Date of Hearing: April 21, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1843 (Elhawary) – As Amended March 2, 2026

SUBJECT: Communicable diseases: hepatitis B and C.

SUMMARY: Prohibits a health plan or health insurer from subjecting direct-acting antiviral drugs that are medically necessary for the treatment of hepatitis C to prior authorization (PA), as specified. Specifically, **this bill**:

1) Prohibits a health plan or health insurer from subjecting direct-acting antiviral drugs that are medically necessary for the treatment of hepatitis C, including, but not limited to, sofosbuvir/velpatasvir, sofosbuvir/ledipasvir, glecaprevir/pibrentasvir, or elbasvir/grazoprevir, to PA, except for as provided in 2) below.

2) Permits, if the United States Food and Drug Administration (FDA) has approved one or more therapeutic equivalents of a drug, device, or product for the treatment of hepatitis C, a health plan or insurer to not cover all of the therapeutically equivalent versions without PA, if at least one therapeutically equivalent version is covered without prior PA.

3) Requires a health plan or insurers clinical criteria for hepatitis C treatment and PA to align with current guidelines and the standard of care consistent with the standards of the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America. Prohibits PA requirements, including, but not limited to, all of the following:

    a) A liver biopsy;

    b) Genotype testing;

    c) Sobriety requirements;

    d) Fibrosis staging thresholds;

    e) Elastography or FibroScan documentation;

    f) Ultrasound documentation; and,

    g) A specialist referral or evaluation.

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 California Department of Insurance (CDI) to regulate health and other insurance. [Health & Safety Code (HSC) § 1340, *et seq*. and Insurance Code (INS) § 106, *et seq*.]

2) Establishes California's essential health benefits (EHBs) benchmark under the Patient Protection and Affordable Care Act (ACA) as the Kaiser Small Group Health Maintenance Organization, establishes existing California health insurance mandates, and the 10 ACA

mandated benefits, including prescription drug coverage. [HSC § 1367.005 and INS § 10112.27]

3) Defines "basic health care services" as all of the following:

   a) Physician services, including consultation and referral;

   b) Hospital inpatient services and ambulatory care services;

   c) Diagnostic laboratory and therapeutic radiologic services;

   d) Home health services;

   e) Preventive health services;

   f) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. Basic health care services includes ambulance and ambulance transport services provided through the 911 emergency response system; and,

   g) Hospice care, as specified. [HSC § 1345 and INS § 10112.281]

4) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for utilization review (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 health plans and disability insurers and any contracted entity that performs UR or UM functions, prospectively, retrospectively, or concurrently, based on medical necessity requests to comply with specified requirements. [HSC § 1367.01 and INS § 10123.135]

6) Requires decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to be made in a timely fashion that does not to exceed five business days from the health plan or health insurer's receipt of the information reasonably necessary and requested by the plan to make the determination. Requires, in cases where the review is retrospective, the decision to be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and be communicated to the provider in a manner that is consistent with current law. [HSC § 1367.01 and INS § 10123.135]

7) Requires 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 enrollee or insured's condition, not to exceed 72 hours when an individual's condition is such that they face an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. [HSC § 1367.01 and INS § 10123.135]

8) Authorizes a health care provider or prescribing provider, enrollee, insured, or their designee or guardian to appeal a denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request consistent with the plan's or insurer's current UM process. [HSC § 1367.206 and INS § 10123.201]

9) Prohibits a health plan or insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of AIDS/HIV, including PrEP or PEP, to PA or step therapy. Permits a health plan or insurer not to cover all of the therapeutically equivalent versions without PA or step therapy, if at least one therapeutically equivalent version is covered without PA or step therapy, if the FDA has approved one or more therapeutic equivalents of a drug, device, or product for the prevention of AIDS/HIV. Limits coverage to a 60-day supply to a single patient once every two years, unless the pharmacist has been directed otherwise by a prescriber. [HSC § 1342.74 and INS § 10123.1933]

10) Excludes from health plan and insurer PA requirements specified covered health care service that have been approved by the plan or insurer 90% or more times as determined by DMHC and CDI after health plan and insurer reporting and evaluation by DMHC and CDI. [HSC § 1367.025 and INS § 10133.52]

