Date of Hearing: July 11, 2023

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
SB 598 (Skinner) – As Amended April 17, 2023

SENATE VOTE: 33-2

SUBJECT: Health care coverage: prior authorization.

SUMMARY: Prohibits a health plan or health insurer, on or after January 1, 2025, from requiring a contracted health professional to complete or obtain a prior authorization (PA) for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the PA requests they submitted in the most recent one-year contracted period (PA exemption). Sets standards for this exemption and its denial, rescission, and appeal. Authorizes a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and authorizes a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. Requires a plan or insurer to provide an electronic PA process. Requires a plan or insurer to have a process for annually monitoring PA 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. Specifically, this bill,

Gold Carding

1) Prohibits a health plan or insurer, on or after January 1, 2025, from requiring a contracted health professional to complete or obtain a PA 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 PA requests submitted by the health professional for the class of health care services or treatments subject to prior authorization for enrollees or insureds.

2) Requires a health professional to have a total contracting history of at least 36 months with the health plan or insurer to be considered eligible for an exemption in 1) above.

3) Specifies that a modification by a plan or insurer of a PA request that is ultimately approved is an approval.

4) Applies a health professional's exemption under 1) above to services, items, and supplies, including drugs, that are covered by the plan contract or insurance policy and are within the contracted health professional's medical licensure, board certification, specialty, or scope of practice.

5) Applies 1) above to any and all product types offered by the health plan or insurer and includes Medi-Cal managed care plans only to the extent permissible under federal law.

6) Requires a health plan or insurer to provide an electronic PA process. Requires a health professional to agree to use the plan or insurer's electronic PA process to be considered eligible for an exemption pursuant to 1) above. Allows a health plan or insurer to waive this

requirement based on the health professional's access to requisite technologies and infrastructure, including broadband internet.

7) Requires a health plan or insurer to evaluate if a contracted health professional without an exemption qualifies for an exemption from PA requirements once every 12 months or upon the request of the health professional, but no more often than once every 12 months. Allows a health plan or insurer to evaluate if a contracted health care professional continues to qualify for an exemption from PA requirements under 1) above not more than once every 12 months. Specifies that this bill does not require plans or insurers to evaluate an existing exemption or prevent the establishment of a longer exemption period. Provides that a contracted health professional is not required to request an exemption to qualify for the exemption.

8) 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.

PA exemption denials

9) Requires a health plan or insurer, upon a health professional's request, to provide a health professional who is denied a PA exemption with the facts and information that supports its denial, including statistics and data for the relevant PA request evaluation period and detailed information sufficient to demonstrate that the health professional does not meet the criteria for an exemption pursuant to 1) above. Requires a health professional's PA exemption to remain in effect until the 30th calendar day after the date the health plan or insurer notifies the health professional of the health plan or insurer's 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 or insurer's determination to rescind the exemption.

10) Authorizes a health plan or insurer to rescind a PA exemption at the end of the 12-month period if the health plan or insurer meets all of the following requirements:

    a) Determines 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;
    b) Complies with other applicable requirements specified in this section, including both of the following;
        i) Notifies the health professional at least 30 calendar days before the proposed rescission is to take effect; and,
        ii) Requires the notice to include both of the following:
            (1) The information and data relied on to make the determination; and,
            (2) A plain-language explanation of how the health professional may appeal and seek an independent review of the determination pursuant to this bill.

11) Requires a determination to rescind or deny a PA 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.

12) Specifies that if a health plan or insurer does not finalize a rescission determination as specified in 10) above, then the individual health professional is considered to have met the criteria under 1) above to continue to qualify for the exemption.

13) Allows a health professional to appeal the decision to deny or rescind a PA exemption and has 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.

14) Allows 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.

15) Requires the health plan or insurer, within 30 calendar days of receipt of the appeal, 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.

16) Bounds a health plan or insurer by the determination made pursuant to 10) above. 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 health plan or insurer's determination to rescind the PA exemption is affirmed pursuant to 10) above.

