SENATE COMMITTEE ON HEALTH
Senator Dr. Susan Talamantes Eggman, Chair

BILL NO: SB 598
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SUBJECT: Health care coverage: prior authorization

SUMMARY: Prohibits a health plan or health insurer from requiring a contracted health professional with a total contracting history of at least 36 months, to complete or obtain a prior authorization for specified covered health care services if, in the most recent one-year contracted period, the health plan approved or would have approved not less than 90% of the prior authorization requests submitted by the health professional for the class of health care services or treatments subject to prior authorization.

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 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurance. [HSC §1340, et seq., INS §106, et seq.]

2) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for utilization review or utilization management 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]

3) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for utilization review or utilization management 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]

4) Requires health plans and disability insurers and any contracted entity that performs utilization review or utilization management functions, prospectively, retrospectively, or concurrently, based on medical necessity requests to comply with specified requirements.

[HSC §1367.01 and INS §10123.135]

5) 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. In the case of concurrent review, prohibits 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]

6) Requires, when the condition is such that the insured or enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process would be detrimental to the insured's life or health or could jeopardize the insured's or enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to be made in a timely fashion, appropriate for the nature of the insured's condition, but not to exceed 72 hours or, if shorter, the period of time required under federal law and any subsequent rules or regulations issued thereunder, after the receipt of the information reasonably necessary and requested by the insurer or plan to make the determination. [HSC §1367.01 and INS §10123.135]

7) Requires, if a health plan or health insurer that provides coverage for prescription drugs fails to respond to a prior authorization or step therapy exception request, as specified, within 72 hours for nonurgent requests, and within 24 hours if exigent circumstances exist, upon the receipt of a completed form, the request to be deemed granted. [HSC §1367.241 and INS §10123.191]

8) Allows for appeal of a denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request by filing an internal appeal pursuant to federal law and any subsequent rules or regulations issued thereunder. [INS §10123.201]

9) Establishes, in DMHC and CDI, the Independent Medical Review System (IMR) which reviews disputed health care services that a plan, or one of its contracting entities, or insurer determines is not medically necessary or is experimental or investigational. [HSC §1374.30-1374.36 and INS §10169]

10) Requires every health plan to establish and maintain a grievance system approved by DMHC under which enrollees may submit their grievances and complaints to the plan. Permits enrollees to submit those grievances to DMHC after undergoing the plan's internal process for at least 30 days, unless the case involves imminent and serious threat, severe pain, potential loss of life, limb, or major bodily function, cancellations, rescissions, or the nonrenewal of a contract or any other case where DMHC determines early review is warranted. Requires to the extent required by federal law and any subsequent rules or regulations, an independent external review pursuant to the standards required by the United States Secretary of Health and Human Services of a health plan's cancellation, rescission, or nonrenewal of an enrollee's or subscriber's coverage. [HSC §1368]

11) Requires under federal law a group health plan and a health insurance issuer offering group or individual health insurance coverage to implement an effective appeals process for appeals of coverage determinations and claims, including an internal claims appeal process with notices in a culturally and linguistically appropriate manner, of available internal and external appeals process. Establishes processes for internal and external reviews. [42 U.S.C. §300gg-19]

This bill:

Prior Authorization Exemption or "Gold Carding"

1) Prohibits, on or after January 1, 2025, a health plan or health insurer from requiring a contracted health professional with a total contracting history of at least 36 months, to complete or obtain a prior authorization for any covered health care services if, in the most recent one-year contracted period, the health plan or insurer approved or would have approved not less than 90% of the prior authorization requests submitted by the health professional for the class of health care services or treatments subject to prior authorization. Indicates the 36-month contracting period does not have to be continuous. Includes as an approval, a modification of a prior authorization request by a plan or insured.

2) Applies this bill to any and all product types offered by the health plan that are regulated by DMHC and insurers regulated by CDI. However, includes Medi-Cal managed care plans only to the extent permissible under federal law.

3) Exempts fully integrated delivery systems (defined as a system that includes a physician organization, health facility or health system, and a nonprofit health care service plan that provides health care services to enrollees in a specific geographic region of the state through an affiliate hospital system and an exclusive contract between the nonprofit health care service plan and a single physician organization in each geographic region to provide those medical services) vision-only and dental-only health plans, policies, and coverage.