11) Establishes the California Health Care Quality and Affordability Act, which creates the Office of Health Care Affordability (OHCA) within the Department of Health Care Access and Information (HCAI). Identifies OHCA's three primary responsibilities: managing spending targets, monitoring system performance, and assessing market consolidation. Requires OHCA to collect, analyze, and publicly report data on total health care expenditures, and enforce spending targets set by a Health Care Affordability Board (Board). [HSC § 127500, *et seq*.]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, hepatitis C is a life-threatening disease that disproportionately affects marginalized communities if left untreated, but it is highly curable, with modern treatments curing over 95% of infections. The author continues that this bill ensures health plans follow current medical guidelines and eliminate extra requirements that are not medically necessary for accessing treatment. The author concludes that by streamlining access to care, this bill helps prevent serious health complications, reduces transmission, saves lives, reduces long-term healthcare costs, and moves California closer to eliminating hepatitis C.

2) **BACKGROUND.** Hepatitis C is a liver disease caused by infection from the hepatitis C virus (HCV), which is transmitted through exposure to infected blood or bodily fluids containing infected blood. Acute hepatitis C occurs within the first 6 months of exposure to HCV; chronic hepatitis C occurs if acute hepatitis C is not recognized and treated and the virus is not cleared by the body within 6 months. Studies estimate that acute hepatitis C leads to chronic infection in most patients. HCV is primarily transmitted by sharing contaminated needles, syringes, or other equipment used to prepare or inject drugs; other risk factors for transmission include multiple sexual partners, nonprofessional tattoo or piercing, prior incarceration, workplace exposure to needle sticks, or being born to an HCV-infected person. Individuals with hepatitis C can develop cirrhosis (advanced, irreversible scarring of the liver that leads to liver failure), liver cancer, and other liver- and non-liver–related complications and are at increased risk of premature death. Based on Department of Public Health data from 2018 (the most recent statewide surveillance data available), the annual rate of newly reported cases of chronic hepatitis C is estimated at 89 cases per 100,000 population in California (about 35,500 cases), which is a 10% decrease from 2017.

   a) **California Health Benefits Review Program (CHBRP).** CHBRP was created in response to AB 1996 (Thomson), Chapter 795, Statutes of 2002, which requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost-sharing, premiums, and other health insurance topics to CHBRP's purview. CHBRP reviewed this bill and included the following impact estimates in their analysis:

      i) **Premium increases & enrollee out-of-pocket decreases.** Premiums paid by employers and enrollees would increase upon enaction of this bill by an estimated $708,000 ($0.0020-$0.0134 per member per month). This premium increase applies to all enrollees regardless of whether they use the benefit. Aggregate cost sharing among enrollees who use direct-acting antiviral drugs would decrease by $40,000.

      ii) **Increased utilization of care.** CHBRP estimates the treatment rate for enrollees diagnosed with hepatitis C would increase to 11%, leading to 34 additional enrollees receiving direct-acting antiviral drugs to treat hepatitis C. Of these newly treated enrollees, 95% are estimated to be cured, reducing average annual costs associated with clinical complications of untreated hepatitis C by $7,650 per enrollee.

      iii) **Medical effectiveness.** CHBRP determined there is very strong evidence that direct-acting antiviral drugs are effective at treating hepatitis C, with cure rates above 95% for most medications. There is strong evidence that there is no difference in effectiveness among different direct-acting antiviral drugs. There is some evidence that removing PA requirements leads to increased utilization of direct-acting antiviral drugs and not enough research to determine whether removing PA for direct-acting antiviral drugs improves health outcomes.

      iv) **Public health impacts.** CHRBP determined that this bill would produce no measurable short-term public health impact at the population level due to the small estimated increase in utilization. However, this bill would likely yield health and

quality-of-life improvements for the 34 additional enrollees using direct-acting antiviral drugs and the 342 enrollees avoiding pretreatment assessments no longer required under PA. Barriers related to cost sharing and access to screening and treatment may remain.

b) UM and UR. UM and UR are processes used by health plans to evaluate and manage the use of health care services. UR can occur prospectively, retrospectively, or concurrently and a plan can approve, modify, delay or deny in whole or in part a request based on its medical necessity. PA is a UR technique used by health plans that requires patients to obtain approval of a service or medication before care is provided. PA is intended to allow plans to evaluate whether care that has been prescribed is medically necessary for purposes of coverage. PA is one type of UM tool that's used by health plans, along with others such as concurrent review and step therapy, to control costs, limit unnecessary care, and evaluate safety and appropriateness of a service.

