Office of Senate Floor Analyses
(916) 651-1520 Fax: (916) 327-4478

THIRD READING

Bill No: SB 598
Author: Skinner (D), et al.
Amended: 4/17/23
Vote: 21

SENATE HEALTH COMMITTEE: 10-0, 4/12/23
AYES: Eggman, Glazer, Gonzalez, Hurtado, Limón, Menjivar, Roth, Rubio, Wahab, Wiener
NO VOTE RECORDED: Nguyen, Grove

SENATE APPROPRIATIONS COMMITTEE: 5-2, 5/18/23
AYES: Portantino, Ashby, Bradford, Wahab, Wiener
NOES: Jones, Seyarto

SUBJECT: Health care coverage: prior authorization

SOURCE: California Academy of Child and Adolescent Psychiatry
California Medical Association

DIGEST: This bill 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.

ANALYSIS:

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) 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

3) 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.

4) 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.

5) 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

6) Requires a health plan or insurer to provide an electronic prior authorization process, and a health professional to agree to use the plan's electronic prior authorization to be eligible for the exemption. Allows waiver of this requirement.

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.

Rescission of Exemption

9) 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 makes a determination that the health professional would not have met the 90% approval criteria based on a retrospective review of a 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, complies with other applicable requirements specified in this bill.

10) 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.

Appeal

11) 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.

12) Permits a health professional to request that the reviewing health professional consider a 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.

Miscellaneous

13) 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.

14) Requires a plan's or procedures policies or procedures to include a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies, including drugs that are regularly approved.

15) Requires a plan or insurer to discontinue requiring prior authorization on services, items, and supplies, including drugs that are approved 95% of the time.

Comments

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.

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. An enrollee or insured can apply for Independent Medical Review (IMR) when they have filed a grievance with the plan, provider or insurer and the decision was upheld or remains unresolved after 30 days.

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.

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:

1) 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;

2) Encourage 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, making these criteria transparent and easily accessible to contracted providers;

3) 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;

4) 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; and,

5) Encourage health care providers, health systems, health plans, and pharmacy benefit managers to accelerate use of existing national standard transactions for electronic prior authorization.

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.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee,

- 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.

SUPPORT: (Verified 5/19/23)

California Academy of Child and Adolescent Psychiatry (co-source)
California Medical Association (co-source)
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 Association of Local Behavioral Health Boards and Commissions
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 Dermatology & Dermatologic Surgery
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
National Association of Pediatric Nurse Practitioners
Nomi Health
Orange County Chapter of National Association of Pediatric Nurse Practitioners
Planned Parenthood Affiliates of California
Psychiatric Physicians Alliance of California
Steinberg Institute
Western Center on Law and Poverty
One individual

OPPOSITION: (Verified 5/19/23)

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
North East Medical Services
One Individual

ARGUMENTS IN 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.

ARGUMENTS IN 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. 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. America's Physician 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 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.

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
5/20/23 13:00:31

****** END ******