Items Covered

4) Applies 1) above specifically to services, items, and supplies, including drugs, that are covered by the contract or policy and are within the contracted health professional's medical licensure, board certification, specialty, or scope of practice. Defines "health professional" as a physician or professional licensed to deliver or furnish health care services.

5) Defines "health care service" to include:

    a) A health care procedure, treatment, or service provided at a health facility licensed in California, or, provided or ordered by a physician and surgeon, or within the scope of practice for which a health care professional is licensed in California; and,
    b) The provision of pharmaceutical products, services or durable medical equipment; and, until January 1, 2028 brand name prescription drugs.

6) Specifies that "health care service" excludes:

    a) Tier four, experimental, investigational, or unproven drugs or products under the applicable enrollee's or insured's coverage, and,
    b) Prescription drugs not approved by the federal Food and Drug Administration.

Process for Exemption

7) Requires a health plan or health insurer to evaluate if a contracted health professional without an exemption qualifies for an exemption from prior authorization requirements once every 12 months or upon the request of the health professional, but no more often than once every 12 months. Does not require contracted health professionals to request this exemption.

8) Permits a health plan or insurer to evaluate if a contracted health care professional continues to qualify for an exemption from prior authorization requirements not more than once every 12 months. Indicates a health plan or insurer does not have to evaluate an existing exemption and permits a health plan or insurer to establish a longer exemption period.

9) Requires a health plan or insurer to provide a health professional who receives an exemption with a notice that includes a statement that the health professional qualifies for an exemption from preauthorization requirements and a statement of the duration of the exemption.

10) Requires a health plan or insurer, upon request, to provide a health professional who is denied a prior authorization exemption with the facts and information that supports the denial, including statistics and data for the relevant prior authorization request evaluation period and detailed information sufficient to demonstrate that the health professional does not meet the criteria for an exemption.

11) Requires a health professional's exemption from prior authorization to remain in effect until the 30th calendar day after the date the health plan or insurer notifies the health professional of the determination to rescind the exemption, or, if the health professional appeals the rescission determination, the fifth business day after the date the independent review affirms the health plan's or insurer's determination to rescind the exemption.

Rescission of Exemption

12) Permits a health plan or insurer to rescind a prior authorization exemption at the end of the 12-month period only if the health plan or insurer:

    a) Makes a determination that the health professional would not have met the 90% approval criteria based on a retrospective review of a random sample of a minimum of 15, but no more than 25, claims for covered services for which the exemption applies for the previous 12 months; and,

    b) Complies with other applicable requirements specified in this bill, including:
        i) The health plan or insurer notifies the health professional at least 30 calendar days before the proposed rescission is to take effect;
        ii) The health plan or insurer provides notice of the information and data relied on to make the determination; and,
        iii) A plain-language explanation of how the health professional may appeal and seek an independent review of the determination.

13) Requires a determination to rescind or deny a prior authorization exemption to be made by a health professional licensed in California of the same or similar specialty as the health professional being considered for an exemption and who has experience in providing the type of services for which the exemption applies.

14) Makes a rescission determination that is not finalized as specified in 10) and 11) above considered to continue the health professional to qualify for the exemption.

Appeal

15) Permits a health professional to appeal the decision to deny or rescind a prior authorization exemption and have a right to have the appeal conducted and completed by a health professional licensed in California of the same or similar specialty as the health professional being considered for an exemption who was not directly involved in making the initial denial or rescission of the exemption.

16) Permits a health professional to request that the reviewing health professional consider another random sample of claims submitted to the health plan or insurer by the health professional during the relevant evaluation period as part of their review.

17) Requires, within 30 calendar days of receipt of the appeal, the health plan or insurer to reconsider the denial or rescission of the exemption and provide a written response to the health professional with the appeal determination and the basis for the determination, including pertinent facts and information relied upon in reaching the determination.

