Date of Hearing: April 24, 2024

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
AB 2169 (Bauer-Kahan) – As Amended March 21, 2024

Policy Committee: Health Vote: 14 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill prohibits a health plan or insurer from limiting or excluding coverage of a prescription drug if an enrollee has continuously used that drug for a medical condition while covered by their current or previous health plan or insurer. This bill also authorizes a licensed health care professional to adjust, without prior authorization, the dose or frequency of a drug to meet the specific medical needs of an enrollee or insured, if specified conditions are met.

FISCAL EFFECT:

1) The Department of Managed Health Care (DMHC) estimates its cost for this bill to be approximately $24,000 in fiscal year (FY) 2024-25, $1.5 million in FY 2025-26, and $2.1 million in FY 2026-27 and annually thereafter (Managed Care Fund). DMHC states it anticipates additional workload to conduct independent medical reviews, revise survey methodology and develop tools to monitor compliance, review health plan filings of utilization management processes, and provide guidance to health plans. Additional costs include clinical and statistical consultants and software licensing. DMHC assumes the Office of Enforcement would need to address eleven referrals annually as a result of this bill. DMHC notes that generally, and depending on final enrollment data, a $1 million dollar increase to the Managed Care Fund could result in a 2-cent per month increase per enrollee on assessments to full-service health plans and a 1-cent increase per enrollee to specialized health plans. To the extent this bill and others result in an additional assessment on health plans, consumers could face increased premiums.

2) The California Department of Insurance (CDI) estimates costs of $70,000 in FY 2024-25 and $80,000 in FY 2025-26 if the bill is implemented after CDI completes development of regulations related to prescription drug utilization management (Insurance Fund).

3) Annual costs in the low hundreds of thousands of dollars to CalPERS (Public Employees Health Care Fund, special funds). For a broader bill, SB 70 (Wiener), of the current legislative session, the California Health Benefits Review Program (CHBRP) estimated expenditures for CalPERS premiums would increase by $310,000. The state pays for approximately 60% of CalPERS enrollees. CalPERS costs for this bill would likely be lower than cost for SB 70.

COMMENTS:

1) **Purpose.** This bill is sponsored by the Crohn's & Colitis Foundation. According to the author:

> According to the California Healthcare Foundation, 38% of Californians are living with one or more chronic medical conditions. Many Californians who suffer from chronic disease or illness rely on prescription medications to survive. One example is inflammatory bowel disease (IBD), a lifelong chronic illness that requires access to specific treatment as there is no "one size fits all" treatment for everyone with IBD. When providers find an effective medication, over time adjustment is often necessary, either by increasing the dose or by decreasing the dosing interval. A change in dosage is not a different treatment, but insurance policies treat them as such. This creates long pre-approval, denial, and appeal processes that make treatment less effective and more expensive over the long term. AB 2169 authorizes prescribers to adjust, up to two times, the dose or frequency of a drug without prior authorization or subsequent utilization management, as long as the drug has been approved for coverage by the plan and the plan's prescribing provider continues to prescribe it.

2) **Continuity Provisions of California Law.** California law requires DMHC- or CDI-regulated plans that include a pharmacy benefit not limit or exclude coverage for a drug for an enrollee when: (a) the drug previously had been approved for coverage by the plan for a medical condition of the enrollee; (b) the plan's prescribing provider continues to prescribe the drug for the medical condition; and (c) the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition. This bill amends existing law to allow a prescriber to adjust the dose or frequency of a drug previously approved for a chronic medical condition or cancer.

3) **Related Legislation.** SB 70 (Wiener) prohibits a health plan or insurer from limiting or excluding coverage of a drug, dose of a drug, or dosage form of a drug that is prescribed for off-label use for a life-threatening or chronic and seriously debilitating condition or cancer, if the health plan or insurer previously covered the drug for the patient, regardless of whether the drug, dose, or dosage form is on the plan's or insurer's formulary. SB 70 also prohibits a health plan or insurance policy from requiring cost sharing for a drug that was previously approved for coverage. SB 70 was held in this committee.

4) **Prior Legislation.**

   a) AB 347 (Arambula), Chapter 742, Statutes of 2021, requires a health plan or health insurer to expeditiously grant a step therapy exception if specified criteria are met, including that the health care provider submit necessary justification and supporting clinical documentation supporting the provider's determination that the required prescription drug is consistent with good professional practice for provision of medically necessary covered services, as specified.

   b) SB 853 (Wiener), of the 2021-22 Legislative Session, was similar to SB 70 and was held in this committee.

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