Date of Hearing: August 23, 2023

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Chris Holden, Chair
SB 598 (Skinner) – As Amended August 14, 2023

Policy Committee: Health Vote: 11 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill prohibits a health care service plan (health plan) or health insurer from requiring a contracted health professional to complete or obtain a prior authorization (PA) for any covered health services if the plan or insurer approved or would have approved at least 90% of the PA requests the health professional submitted in the most recent one-year contracted period (PA exemption).

This bill also:

1) Sets standards for exemption, denial, rescission, and appeal of the PA exemption.

2) Authorizes a health plan or insurer to evaluate the continuation of a PA exemption not more than once every 12 months, and to rescind an exemption only at the end of the 12-month period and only if specified criteria are met.

3) Requires a health plan or insurer to provide an electronic PA process.

4) Requires a health plan or insurer to have a process for monitoring PA approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue PA on those services, items, and supplies that are approved 95% of the time.

5) Applies a health professional's PA exemption 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.

6) 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 specified requirements.

7) 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.

8) Allows a health professional to appeal the decision to deny or rescind a PA exemption and requires the review be conducted by a health professional licensed in California in the same or similar specialty and who was not directly involved in making the initial denial or rescission of the exemption.

9) Applies provisions of this bill to a pharmacy benefit manager under contract with a health plan or insurer.

10) Requires the Department of Managed Health Care (DMHC) and 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. Requires DMHC and CDI to submit reports to the Legislature on or before July 1, 2029.

FISCAL EFFECT:

CDI estimates costs of $202,000 in fiscal year (FY) 2024-25 and $189,000 in FY 2025-26 and FY 2026-27 (Insurance Fund).

DMHC estimates costs to be approximately $4.4 million in FY 2023-24, $15.1 million in FY 2024-25, $13.9 million in FY 2025-26, $14.4 million in FY 2026-27, and $14.3 million in FY 2027-28 and annually thereafter (Managed Care Fund (MCF)).

COMMENTS:

1) **Purpose.** This bill is sponsored by the California Medical Association and the California Academy of Child and Adolescent Psychiatry. According to the author:

> 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 they've 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. Prior authorization also can cause serious adverse medical events, and even life-threatening or permanently impairing damage.
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> SB 598 will bar insurance companies from harming California patients solely for the purpose of protecting their bottom line.

2) **Background.**

PA. To manage health care costs, most payers use some type of utilization management, such as PA, which requires clinicians to obtain advance payment coverage approval from a health plan or insurer before providing a medication, procedure, service, medical device, or supply to a patient. PA requirements can be challenging for patients, health care providers who must spend time and resources to get approvals, and payers because of the effort to design and administer increasingly complex PA systems. The author indicates 88% of physicians rank PA as either a high or extremely high administrative burden for their practice, and physicians

complete an average of 45 PAs per week—averaging two days a week—on requests for medically necessary care that is ultimately approved a vast majority of the time.

"Gold Card" Programs. A "gold card" program is an audit-based system where PA is waived for a clinician who is deemed high-performing, meaning they regularly have prior authorizations approved, for a specified period of time. For example, Vermont's gold carding system for radiology procedures required a denial rate of 3% or less on at least 100 imaging requests in 18 months for gold card status. This bill requires a denial rate of 10% for a PA exemption or "gold card" status. Implementation of audit-based systems such as gold carding has been challenged by difficulties identifying high-performing clinicians with available data.

3) **Other Approaches.** Other strategies for streamlining PA include sunsetting PA requirements on therapeutics or services that are usually approved, as well as electronic PA, which appears to be faster, less expensive, and acceptable to physicians. Vermont requires insurers to implement a gold card 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 federal Centers for Medicare and Medicaid Services issued a proposed rule designed to address the administrative burden of PA by requiring certain payers to implement an automated process, meet shorter time frames for decision making, and improve transparency. 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.

4) **Prior Legislation**.

   a) SB 250 (Pan), of the 2021-22 Legislative Session, was substantially similar to this bill. SB 250 was held on this committee's suspense file.

   b) AB 1268 (Rodriguez), of the 2019-20 Legislative Session, would have required a health plan or insurer to report to the appropriate department the number of times in the preceding calendar year that it approved or denied each of 30 health care services for which PA was most frequently requested. AB 1268 was held on this committee's suspense file.

Analysis Prepared by: Allegra Kim / APPR. / (916) 319-2081