18) Requires a health plan or insurer to be bound by a determination made pursuant to 9) though 14) above, and prohibits a health plan or insurer from retroactively denying or modifying a covered health care service on the basis of a rescission of an exemption, even if the determination to rescind the prior authorization exemption is affirmed.

19) Makes a health professional eligible for consideration of an exemption after a 12-month period following a final determination or review affirming the rescission or denial of an exemption.

Miscellaneous

20) Prohibits a health plan or insurer from denying or reducing payment for a covered health care service exempted from a prior authorization requirement pursuant to this bill, including a covered health care service performed or supervised by another health care professional when the performing or supervising health care professional or other health care professional who ordered the service received a prior authorization exemption, unless the performing or supervising health care professional or other health care professional did either of the following:
    a) Knowingly and materially misrepresented the health care service in a request for payment submitted to a health care service plan with the specific intent to deceive and obtain an unlawful payment from the health care service plan; or,
    b) Failed to substantially perform the health care service.

21) Indicates this bill does not prevent a health plan or insurer from taking action, including rescinding a prior authorization exemption at any time, against a contracted health professional that has been found, through an investigation by the plan, to have committed fraud or to have a pattern of abuse in violation of the contract.

22) Requires a grievance or appeal submitted by or on behalf of an enrollee or insured regarding a delay, denial, or modification of health care services to be reviewed by a physician and surgeon of the same or similar specialty as the physician requesting authorization for those

health care services.

23) Prohibits a plan or insurer from delegating the requirements in this bill to a delegated provider unless the parties have negotiated and agreed upon a new provision to the parties' contract pursuant to the Health Care Provider's Bill of Rights, as specified. Requires that change to the parties' contract to be considered a material change.

24) Requires DMHC and CDI to conduct an analysis of the inclusion of brand name prescription drugs as a health care service for purposes of this bill, including an analysis of the costs and savings, prospects for continuing or expanding the gold card program for brand name prescription drugs, feedback received from the provider community, and an assessment of the administrative costs to the plan of administering or implementing the gold card program for brand name prescription drugs. Requires DMHC and CDI to submit reports on their findings to the Legislature on or before July 1, 2027, as specified. Sunsets this report provision on January 1, 2029.

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

COMMENTS:

1) *Author's statement.* According to the author, California patients are too often denied life-saving care or are forced to endure excruciating pain because of unnecessary bureaucratic red tape in the health care industry. Insurance companies routinely use a tool known as "prior authorization" to control costs, often at the expense of patients who need essential care. This barrier to care also results in unnecessary denials and delay, forcing providers and clinicians to waste their valuable time on advocating for patients rather than treating their health care issues. Often, by the time the treatment is finally approved, the patient is in significantly worse condition, sometimes rendering the treatment ineffective. Prior authorization also can cause serious adverse medical events, and even life-threatening or permanently impairing damage. This bill will bar insurance companies from harming California patients solely for the purpose of protecting their bottom line. This bill creates a prior authorization exemption program for providers with a proven record of prescribing medically appropriate treatments. Providers must continue to prove they are responsibly prescribing treatments to maintain the exemption for subsequent years. The bill also ensures insurance reviewers understand the disease they are evaluating by requiring them to have the same medical expertise as the physician ordering the treatment under review. These reforms strike an appropriate balance by holding medical providers accountable for the treatments they prescribe without sacrificing the health and well-being of patients in the process.

2) *Prior authorization.* Prior authorization is a form of utilization review or utilization management. Utilization review can occur prospectively, retrospectively, or concurrently and a plan or insurer can approve, modify, delay or deny in whole or in part a request based on its medical necessity. California law requires written policies and procedures that are consistent with criteria or guidelines that are supported by clinical principles and processes. These policies and procedures must be filed with regulators, and disclosed, upon request, to providers, plans and enrollees or insureds. There are timelines in the law for plans and insurers to respond to requests once any requested medical information that is reasonably necessary to make the determination is provided. California also has a standardized form for prior authorization submissions. If a health plan or insurer fails to respond to the prior authorization request within 72 hours for nonurgent requests, and within 24 hours if exigent

circumstances exist, upon the receipt of a completed form, the request is deemed granted.