   i) **Overall impact of PA**. In 2023, CHBRP published a report to help the Legislature better understand the ways in which PA is used in California. CHBRP noted that PA is an imperfect instrument that is utilized in a myriad of ways. This poses a challenge for policymakers, payers, patients, and providers since PA is generally intended to decrease costs, but it may also contribute to delays in treatment and additional barriers to care. Currently, evidence is limited as to the extent to which health insurance uses PA and its impact on the performance of the health care system, patient access to appropriate care, and the health and financial interests of the general public. Despite the limited evidence, there is clear frustration from both patients and providers regarding PA practices. According to CHBRP, complaints range from the time required to complete the initial authorization request and pursue denials, to delays in care, to a general lack of transparency regarding the process and criteria used to evaluate PA requests. CHBRP further notes that people with disabilities, younger patients, African Americans, and people with lower incomes are more likely to report administrative burdens, including delays in care, due to PA.

c) OHCA cost targets. OHCA was established in 2022 in response to widespread cost-related access challenges across California. According to the California Health Care Foundation (CHCF), over half of Californians say they skip or delay health care due to costs. OHCA collects, analyzes, and publicly reports data on total health care expenditures and enforces spending targets. OHCA's spending targets are intended to reduce excess spending and slow health care spending growth. In April of 2024, OHCA approved a statewide cost growth target of 3.5% starting in 2025 and phasing down to 3% by 2029. Health care entities, including health plans and insurers, are subject to the statewide spending target and are subject to progressive enforcement if the entity's costs exceed the target. Some entities have raised concerns that new legislative insurance mandates will make it difficult for them to meet the established cost growth target.

Current law does not explicitly require OHCA to adjust the cost growth targets based on changes to state policy, such as insurance mandates, that may increase spending. However, it does require OHCA to consider state benefit mandates in its development and enforcement of cost growth targets. Specifically, when establishing cost growth target methodology, OHCA is required to review relevant state policy changes impacting covered benefits, provider reimbursement, and costs, among other factors. In addition, in

enforcing cost growth targets, OHCA is required to consider factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target.

3) **SUPPORT.** End Hep C SF supports this bill, stating that reducing barriers to HCV treatment access is essential to achieving elimination and ensuring people can access timely, and life-saving care. End Hep C SF notes that based on the clinical guidelines in this bill and cost-effectiveness analyses, the Department of Health Care Services has in recent years eliminated from the Medi-Cal Rx formulary all potential barriers to treatment, including PA requirements. In contrast, End Hep C SF states that many commercial health insurers selling policies in California do impose PA requirements on treatment. In addition, as part of their PA processes, many of these insurers request information or procedures that are no longer required for treatment. End Hep C SF shares the example that some insurers ask for the "genotype" (i.e., distinct genetic strain) of the patient's HCV, but current medications treat all genotypes. End Hep C SF continues that others request liver biopsies, which are not recommended before HCV treatment–but are costly and dangerous. End Hep C SF argues that requiring PA for HCV medications, and requesting unnecessary information or procedures as part of PA processes, often results in people with HCV not getting the treatment they need. End Hep C SF continues that the Legislature and Governor Newsom enacted Senate Bill 306 (Becker), Chapter 408, Statutes of 2025, in an effort to comprehensively reform PA. Unfortunately, End Hep C SF notes that bill does not apply to drugs in tier three or four of a health insurer's formulary, and current first-line treatments for HCV are all typically placed in those tiers. End Hep C SF argues that to solve the problem of PA for hepatitis C treatment, the Legislature must go one step further. End Hep C SF concludes that removing unneeded impediments to HCV treatment for Californians with commercial insurance—just as the state has done for Medi-Cal enrollees—will clear the way for people with HCV to get cured, lowering health care spending and bringing us closer to ending the HCV epidemic in the Golden State.

4) **OPPOSITION.** The California Association of Health Plans and Association of California Life Insurance Companies are opposed to this bill, stating that this bill can impact a plan's ability to manage healthcare spending at a time when healthcare spending is at an all time high. Additionally, the opposition notes that they are also concerned with the provision of the bill that requires health plans/insurers to align their clinical criteria with the standards set by the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America. The opposition notes that while guidelines can help establish the efficacy and safety of diagnostic testing or therapeutic interventions, codifying them into law is problematic because populations might differ and treatment evidence may evolve. Finally, the opposition continues to remain opposed to the high cost of prescription drugs, noting that cost of the drugs under this bill – which are a one time treatment – can be as high as $33,000. The opposition urges the Legislature, as they consider mandates that affect a health plan's/insurer's ability to manage costs, to take careful consideration of the significant costs associated with prescription drugs, which continue to be one of the primary drivers of health care spending.

