SENATE COMMITTEE ON APPROPRIATIONS
Senator Anna Caballero, Chair
2023 - 2024 Regular Session

AB 2169 (Bauer-Kahan) - Prescription drug coverage: dose adjustments

Version: March 21, 2024
Urgency: No
Hearing Date: August 5, 2024
Policy Vote: HEALTH 10 - 0
Mandate: Yes
Consultant: Agnes Lee

Bill Summary: AB 2169 would provide that a licensed health care professional may request, and must be granted, the authority to adjust the dose or frequency of a drug without prior authorization or subsequent utilization management if specified conditions are met.

Fiscal Impact:

- The Department of Managed Health Care (DMHC) estimates costs of approximately $24,000 in 2024-25, $1,488,000 in 2025-26, $2,084,000 in 2026-27, $2,085,000 in 2027-28, and $2,101,000 in 2028-29 and annually thereafter for state administration (Managed Care Fund).

- The California Department of Insurance (CDI) indicates that if the bill is enacted after regulations have been promulgated, then one-time costs would be $70,000 in 2024-25 and $80,000 in 2025-26 for state administration (Insurance Fund).

Background: The DMHC regulates health plans under the Knox-Keene Act and the CDI regulates health insurance. Prior authorization is when the health plan/insurer or pharmacy benefit manager must authorize a particular prescription before it can be filled. Step therapy is a type of prior authorization for drugs that begins medication for a medical condition with the most preferred drug therapy and progresses to other therapies only if necessary. Prior authorization also may be used in conjunction with a step therapy system, so that a patient might be required to try a less expensive drug before receiving authorization to receive the drug originally requested. State law permits, if there is more than one drug that is clinically appropriate for the treatment of a medical condition, a health plan or insurer that provides coverage for prescription drugs to require step therapy.

If a health plan or insurer that provides coverage for prescription drugs fails to respond to a prior authorization or step therapy exception request within 72 hours for non-urgent requests, and within 24 hours if exigent circumstances exist, upon the receipt of a completed form, the request is deemed granted. Current law also requires a health plan or insurer to expeditiously grant a request for a step therapy exception if the provider submits the necessary justification and clinical detail, as specified.

Proposed Law: Specific provisions of the bill would:

- Provide that a licensed health care professional may request, and must be granted by the health plan/insurer, the authority to adjust the dose or frequency of a drug to

meet the specific medical needs of the enrollee/insured without prior authorization or subsequent utilization management if the following conditions are met:

  - The drug previously had been approved for coverage by the plan/insurer for an enrollee's/insured's chronic medical condition or cancer treatment and the plan's/insurer's prescribing provider continues to prescribe the drug for the enrollee's/insured's chronic medical condition or cancer treatment.

  - The drug is not an opioid or a scheduled controlled substance.

  - The dose has not been adjusted more than two times without prior authorization.

- Require that if the enrollee/insured has been continuously using a prescription drug selected by the enrollee's/insured's prescribing provider for the medical condition under consideration while covered by their current or previous health coverage, the health plan/insurer cannot limit or exclude coverage of that prescription.

- Exempt Medi-Cal managed care plans.

-- END --