17) Following a final determination or review affirming the rescission or denial of an exemption, a health professional is eligible for consideration of an exemption after a 12-month period.

18) Prohibits a health plan from denying or reducing payment for a covered health care service exempted from a PA requirement pursuant to 1) above, 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 PA 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 plan or insurer with the specific intent to deceive and obtain an unlawful payment from the health plan or insurer; or,
    b) Failed to substantially perform the health care service.

19) Allows a health plan or insurer to take action, including rescinding a prior authorization exemption granted under 1) above at any time, against a contracted health professional that has been found, through an investigation by the plan or insurer, to have committed fraud or to have a pattern of abuse in violation of the plan's contract or insurer's policy.

20) 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 and surgeon requesting authorization for those health care services.

Policies and Procedures

21) Requires a health plan or insurer's utilization review (UR) policies and procedures to include a process for annually monitoring PA approval, modification, appeal, and denial rates to identify services, items, and supplies, including drugs, that are regularly approved.

22) Authorizes a health plan or insurer to discontinue requiring PA on services, items, and supplies, including drugs, that are approved 95% of the time.

Delegation

23) Prohibits a health plan from delegating the requirements of this bill to a delegated provider unless the parties have negotiated and agreed upon a new provision to the parties' contract, as specified. Considers this change to the parties' contract to be a material change.

24) Exempts fully integrated delivery systems, as defined; and, vision-only and dental-only health plans and insurers from the provisions of this bill.

25) Applies provisions of this bill to a pharmacy benefit manager under contract with a health plan or insurer to administer PA for prescription drugs.

Prescription drugs

26) Requires the Department of Managed Health Care (DMHC) or the California Department of Insurance (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 or insurer of administering or implementing the gold card program for brand name prescription drugs.

27) Requires DMHC or CDI to submit a report on its findings to the Legislature on or before July 1, 2027.

28) Sunsets 26) and 27) above on January 1, 2029.

Definitions

29) Defines the following for purposes of this bill:
    a) Health professional as a physician and surgeon or other professional who is licensed in California to deliver or furnish health care services.
    b) Health care service as a health care procedure, treatment, or service that is either of the following: 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.
        i) Includes the provision of pharmaceutical products or services or durable medical equipment (DME);
        ii) Includes brand name prescription drugs until January 1, 2028;
        iii) Excludes any of the following:

(1) Tier four prescription drugs, as defined, under the applicable enrollee's coverage or indured's policy;
(2) Experimental, investigational, or unproven drugs or products under the applicable enrollee's coverage or insured's policy; or,
(3) Prescription drugs not approved by the federal Food and Drug Administration.

c) PA as the process by which UR determines the medical necessity or medical appropriateness of otherwise covered health care services before or concurrent with the rendering of those health care services. Includes a health care service plan requirement that an enrollee or health professional notify the health care service plan before providing a health care service, including preauthorization, precertification, and prior approval.

EXISTING LAW:

1) Establishes the DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and CDI to regulate health insurance. [Health and Safety Code (HSC) §1340, *et seq*., Insurance Code (INS) §106, *et seq*.]

2) Establishes the Medi-Cal program, administered by the Department of Health Care Services, under which low-income individuals are eligible for medical coverage. [Welfare and Institutions Code § 14000, et seq.]

3) Establishes as California's essential health benefits benchmark the Kaiser Small Group Health Maintenance Organization, existing California mandates, and 10 federal Patient Protection and Affordable Care Act mandated benefits. [HSC §1367.005 and INS §10112.27]

4) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for UR or utilization management (UM) 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]

5) Requires reviews, for purposes of Independent Medical Review, to determine whether the disputed health care service was medically necessary based on the specific medical needs of the enrollee or insured and any of the following:
   a) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service;
   b) Nationally recognized professional standards;
   c) Expert opinion;
   d) Generally accepted standards of medical practice; or,
   e) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious. [HSC §1374.33 and INS §10169.3]

6) Requires health plans to demonstrate that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. [HSC §1367]