3) *IMR process.* An enrollee or insured can apply for IMR when they have filed a grievance with the plan, provider or insurer and the decision was upheld or remains unresolved after 30 days. A grievance requiring expedited review can go to IMR after three days of the grievance process. Enrollees and insureds can apply for IMR when a) the provider has recommended a health care service as medically necessary; b) the enrollee or insured has received urgent care or emergency services that a provider determined was medically necessary; c) the enrollee has received experimental or investigational treatment for a serious condition; or, d) the enrollee or insured has been seen by an in-plan provider for the diagnosis or treatment of the medical condition and the disputed health care service has been denied, modified, or delayed by the plan or insurer or by one of its contracting providers, based on a decision that it is not medical necessary. IMR is free to the enrollee or insured, and in most cases decided within 30 days of IMR qualification and receipt of all required documentation. For more urgent situations, an expedited IMR can be requested and is usually decided within seven days after the supporting documentation is provided. An IMR can take longer if all of the medical records needed are not provided in a timely manner. In approximately 68% of IMR cases at the DMHC, the health plan's denial of service was reversed by the health plan or overturned by the IMR organization and the enrollee received authorization for the requested service or treatment. If the IMR decision is in favor of the enrollee, the health plan must authorize the service or treatment within five business days. CDI's Annual Report indicates a total number of 191 IMR cases for 2021, in which 121 (63%) were overturned in favor of the insured.

4) *Impacts on cost and quality.* A November 2019 brief funded by the National Institute for Health Reform, titled "Impacts of Prior Authorization on Health Care Cost and Quality" is a review of peer-reviewed and gray literature and interviews with experts. This report indicates that payers use prior authorization to reduce utilization of overused or low-value services, reduce spending, and improve quality. Prescription drugs, durable medical equipment, diagnostic radiology, surgical procedures, inpatient stays, and behavioral health treatments are commonly subject to prior authorization requirements, and pharmacy benefit managers often play a role in prior authorization of prescription drugs. Many initial denials of prior authorization are due to incomplete information, which are approved once complete information is provided. According to the report, physicians report overall 72% of requests are approved upon initial request and 7% are approved upon appeal. With respect to health outcomes, the report indicates there is evidence that prior authorization can delay receipt of care or result in patients abandoning prescribed care. The extent to which either negatively affects patient outcomes is less clear. The report suggests the following as improvements to prior authorization: standardizing prior authorization across payer groups, standardizing the submission process, automation, strategic application of prior authorization requirements, such as ending requirements on drugs or services where the majority of requests are approved, gold card or exclusion programs, and provider process improvements such as a centralized clinical team to handle prior authorization requests. The report concludes with the following: "Research has not yet definitively established (1) the net economic impact of prior authorization across all system costs and benefits and (2) the downstream health impacts. For today, standardizing, streamlining, and automating the process and targeting the requirements are consensus approaches to decreasing the burden, thus increasing the net benefit of these programs."

5) *Consensus statement:* Six national health care organizations (American Hospital Association, America's Health Insurance Plans (AHIP), American Medical Association, American

Pharmacists Association, BlueCross BlueShield Association, and the Medical Group Management Association) adopted a consensus statement on improving the prior authorization process in 2018. Some of the agreements related to this bill include:

a) Encourage the use of programs that selectively implement prior authorization requirements based on stratification of health care providers' performance and adherence to evidence-based medicine;
b) Encourage (1) the development of criteria to select and maintain health care providers in these selective prior authorization programs with the input of contracted health care providers and/or provider organizations; and, (2) making these criteria transparent and easily accessible to contracted providers;
c) Encourage appropriate adjustments to prior authorization requirements when health care providers participate in risk-based payment contracts;
d) Encourage review of medical services and prescription drugs requiring prior authorization on at least an annual basis, with the input of contracted health care providers and/or provider organizations;
e) Encourage revision of prior authorization requirements, including the list of services subject to prior authorization, based on data analytics and up-to-date clinical criteria;
f) Encourage the sharing of changes to the lists of medical services and prescription drugs requiring prior authorization via: (1) provider-accessible websites; and (2) at least annual communications to contracted health care providers;
g) Encourage health care providers, health systems, health plans, and pharmacy benefit managers to accelerate use of existing national standard transactions for electronic prior authorization;
h) Advocate for adoption of national standards for the electronic exchange of clinical documents (i.e., electronic attachment standards) to reduce administrative burdens associated with prior authorization;
i) Advocate that health care provider and health plan trading partners, such as intermediaries, clearinghouses, and electronic health records and practice management system vendors, develop and deploy software and processes that facilitate prior authorization automation using standard electronic transactions; and,
j) Encourage the communication of up-to-date prior authorization and step therapy requirements, coverage criteria and restrictions, drug tiers, relative costs, and covered alternatives: (1) to electronic health records, pharmacy system, and other vendors to promote the accessibility of this information to health care providers at the point-of-care via integration into ordering and dispensing technology interfaces; and, (2) via websites easily accessible to contracted health care providers.

