to do so, any** utilization review of the treatment provided under this subparagraph may include a review of all services provided during such outpatient treatment, including all services provided during the first four weeks of continuous treatment, not to exceed twenty-eight visits, of such outpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial four weeks of continuous treatment, not to exceed twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of [~~alcoholism and substance abuse services~~] **addiction services and supports**. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

§ 3. Subparagraph (G) of paragraph 35 of subsection (i) of section 3216 of the insurance law, as added by section 8 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(G) This subparagraph shall apply to hospitals in this state that are licensed**, certified or otherwise authorized** by the office of mental health that are participating in the insurer's provider network. Where the policy provides coverage for inpatient hospital care, benefits for inpatient hospital care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law [~~provided to individuals who have not attained the age of eighteen~~] shall not be subject to preauthorization. Coverage provided under this subparagraph shall also not be subject to concurrent utilization review during the first fourteen days of the inpatient admission, provided the facility notifies the insurer of both the admission and the initial treatment plan within two business days of the admission **on a standardized form developed by the department in consultation with the department of health and the office of mental health**, performs daily clinical review of the patient, and [~~participates in periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the insurer which is approved by the office of mental health and appropriate to the age of the patient, to ensure that the inpatient care is medically necessary for the patient~~] **consults periodically with the insurer regarding the patient's progress, course of treatment, and discharge plan**. [~~All~~] **Insurers shall actively participate in facility-initiated periodic consultations prior to the patient's discharge and except where the insurer fails to do so, all** treatment provided under

this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

§ 4. Subparagraph (G) of paragraph 5 of subsection (l) of section 3221 of the insurance law, as added by section 14 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(G) This subparagraph shall apply to hospitals in this state that are licensed**, certified or otherwise authorized** by the office of mental health that are participating in the insurer's provider network. Where the policy provides coverage for inpatient hospital care, benefits for inpatient hospital care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law [~~**provided to individuals who have not attained the age of eighteen**~~] shall not be subject to preauthorization. Coverage provided under this subparagraph shall also not be subject to concurrent utilization review during the first fourteen days of the inpatient admission, provided the facility notifies the insurer of both the admission and the initial treatment plan within two business days of the admission **on a standardized form developed by the department in consultation with the department of health and the office of mental health**, performs daily clinical review of the patient, and [~~**participates in periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the insurer which is approved by the office of mental health and appropriate to the age of the patient, to ensure that the inpatient care is medically necessary for the patient**~~] **consults periodically with the insurer regarding the patient's progress, course of treatment, and discharge plan**. [~~**All**~~] **Insurers shall actively participate in facility-initiated periodic consultations prior to the patient's discharge and except where the insurer fails to do so, all** treatment provided under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

§ 5. Subparagraph (D) of paragraph 6 of subsection (l) of section 3221 of the insurance law, as amended by section 15 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(D) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of [~~**alcoholism and substance abuse services**~~] **addiction services and supports** that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall also not be subject to concurrent utilization review during the first twenty-eight days of the inpatient admission provided that the facility notifies the insurer of both the admission and the initial treatment plan within two business days of the admission **on a standardized form developed by the department in consultation with the department of health and the office of addiction services and supports**. The facility shall perform daily clinical review of the patient[~~**, including periodic**~~] **and consult periodically with the insurer regarding the patient's progress, course of treatment, and discharge plan. Periodic** consultation with the insurer [~~**at or just prior to**~~] **shall occur no later than** the fourteenth day of treatment [~~**to ensure that the facility is using the evidence-based and peer reviewed clinical**~~

~~review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient~~]. Prior to discharge, the facility shall provide the patient and the insurer with a written discharge plan which shall describe arrangements for additional services needed following discharge from the inpatient facility as determined using the evidence-based and peer-reviewed clinical review tool utilized by the insurer which is designated by the office of [~~alcoholism and substance abuse services~~] addiction services and supports. Prior to discharge, the facility shall indicate to the insurer whether services included in the discharge plan are secured or determined to be reasonably available. [~~Any~~] Insurers shall actively participate in facility-initiated periodic consultations prior to the patient's discharge and except where the insurer fails to do so, any utilization review of treatment provided under this subparagraph may include a review of all services provided during such inpatient treatment, including all services provided during the first twenty-eight days of such inpatient treatment. Provided, however, the insurer shall be required to process claims for the provision of such services within the timeframes established in subsection (a) of section three thousand two hundred twenty-four-a of this article and shall only deny coverage for any portion of the initial twenty-eight day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of [~~alcoholism and substance abuse services~~] addiction services and supports. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