7) Requires, if a health plan or health insurer that provides coverage for prescription drugs or a contracted physicians group fails to respond to a PA, 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 request form, the request is deemed granted. [HSC §1367.241 and INS §10123.191]

8) Authorizes a health plan or insurer that provides coverage for prescription drugs to require step therapy if there is more than one drug that is clinically appropriate for the treatment of a medical condition. [HSC §1367.206 and INS §10123.201]

9) Requires a health plan or insurer to expeditiously grant a request for a step therapy exception within the applicable time limit described in 7) above if a prescribing provider submits necessary justification and supporting clinical documentation that the required prescription drug is inconsistent with good professional practice for provision of medically necessary covered services, taking into consideration the enrollee's or insured's needs and medical history. Permits the basis of the provider's determination for a step therapy exception to include, but not be limited to, any of the following criteria:

    a) The prescription drug required by the plan or insurer is contraindicated or is likely, or expected, to cause an adverse reaction or physical or mental harm in comparison to the requested prescription drug;
    b) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the enrollee or insured and the known characteristics and history of the enrollee's or insured's prescription drug regimen;
    c) The enrollee or insured has tried the required prescription drug while covered by their current or previous health coverage or Medicaid, and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse reaction. Permits the plan or insurer to require the submission of documentation demonstrating that the enrollee or insured tried the required prescription drug before it was discontinued;
    d) The required prescription drug is not clinically appropriate for the enrollee or insured because the required drug is expected to do any of the following, as determined by the prescribing provider:
        i) Worsen a comorbid condition;
        ii) Decrease the capacity to maintain a reasonable functional ability in performing daily activities; or,
        iii) Pose a significant barrier to adherence to, or compliance with, the enrollee or insured's drug regimen or plan of care.
    e) The enrollee or insured is stable on a prescription drug selected by the prescribing provider for the medical condition under consideration while covered by their current or previous health coverage or Medicaid. [HSC §1367.206 and INS §10123.201]

10) Prohibits a health plan contract from limiting or excluding coverage for a drug for an enrollee if the drug previously had been approved for coverage by the plan for a medical condition of the enrollee and the plan's prescribing provider continues to prescribe the drug for the medical condition, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's condition. Permits the prescriber to prescribe another covered drug that is medically appropriate or a generic substitution, as authorized. [HSC §1367.22]

11) Requires contracts between providers and health plans to be in writing and prohibits, except for applicable copayments and deductibles, a contracted provider from invoicing or balance billing a health plan's enrollee for the difference between the provider's billed charges and the reimbursement paid by the health plan or the health plan's capitated provider for any covered benefit. Prohibits a provider, in the event that a contract has not been reduced to writing, or does not contain the prohibition above, from collecting or attempting to collect from the subscriber or enrollee sums owed by the health plan. [HSC §1379]

12) Specifies that the obligation of the plan to comply with existing law is not waived when the plan delegates any services that it is required to perform to its medical groups, independent physician associations, or other contracting entities. [HSC §1399.873]

13) Establishes the Health Care Providers' Bill of Rights that specifies that a health plan change to a material term of the contract must negotiated and agreed to by the provider. [HSC §1375.7]

FISCAL EFFECT: According to the Senate Appropriations Committee,

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

2) DMHC estimates annual costs of approximately $14 million (Managed Care Fund), at full implementation, for state administration;

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

COMMENTS:

1) PURPOSE OF THIS BILL. 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" ostensibly to control costs, but that practice is often at the expense of patients who need essential care. This barrier to care can result in unnecessary denials and delay, forcing providers and clinicians to waste valuable time advocating for the care already deemed necessary and essential for their patient's health. Often, by the time the treatment is finally approved, the patient is in significantly worse condition, sometimes rendering the treatment ineffective. PA also can cause serious adverse medical events, and even life-threatening or permanently impairing damage. The author states that this bill will bar insurance companies from harming California patients solely for the purpose of protecting their bottom line. This bill creates a PA 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. This 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. The author concludes that medical providers and their patients are the

most qualified people to make medical decisions, not insurance companies whose primary goal is to protect their bottom line.