6) *Streamlining prior authorization.* A July 2020 paper published in *Circulation: Cardiovascular Quality and Outcomes,* describes streamlining prior authorization is an audit-based system where prospective prior authorization is waived for clinicians deemed high-performing. This gold carding recognizes clinicians who regularly have prior authorizations approved and lifts requirements for them for a time period. Blue Cross and Blue Shield of Nebraska has allowed clinicians who reached gold card status to use a special fax sheet for automatic approval since 2018. Under this program, a clinician must have a low denial rate of (≤6%) for nine to 12 months, and is awarded gold card status for 12 months. Similarly, Vermont's gold carding system for radiology procedures required a denial rate of ≤3% on at least 100 imaging requests in 18 months, and Alabama required a ≤5% denial rate in the same time period. Some challenges with audit based systems, include potentially exacerbating existing inequities in care. For example, larger integrated health systems often

have more time and resources to successfully obtain prior authorization approvals and appeals, especially compared with smaller practices. In contrast, some Medicaid and lower-cost managed care plans may have lower prior authorization approval rates than more expensive plans. Therefore, it is possible for audit-based systems to worsen inequities, as patients served by larger health systems would have increased access to drugs and services compared with lower resource settings. There can also be challenges identifying high-performing clinicians with available data.

7) *Carrier Efforts.* According to a July 2022 AHIP brief, prior authorization is most often focused on areas such as: high-tech imaging, elective services, and specialty drugs. Plans are waiving or reducing prior authorization as more providers are entering risk-based contracts for medical services and prescription medications. Plans are using gold carding programs but with mixed reviews. While 69% of plans with gold carding programs observed some positive outcomes such as reduced administrative burden and improved provider satisfaction, 73% reported negative outcomes such as reduced quality of care for patients, higher costs, and administratively difficult implementation. The 2019 report on cost and quality indicates that AHIP also reports that performance tends to slip once the provider has gold card status. More insurers are streamlining prior authorization through electronic prior authorization for prescription medications and medical services. Through technology initiatives median time between submitting requests and receiving a decision was three times faster. Experienced users of the system reported less time on phone calls and faxing.

8) *Related legislation.* SB 324 (Limón) prohibits health plans, insurers, and the Medi-Cal program from requiring prior authorization or other utilization review for any clinically indicated treatment for endometriosis, as determined by the treating physician and consistent with nationally recognized evidence-based clinical guidelines. *SB 324 is scheduled to be heard in the Senate Health Committee on April 11, 2021.*

   SB 427 (Portantino) prohibits a nongrandfathered health plan contract or health insurance policy from imposing any cost-sharing or utilization review requirements for antiretroviral drugs, devices, or products that are either approved by the federal Food and Drug Administration or recommended by the federal Centers for Disease Control and Prevention for the prevention of AIDS/HIV, including preexposure prophylaxis or postexposure prophylaxis. *SB 427 is pending in the Senate Health Committee.*

   AB 931 (Irwin) prohibits a health plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2025 that provides coverage for physical therapy from requiring prior authorization for the initial 12 treatment visits for physical therapy. *AB 931 is scheduled to be heard in the Assembly Health Committee on April 11, 2023.*