§ 6. Subparagraph (E) of paragraph 7 of subsection (l) of section 3221 of the insurance law, as amended by section 17 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(E) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of [~~alcoholism and substance abuse services~~] addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall not be subject to concurrent review for the first four weeks of continuous treatment, not to exceed twenty-eight visits, provided the facility notifies the insurer of both the start of treatment and the initial treatment plan within two business days on a standardized form developed by the department in consultation with the department of health and the office of addiction services and supports. The facility shall perform clinical assessment of the patient at each visit[~~, including periodic~~] and consult periodically with the insurer regarding the patient's progress, course of treatment, and discharge plan. Periodic consultation with the insurer [~~at or just prior to~~] shall occur no later than the fourteenth day of treatment [~~to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient~~]. [~~Any~~] Insurers shall actively participate in facility-initiated periodic

consultations prior to the patient's discharge and except where the insurer fails to do so, any utilization review of the treatment provided under this subparagraph may include a review of all services provided during such outpatient treatment, including all services provided during the first four weeks of continuous treatment, not to exceed twenty-eight visits, of such outpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial four weeks of continuous treatment, not to exceed twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of [~~alcoholism and substance abuse services~~] addiction services and supports. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

§ 7. Subsection (a) of section 3224-a of the insurance law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile. The obligation of an insurer or organization to make payment to a health care provider for mental health or substance use disorder services that are not subject to preauthorization or concurrent review pursuant to sections three thousand two hundred sixteen, three thousand two hundred twenty-one, or four thousand three hundred three of this chapter shall not be considered not reasonably clear solely because the insurer or organization intends to perform concurrent review for such services before or after the expiration of the timeframes established by this subsection.

§ 8. Paragraph 8 of subsection (g) of section 4303 of the insurance law, as added by section 23 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(8) This paragraph shall apply to hospitals in this state that are licensed, certified or otherwise authorized by the office of mental health that are participating in the [~~corporation's~~] insurer's provider network. Where the contract provides coverage for inpatient hospital care, benefits for inpatient hospital care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law [~~provided to individuals who have not attained the age of eighteen~~] shall not be subject to preauthorization. Coverage provided under this paragraph shall also not be subject to concurrent utilization review during the first fourteen days of the inpatient admission, provided the facility notifies the [~~corporation~~] insurer of both the admission and the initial treatment plan within two business days of the admission on a standard-

ized form developed by the department in consultation with the department of health and the office of mental health, performs daily clinical review of the patient, and [~~participates in periodic consultation with the corporation to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the corporation which is approved by the office of mental health and appropriate to the age of the patient, to ensure that the inpatient care is medically necessary for the patient~~] consults periodically with the insurer regarding the patient's progress, course of treatment, and discharge plan. [~~All~~] Insurers shall actively participate in facility-initiated periodic consultations prior to the patient's discharge and except where the insurer fails to do so, all treatment provided under this paragraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

§ 9. Paragraph 4 of subsection (k) of section 4303 of the insurance law, as amended by section 26 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(4) This paragraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of [~~alcoholism and substance abuse services~~] addiction services and supports that are participating in the [~~corporation's~~] insurer's provider network. Coverage provided under this subsection shall not be subject to preauthorization. Coverage provided under this subsection shall also not be subject to concurrent utilization review during the first twenty-eight days of the inpatient admission provided that the facility notifies the [~~corporation~~] insurer of both the admission and the initial treatment plan within two business days of the admission on a standardized form developed by the department in consultation with the department of health and the office of addiction services and supports. The facility shall perform daily clinical review of the patient[~~, including periodic consultation~~] and consult periodically with the insurer regarding the patient's progress, course of treatment, and discharge plan. Periodic consultation with the [~~corporation at or just prior to~~] insurer shall occur not later than the fourteenth day of treatment [~~to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient~~]. Prior to discharge, the facility shall provide the patient and the [~~corporation~~] insurer with a written discharge plan which shall describe arrangements for additional services needed following discharge from the inpatient facility as determined using the evidence-based and peer-reviewed clinical review tool utilized by the [~~corporation~~] insurer which is designated by the office of [~~alcoholism and substance abuse services~~] addiction services and supports. Prior to discharge, the facility shall indicate to the [~~corporation~~] insurer whether services included in the discharge plan are secured or determined to be reasonably available. [~~Any~~] Insurers shall actively participate in facility-initiated periodic consultations prior to the patient's discharge and except where the insurer fails to do so, any utilization review of treatment provided under this paragraph may include a review of all services provided during such inpatient treatment, including all services provided during the first twenty-eight days of such inpatient treatment. Provided, however, the [~~corporation~~] insur-

er shall be required to process claims for the provision of such services within the timeframes established in subsection (a) of section three thousand two hundred twenty-four-a of this chapter and shall only deny coverage for any portion of the initial twenty-eight day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the [~~corporation~~] insurer which is designated by the office of [~~alcoholism and substance abuse services~~] addiction services and supports. An insured shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