2) BACKGROUND.

a) Health Care Expenditures. According to California's Office of Health Care Affordability, health care spending in California reached $10,299 per capita and $405 billion overall in 2020, up 30% from 2015. Californians with job-based coverage are facing higher out-of-pocket costs, with the share of workers with a large deductible ($1,000 or more) increasing from 6% in 2006 to 54% in 2020. For the third consecutive year, the 2022 California Health Care Foundation California Health Policy Survey found that half of Californians (49%), and fully two-thirds of those with lower incomes (under 200% of the federal policy level), reported skipping or delaying at least one kind of health care due to cost in the past 12 months. Among those who reported skipping or delaying care due to cost, about half reported that their conditions worsened as a result.

b) PA. PA is a decision by a health plan or insurer that a health care service, treatment plan, prescription drug, or DME is medically necessary. The health plan or insurer may require preauthorization for certain services before an individual receives them, except in an emergency.

Health plans and insurers are subject to various requirements in California, as stated in existing law above, including an obligation to file policies and procedures that describe UR or UM functions, used to authorize, modify, or deny health care services under the benefits provided by the health plan. Additionally, existing law requires these policies and procedures to ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes.

Furthermore, California law requires DMHC to conduct a routine medical survey of each licensed full service and specialty health plan at least once every three years. DMHC may also perform an investigative medical survey as often as deemed necessary by DMHC's Director. The medical survey is a comprehensive evaluation of the plan's compliance with the law in the following health plan program areas:

i) Quality Assurance;
ii) Grievances and Appeals (enrollee complaints);
iii) Access and Availability;
iv) UM (referrals and authorizations); and,
v) Overall plan performance in meeting enrollees' health care needs.

According to the Kaiser Family Foundation (KFF), insurers use PA to reduce payments for care that is not medically necessary or appropriate, which in turn helps to keep premiums down. However, PA has come under scrutiny for creating unnecessary burdens for providers, plans, and patients. Patients can find it challenging to know what services require PA, the process and criteria plans use to make a PA coverage decision, and whether providers are giving the needed information to a plan to determine coverage. Inefficient processes can delay decisions and consequently access to care, increasing health risks to patients. Improper denials may increase patient out-of-pocket costs or cause patients to abandon care. The process itself may have a chilling effect on individuals seeking out care and providers recommending it.

c) Industry efforts. In January 2018, America's Health Insurance Plans (AHIP) issued a Consensus Statement identifying that physicians, pharmacists, medical groups, hospitals, and health insurance providers are working together to improve PA processes for patients' medical treatments, also known as pre-approval. These groups acknowledge that this will help patients have access to safe, timely, and affordable care, while reducing administrative burdens for both health care professionals, hospitals and health insurance providers. According to the Consensus Statement, these health care leaders will work together to:

i) Reduce the number of health care professionals subject to PA requirements based on their performance, adherence to evidence-based medical practices, or participation in a value-based agreement with the health insurance provider;

ii) Regularly review the services and medications that require PA and eliminate requirements for therapies that no longer warrant them;

iii) Improve channels of communications between health insurance providers, health care professionals, and patients to minimize care delays and ensure clarity on PA requirements, rationale, and changes;

iv) Protect continuity of care for patients who are on an ongoing, active treatment or a stable treatment regimen when there are changes in coverage, health insurance providers or PA requirements; and,

v) Accelerate industry adoption of national electronic standards for PA and improve transparency of formulary information and coverage restrictions at the point-of-care.

In 2022, AHIP documented an update to improve PA processes and noted that increasing the adoption of electronic PA was one of the major opportunities identified for improving PA.