   AB 1288 (Reyes) prohibits a health plan or insurer from subjecting to prior authorization a buprenorphine product, methadone, or long-acting injectable naltrexone for detoxification or maintenance of a substance use disorder prescribed according to generally accepted national professional guidelines for the treatment of a substance use disorder. *AB 1288 is scheduled to be heard in the Assembly Health Committee on April 25, 2023.*

9) *Prior legislation.* SB 250 (Pan of 2022) is similar to this bill. *SB 250 was held in the Assembly Appropriations Committee suspense file.*

   AB 1880 (Arambula of 2022) would have required a health plan or health insurer's utilization

management process to ensure that an appeal of a denial, is reviewed by a clinical peer, as specified. AB 1880 would have defined "clinical peer" as a physician or other health professional who holds an unrestricted license or certification from any state and whose practice is in the same or a similar specialty as the medical condition, procedures, or treatment under review. AB 1880 would have required health plans and insurers that require step therapy or prior authorization to maintain specified information, including, but not limited to, the number of step therapy exception requests and prior authorization requests received by the plan or insurer, and, upon request, to provide the information in a deidentified format to the DMHC or the CDI commissioner, as appropriate. *AB 1880 was vetoed by the Governor, who stated:*

> *This bill would require a health plan or insurer to have a clinical peer review when a provider appeals a denial of requests for step therapy exception, exception requests for coverage of nonformulary drugs, and prior authorization of prescription drugs.*
>
> *Health plans and health insurers should make every effort to streamline utilization management processes and reduce barriers to all medically necessary care. However, the bill's requirements, which are limited to denied authorizations for prescription drugs, are duplicative of California's existing Independent Medical Review requirements, which provide enrollees, insureds, and their designated representatives with the opportunity to request an external review from an independent provider. I encourage the Legislature to pursue options that leverage existing requirements and resources, rather than creating duplicative new processes.*

AB 1268 (Rodriguez of 2019) would have required a health plan or insurer to report the number of times in the preceding calendar year that it approved or denied each of the 30 health care services for which prospective review was most frequently requested. *AB 1268 was held on the Assembly Appropriations Committee suspense file.*

10) *Support.* The California Medical Association, one of this bill's cosponsors, writes this bill will ensure timely access to treatments, improve patient health outcomes and improve the efficiency and effectiveness of physician practices to increase patient access to care. This bill takes a comprehensive approach to reforming the prior authorization process, by requiring plans to create a prior authorization exemption program that allows physicians who are practicing within the plan's utilization criteria 90% of the time to get a one-year exemption from prior authorizations, and giving a treating physician that does not have a prior authorization exemption the right to have a physician of the same or similar specialty conduct an appeal of a prior authorization denial. The California Academy of Child and Adolescent Psychiatry (another cosponsor) writes that while patient-centered care may be the stated goals of many insurance companies, patient stories have shed light on how insurers are using the prior authorization process to protect profit margins and leave patients without the care they need. This bill is a balanced approach that ensures providers practice within the plan's criteria, while also allowing the provider to care for the needs of their patients without undue influence from health plans. In a December 2022 physician survey, the American Medical Association found that 94% of physicians reported prior authorization results in care delays and 89% reported a negative impact on patient health outcomes because of prior authorization results and delays. California's health care system should revolve around a patient's needs and their ability to receive their treatments promptly. Patient-centered care, not corporate health plan profits, is what should drive medical decision making, however, patient horror stories have shed light on how insurers are using the prior authorization

process to protect profit margins and leave patients without the care they need. This practice leaves California patients to navigate a complex system while their symptoms and condition worsen, making it more expensive to treat and extending their recovery time. The status quo is proving ineffective at delivering timely treatments to patients who need them most.

