SENATE COMMITTEE ON APPROPRIATIONS
Senator Anthony Portantino, Chair
2023 - 2024 Regular Session

SB 598 (Skinner) - Health care coverage: prior authorization

Version: April 17, 2023
Urgency: No
Hearing Date: April 24, 2023
Policy Vote: HEALTH 10 - 0
Mandate: Yes
Consultant: Agnes Lee

Bill Summary: SB 598 would prohibit 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.

Fiscal Impact:

- Unknown, ongoing cost pressures in the Medi-Cal program (General Fund and federal funds) to the extent prior authorization or other utilization review is prohibited and would lead to potentially greater utilization of services.

- The Department of Managed Health Care estimates annual costs of approximately $14 million (Managed Care Fund), at full implementation, for state administration.

- The Department of Insurance estimates costs of $202,000 in 2024-25, $189,000 in 2025-26 and $189,000 in 2026-27 (Insurance Fund) for state administration.

Background: Existing law establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Act and the California Department of Insurance (CDI) to regulate health insurance.

Prior authorization is a form of utilization review or utilization management used by health plans and insurers to determine whether to authorize, modify, or deny health care services. 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 non-urgent requests, and within 24 hours if exigent circumstances exist, upon the receipt of a completed form, the request is deemed granted.

Proposed Law: Specific provisions of the bill would:

- Prohibit, 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 specified 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. The bill would include Medi-Cal managed care plans only to the extent permissible under federal law.

- Establish standards and a process for the above exemptions from prior authorization requirements, including denial, rescission, and appeal.

- Require a health plan or health insurer to have a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time.

- Require 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. The bill would require DMHC and CDI to submit reports on their findings to the Legislature on or before July 1, 2027, as specified and sunset this report provision on January 1, 2029.

Related Legislation: SB 250 (Pan, 2022) was similar to this bill. This bill was held on the suspense file in the Assembly Appropriations Committee.

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