3) **ADMINISTRATIVE BURDEN**. According to information provided by the author, 88% of physicians rank PA as either a high or an extremely high administrative burden for their practice. This is not surprising given that physicians complete an average of forty-five PAs per week (averaging two days a week) on requests for medically necessary care that is ultimately approved a vast majority of the time. The author states that this extra administrative burden is a nuisance for physicians, but it is the patients who truly suffer, patients receive less attention from their providers because their time is used up on paperwork and the quality of care is decreased due to unnecessary delays or refusal to cover medically necessary treatments. According to the American Medical Association (AMA), the vast majority of physicians report that prior authorization causes negative health care outcomes, 93% of physicians report that prior authorization causes delays in care and 82% report it results in treatment abandonment by patients. Many physicians also report that PA causes more severe health care consequences including unnecessary hospitalization, permanent medical harm, and life-threatening events.

4) **OTHER STATES AND FEDERAL PROPOSALS**. According to the AMA, under Texas law, physicians who have a 90% prior authorization approval rate over a six-month period on certain services will be exempt, or "gold carded," from prior authorization requirements for those services. AHIP expressed concern in 2021 about the law in Texas in a statement

provided to *MedPage Today*, that gold carding may be targeted to specific services, and where used, provider performance can be regularly reviewed to ensure consistently high-quality care and patient safety, but the Texas law distorts this concept by mandating broad provider exemptions with no accountability from providers. Other states like Colorado allow carriers to offer providers with a history of adherence to the carrier's PA requirements at least one alternative to PA, including an exemption from PA requirements for a provider that has at least an 80% approval rate of PA requests over the immediately preceding 12 months and requires the carrier to re-evaluate the provider at least annually. Vermont requires insurers to implement a gold carding pilot program by January 15, 2022 and requires any plan with more than 1,000 covered lives to implement a pilot program that automatically exempts from or streamlines certain PA requirements for a subset of participating providers.

In February of this year, the Centers for Medicare and Medicaid Services issued a proposed rule designed to address the administrative hassles of PA by requiring certain payers to implement an automated process, meet shorter time frames for decision making, and improve transparency, according to the KFF. The proposal applies to payer processes mainly in public programs, with more limited application to health insurance marketplaces and no requirements on employer-sponsored coverage. The proposal launches the government's next step in addressing a longstanding goal to improve health care administration through "interoperable" systems based on the use of standardized protocols for payers and providers across federal health programs.

5) **SUPPORT**. The California Medical Association (CMA), sponsor, writes that this bill is a balanced approach that ensures physicians practice within the plan's criteria, while also allowing the physician to care for the needs of their patients without undue burden from health plans. CMA points out there are patient safety, fraud and waste protections built into the bill that are consistent with current practice and law. Additionally, there is a three year sunset and a report on the exemption program for prescriptions, to ensure there are no significant cost impacts to patients or misuse by physicians. Finally, a provider with a PA exemption cannot provide services that are outside of their general specialty or scope of practice. On average, physicians complete 45 PAs per week, taking nearly two working days (14 hours) out of the week to complete. Time spent on unnecessary bureaucracy like this is valuable time that could be better spent with patients in the exam room, coordinating care for patients with chronic conditions and increasing clinical time available to new patients. This bill is necessary to streamline a process that has led to significant patient care delays, worsened patient outcomes, increased health care costs, and bogged physicians down with administrative red tape. CMA concludes that in total, these reforms will allow physicians to practice medicine in the best interest of their patients without costly delays and undue interference from health plans.

6) **OPPOSE UNLESS AMENDED.** The Association of California Life and Health Insurance Companies (ACLHIC), states that the targeted attack on PA directed at Preferred Provider Organization products could not only lead to an increase in unnecessary and ultimately harmful patient services being authorized but will most certainly result in disparate treatment of enrollees/insureds based on the healthcare products they have access to. Furthermore, health plans and insurers act as stewards of the premium dollar and as such have an obligation to invest those dollars in proper and effective care. ACLHIC writes that if a provider meets the criteria in this bill, PA is waived for all services and most drugs rendered by the provider. This waiver would even apply to services that are associated with a high risk

of fraud, waste, and abuse. This would 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 12 month no-look back period. Additionally, this bill defeats an essential purpose of utilization management and obstructs the "right care, right place, right time" imperative. Broadly waiving PA could lead to clinically inappropriate prescribing, exposing our enrollees and insureds to potential harm by using a service or drug where there is little to no evidence of clinical benefit. Further, it could harm patients by allowing doctors to prescribe medication that could have a harmful interaction with another medication the patient is using – which is checked during the PA process. It will also increase waste through use of drugs with no evidence of clinical benefit. This outcome would be irresponsible from both a care and cost perspective.