11) *Opposition.* The California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC), and AHIP write that this bill will increase the cost of health care and lead to poor patient outcomes, specifically increasing unnecessary and ultimately harmful patient services. Medical and utilization management tools, like prior authorization, are key to promoting safe, effective, and smart care for plan enrollees and insureds. Health plans and insurers are also stewards of the premium dollar and have an obligation to invest those dollars in proper and effective care. In recognition of the need to streamline the process, many health plans and insurers are currently implementing their own enhanced prior authorization programs to help ease the burden on providers and enrollees. This bill will disrupt those efforts and potentially harm all the good work that has been done to date. CAHP, ACLHIC, and AHIP indicate that this waiver would even apply to services that are associated with a high risk of fraud, waste, and abuse, and presumably apply to drugs that are known to have serious side effects for certain patients. This bill takes no steps to ensure that the rate of fraudulent and wasteful care does not increase during the twelve-month no-look back period. This bill defeats an essential purpose of utilization management and obstructs the "right care, right place, right time" imperative. Broadly waiving prior authorization could lead to clinically inappropriate prescribing, exposing enrollees and insureds to potential harm by using a service or drug where there is little to no evidence of clinical benefit. It will also increase waste through use of drugs with no evidence of clinical benefit. America's Physician's Groups (APG) writes referencing the Provider Bill of Rights does not provide any actual carve out of APG member physician organizations, they will remain subject to the provisions that also apply to health plans and insurers under the bill. The physician organizations would be de-delegated for the preauthorization oversight. APG has attempted to work with CMA to discuss alternatives, and will continue to dialogue in good faith but APG's concerns are not reflected in the current version of the bill, and APG must remain opposed. The California Chamber of Commerce writes that prohibiting the prior authorization process in a vast majority of instances as this bill outlines would increase health care costs. While not identical, this bill is modeled after HB 3459 which was recently signed into law in Texas. While the bill has been extremely difficult to implement, it has been posited that the new law will substantially increase premiums for small businesses and individuals in the fully insured market. While there are situations where this process could make sense, the one-size-fits-all approach will inevitably result in preventable and unnecessary waste within the medical system.

12) *Policy comment.* There is limited evidence-based data available to determine how Californians are being impacted by prior authorization policies. One article provided by the bill's sponsor described a physician who had to complain on social media in order to get a high cost cancer treatment covered by a California patient's health insurance company. There are many policy efforts that have been approved by the Legislature that are underway to control high health care costs and encourage the use of health care data exchange with the goal to improve access, quality and affordability for patients. Individual bills should be evaluated in this context. This is one of several bills that are being advanced to address health insurance prior authorization policies. In contrast to the others, this bill is broad in its application with respect to the services and treatments covered. Policymakers may wish to narrow the scope of this bill in a way that can moderate administrative burdens, improve

patient care, and control low value and unnecessary over utilization of services.

13) *Amendments.* The Chair has requested and the author has accepted amendments to support and encourage health care providers and plans to make progress toward the 2018 consensus agreements to improve prior authorization. Specifically:
   a) Plans and insurers should annually monitor prior authorization approval, modification, appeal, and denial rates;
   b) Plans and insurers should end prior authorization requirements on procedures, treatments, or services that are approved 95% of the time;
   c) Plans must offer and professionals must agree to electronic prior authorization in order to be considered eligible for gold carding;
   d) Allow plans and insurers to choose the sample of claims for audit when determining if gold carding exemption should continue; and,
   e) Apply the gold carding to pharmacy benefit managers that are under contract with plans and insurers to administer prior authorization for prescription drugs.

SUPPORT AND OPPOSITION:

Support: California Medical Association (cosponsor)
California Academy of Child and Adolescent Psychiatry (cosponsor)
American College of Physicians California Services Chapter
American Medical Association
Association for Clinical Oncology
Association of Northern California Oncologists
California Academy of Eye Physicians and Surgeons
California Chapter American College of Cardiology
California Chronic Care Coalition
California Life Sciences
California Nurses Association
California Optometric Association
California Orthopedic Association
California Physical Therapy Association
California Podiatric Medical Association
California Radiology Society
California Rheumatology Alliance
California Society of Anesthesiologists
California Society of Pathologists
California Society of Plastic Surgeons
California State Association of Psychiatrists
Children's Specialty Care Coalition
Medical Oncology Association of Southern California
Planned Parenthood Affiliates of California
Western Center on Law and Poverty
One Individual

Oppose: America's Health Insurance Plans
America's Physician Groups
Association of California Life and Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce
CIGNA

Health Care LA IPA
Hill Physicians Medical Group
One Individual

-- END --