§ 10. Paragraph 5 of subsection (l) of section 4303 of the insurance law, as amended by section 28 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(5) This paragraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of [~~alcoholism and substance abuse services~~] addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the corporation's provider network. Coverage provided under this subsection shall not be subject to preauthorization. Coverage provided under this subsection shall not be subject to concurrent review for the first four weeks of continuous treatment, not to exceed twenty-eight visits, provided the facility notifies the corporation of both the start of treatment and the initial treatment plan within two business days on a standardized form developed by the department in consultation with the department of health and the office of addiction services and supports. The facility shall perform clinical assessment of the patient at each visit[~~, including periodic~~] and consult periodically with the insurer regarding the patient's progress, course of treatment, and discharge plan. Periodic consultation with the corporation [~~at or just prior to~~] shall occur no later than the fourteenth day of treatment [~~to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient~~]. [~~Any~~] Insurers shall actively participate in facility-initiated periodic consultations prior to the patient's discharge and except where the insurer fails to do so, any utilization review of the treatment provided under this paragraph may include a review of all services provided during such outpatient treatment, including all services provided during the first four weeks of continuous treatment, not to exceed twenty-eight visits, of such outpatient treatment. Provided, however, the corporation shall only deny coverage for any portion of the initial four weeks of continuous treatment, not to exceed twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of [~~alcoholism and substance abuse services~~] addiction services and supports. [~~A subscriber~~] An insured shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

§ 11. Section 109 of the insurance law is amended by adding a new subsection (e) to read as follows:

(e) In addition to any right of action granted to the superintendent pursuant to this section, any person who has been injured by reason of a violation of paragraphs thirty, thirty-one, thirty-one-a and thirty-five of subsection (i) of section three thousand two hundred sixteen, paragraphs five, six, seven and seven-a of subsection (l) of section three thousand two hundred twenty-one, and subsections (g), (k), (l) or (l-1) of section four thousand three hundred three of this chapter by an insurer subject to article thirty-two or forty-three of this chapter may bring an action in his or her own name to enjoin such unlawful act or practice, an action to recover his or her actual damages or one thousand dollars, whichever is greater, or both such actions. The court may, in its discretion, award the prevailing plaintiff in such action an additional award not to exceed five thousand dollars, if the court finds the defendant willfully violated the provisions of this section. The court may award reasonable attorneys' fees to a prevailing plaintiff.

§ 12. This act shall take effect January 1, 2023.

PART B

Section 1. Subparagraph (A) of paragraph 31-a of subsection (i) of section 3216 of the insurance law, as added by chapter 748 of the laws of 2019, is amended to read as follows:

(A) No policy that provides medical, major medical or similar comprehensive-type coverage and provides coverage for prescription drugs for medication for the treatment of a substance use disorder shall require prior authorization for an initial or renewal prescription for such drugs for the detoxification or maintenance of a substance use disorder, including all buprenorphine products, methadone [~~or~~], long acting injectable naltrexone [~~for detoxification or maintenance treatment of a substance use disorder~~] and medication for opioid overdose reversal prescribed or dispensed to an individual covered under the policy, except where otherwise prohibited by law.

§ 2. Subparagraph (A) of paragraph 7-a of subsection (l) of section 3221 of the insurance law, as added by chapter 748 of the laws of 2019, is amended to read as follows:

(A) No policy that provides medical, major medical or similar comprehensive-type small group coverage and provides coverage for prescription drugs for medication for the treatment of a substance use disorder shall require prior authorization for an initial or renewal prescription for such drugs for the detoxification or maintenance of a substance use disorder, including all buprenorphine products, methadone, long acting injectable naltrexone, and medication for opioid overdose reversal prescribed or dispensed to an individual covered under the policy, except where otherwise prohibited by law. Every policy that provides medical, major medical or similar comprehensive-type large group coverage shall provide coverage for prescription drugs for medication for the treatment of a substance use disorder and shall provide immediate coverage for all buprenorphine products, methadone [~~or~~], long acting injectable naltrexone, and medication for opioid overdose reversal prescribed or dispensed to an individual covered under the policy without prior authorization for the detoxification or maintenance treatment of a substance use disorder, except where otherwise prohibited by law.

§ 3. Subparagraph (A) of paragraph (l-1) of section 4303 of the insurance law, as added by chapter 748 of the laws of 2019, is amended to read as follows:

(A) **No contract that provides medical, major medical or similar comprehensive-type individual or small group coverage and provides coverage for prescription drugs for medication for the treatment of a substance use disorder shall require prior authorization for an initial or renewal prescription for such drugs for the detoxification or maintenance of a substance use disorder, including all buprenorphine products, methadone, long acting injectable naltrexone, and medication for opioid overdose reversal prescribed or dispensed to an individual covered under the contract, except where otherwise prohibited by law.** Every contract that provides medical, major medical, or similar comprehensive-type large group coverage shall provide **coverage for prescription drugs for medication for the treatment of a substance use disorder and shall provide** immediate coverage for all buprenorphine products, methadone [~~or~~]**,** long acting injectable naltrexone**, and medication for opioid overdose reversal prescribed or dispensed to an individual covered under the contract** without prior authorization for the detoxification or maintenance treatment of a substance use disorder**, except where otherwise prohibited by law**.

§ 4. This act shall take effect immediately.

§ 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

§ 3. This act shall take effect immediately provided, however, that the applicable effective date of Parts A through B of this act shall be as specifically set forth in the last section of such Parts.