ACLHIC with physician group partners at America's Physician Groups propose amendments to strike the appropriate balance of providing immediate relief to all enrollees/insureds while also protecting the integrity of the healthcare system as a whole. These amendments seek to set in place a universal standard by which all commercial plans/insurers would be required to evaluate and eliminate PA when appropriate. These amendments will ensure that all enrollees/insureds are treated equally and that both patients and providers will directly benefit from a streamlined process. Ultimately, the proposed amendments accomplish goals to help eliminate unnecessary administrative burdens while preserving the integrity of the system so that patients continue to receive appropriate high-quality care.

7) **OPPOSITION**. Local Health Plans of California (LHPC) writes that this bill makes it nearly impossible for plans to retract a PA exemption from a provider, it simply goes too far and fails to provide necessary safeguards. Additionally, recent amendments take this bill beyond the original scope to provide relief from PA for providers with good track records to categorically requiring removal of PA of services, items, and supplies with high approval rates. This bill does not account for how PA works in health plans today. PA serves as a tool to ensure that members are receiving medically necessary services, and it communicates information about the provider and requested service that is needed for health plans to pay a claim from a provider. It is not uncommon for a provider to order a service to be rendered by another provider. In this scenario, if the ordering provider has a PA exemption but the provider rendering the service does not, the plan will likely deny the claim submitted by the other provider because they would have no reason to know to pay it. Although the sponsors have indicated the PA exemption is not intended to apply to services ordered by exempted providers, LHPC believes the language of this bill, as written, would in fact apply in these circumstances. This bill routinely omits the term "medically necessary" when referring to the type of services that should be subject to PA exemption. Medical necessity is a cornerstone of health care and LHPC believes the addition of this language is clarifying yet critical. Health plans and providers share the responsibility of ensuring that members are receiving care that is medically necessary. The absence of this term throughout the bill is problematic. There are certain services, items and supplies that should never be included in a PA exemption because they have little to do with physician judgement and decision making. For example, certain DME such as prosthetics are ordered by a physician but all of the customization is determined by the DME company. This is one area that is rife for fraud, waste, and abuse because there are financial incentives for these companies to choose certain modifications. LHPC concludes that although the idea of streamlining PA has merits, this bill weakens provider oversight and creates operational complexities.

8) **RELATED LEGISLATION**. AB 931 (Irwin) prohibits a health plan or health insurance policy issued, amended, or renewed on or after January 1, 2025, that provides coverage for physical therapy from imposing PA for the initial 12 treatment visits for a new episode of care for physical therapy. Requires a physical therapy provider to verify an enrollee's or an insured's coverage and disclose their share of the cost of care, as specified. Requires a physical therapy provider to disclose if the provider is not in the network of the enrollee's plan or the insured's policy, and if so, to obtain the enrollee's or the insured's consent in writing to receive services from the noncontracting provider prior to initiating care. AB 931 is pending in the Senate Appropriations Committee.

9) **PREVIOUS LEGISLATION**.

   a) SB 250 (Pan) of 2022 would have prohibited a health plan or health insurer from requiring a contracted health professional to complete or obtain a PA for any health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent one-year contracted period; would have included brand name prescription drugs in the exemption request process until January 1, 2027; and, would have required DMHC or CDI to each conduct an analysis of the inclusion of brand name prescription drugs as a health care service and report its findings to the Legislature by July 1, 2026. SB 250 was held on suspense in the Assembly Appropriations Committee.

   b) AB 1268 (Rodriguez) of 2019 would have required a health plan or health insurer, on or before July 1, 2020, and annually on July 1 thereafter, to report to the appropriate department 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 suspense in the Assembly Appropriations Committee.

10) **AUTHOR'S AMENDMENTS.** The author is proposing the following amendments to address concerns in this bill:

   a) Delay implementation to 2026;

   b) Extend the inclusion of brand name drugs until January 1, 2029 from January 1, 2028, consistent with the delayed implementation;

   c) Excludes from prior authorization requirements, the UR used and submitted by health facilities, such as hospitals, skilled nursing facilities, long-term care facilities, and acute rehab facilities, used to track the ongoing appropriateness of care and confirm payment to the facilities from health plans or insurers;

   d) Allow for an appeal review to be performed by a health plan or insurer's contracted specialist reviewer, provided the reviewer is a licensed health professional of the same or similar specialty as the health professional seeking the appeal;

   e) Excludes PA that is delegated by a health plan or insurer to a risk bearing organization; and,

   f) Make other conforming changes, including to delay implementation of the DMHC and CDI reporting requirements.

11) POLICY COMMENTS.

a) Potential Implementation Issues. Given that other states are experiencing implementation issues with their gold card programs, and since there are no data to prove the effectiveness of these programs, it is unclear what challenges California and health plans would face when this bill is implemented.

b) Costs of appeals. This bill is currently silent as to which entity is financially responsible for the appeals cost of a denied gold card exemption. It should be noted that current law specifies for surprise balance billing claims dispute in AB 72 (Bonta), Chapter 942, Statutes of 2016, that the regulator establish reasonable and necessary fees for the purpose of administering independent dispute resolution process, to be paid by both parties. The Committee recommends that the appeal costs under this bill should also be borne by both parties.

c) Cost containment and Potential Unintended Consequences. The purpose of UR is that unnecessary care can be controlled, saving substantial amounts of money and improving quality of care. PAs are used to encourage the appropriate use of procedures and medications, to assist in the reduction of drug costs for all beneficiaries, and to promote safe and evidence-based utilization. Prohibiting the use of PA can increase health care costs and takes away protocols that are in place to prevent adverse outcomes. Concerns have been raised that this bill could negatively impact consumers, indirectly through increased and unnecessary administrative costs for health plans and insurers, which could be passed on to consumers, and lack oversight of their clinical decisions for a period. At this time, the impact on costs and to prescribing patterns as a result of the gold card program are unknown. Does this bill strike the appropriate balance between patient access to timely care and services and controlling unnecessary utilization of services?

REGISTERED SUPPORT / OPPOSITION:

Support

Albie Aware Breast Cancer Foundation
American College of Physicians California Services Chapter
American GI Forum Education Foundation of Santa Maria, CA
American Medical Association
Association for Clinical Oncology
Association of Northern California Oncologists
California Academy of Child and Adolescent Psychiatry
California Academy of Eye Physicians and Surgeons
California Academy of Family Physicians
California Chapter American College of Cardiology
California Chronic Care Coalition
California Council of Community Behavioral Health Agencies
California Health+Advocates, Subsidiary of The California Primary Care Association
California Life Sciences
California Medical Association
California Nurses Association
California Optometric Association
California Orthopedic Association

California Physical Therapy Association
California Podiatric Medical Association
California Radiological 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 Now
Children's Specialty Care Coalition
Chronic Disease Coalition
Connection Coalition
Everylife Foundation for Rare Diseases
Medical Oncology Association of Southern California
Mental Health America of California
National Multiple Sclerosis Society, MS-CAN
Nomi Health
Orange County Chapter of National Association of Pediatric Nurse Practitioners
Planned Parenthood Affiliates of California
Psychiatric Physicians Alliance of California
San Francisco Marin Medical Society
Steinberg Institute
The California Association of Local Behavioral Health Boards and Commissions
Western Center on Law & Poverty, INC.

Opposition

America's Health Insurance Plans
America's Physician Groups
California Association of Health Plans
California Chamber of Commerce
Cigna
Health Care LA IPA
Hill Physicians Medical Group
Local Health Plans of California
North East Medical Services
Santa Clara Family Health Plan

Analysis Prepared by: Kristene Mapile / HEALTH / (916) 319-2097