5) **RELATED LEGISLATION.** AB 1887 (Zbur) would prohibit PA, step therapy, or any other UM for a drug approved for the treatment of a rare disease, as specified. AB 1887 is currently pending in the Assembly Health Committee.

6) PREVIOUS LEGISLATION.

a) SB 306 (Becker) excludes from health plan and insurer prior authorization requirements specified covered health care service that have been approved by the plan or insurer 90% or more times as determined by DMHC and CDI after health plan and insurer reporting and evaluation by DMHC and CDI.

b) AB 384 (Connolly) of 2025, would have prohibited a health plan, health insurer, or Medi-Cal from requiring PA for an individual to be admitted to medically necessary 24-hour inpatient settings for mental health and substance use disorders (SUDs) and for any medically necessary health care services provided to an individual while admitted for that care. AB 384 was held on the Assembly Appropriations Committee suspense file.

c) AB 510 (Addis) of 2025, would have required, upon request, an appeal or grievance regarding a decision by a health plan or health insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, to be reviewed by a peer physician or health care professional of the same or similar specialty as the requesting provider. AB 510 was held on the Assembly Appropriations Committee suspense file.

d) AB 512 (Harabedian) of 2025, would have required health plan and health insurer decisions based on medical necessity to approve, modify, or deny requests by providers prior to the provision of health care services to enrollees to be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 48 hours for standard requests, or 24 hours for urgent requests, from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. AB 512 was vetoed by Governor Newsom, who said in part:

"I strongly support the goal of improving the PA process. Accordingly, I recently signed SB 306 (Becker), which seeks to ensure that enrollees receive timely responses to requests for care by taking a holistic approach to improve the PA process. Under this new law, health plans and health insurers are required to submit data to DMHC and CDI, respectively, regarding the types of health care services subject to PA requirements. The departments must analyze the data and then issue a list of services that should not be subject to a PA requirement by 2027."

e) AB 539 (Schiavo) of 2025, would have required a PA for a health care service to remain valid for a period of at least one year from the date of approval. AB 539 is a two-year bill in the Senate Health Committee.

f) AB 574 (Mark González) of 2025, would have prohibited a health plan or health insurer that provides coverage for physical therapy (PT) from requiring PA for the initial 12 treatment visits for a new condition for PT. For a recurring condition, this bill would have allowed a health plan or insurer to impose PA if the individual seeks care within 180 days of their last physical therapy intervention for that condition. AB 574 was vetoed by Governor Newsom whose veto message was similar to that for AB 512.

g) AB 669 (Haney) of 2025, would have prohibited concurrent or retrospective review of medical necessity for the first 28 days of in-network inpatient SUD stay. Would have prohibited concurrent or retrospective review of medical necessity of in-network

outpatient SUD visits. Would have prohibited retrospective review of medical necessity for the first 28 days of in-network intensive outpatient or partial hospitalization SUD services, as specified. Would have prohibited PA for in-network coverage of medically necessary outpatient prescription drugs to treat SUD. AB 669 was held on the Senate Appropriations Committee suspense file.

h) SB 516 (Skinner) of 2024, would have required DMHC and CDI, by July 1, 2025, to issue instructions, including a standard reporting template, to health plans and insurers to report specified information, including all covered health care services, items, and supplies subject to PA. SB 516 was not heard in the Assembly Health Committee.

i) SB 598 (Skinner) of 2023, would have prohibited a health plan or insurer from requiring a contracted health professional to complete or obtain a 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 completed one-year contracted period. SB 598 was held on suspense in the Assembly Appropriations Committee.

j) SB 250 (Pan) of 2022 was similar to SB 598 and was held on suspense in the Assembly Appropriations Committee.

k) AB 1880 (Arambula) of 2022 would have required a health plan or insurer's UM process to ensure that an appeal of a denial, is reviewed by a clinical peer, as specified. 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 was vetoed by Governor Newsom who stated in part:

"Health plans and health insurers should make every effort to streamline UM 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."

l) 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.

REGISTERED SUPPORT / OPPOSITION:

Support

Aids Healthcare Foundation
American Academy of HIV Medicine California/Hawaii Steering Committee
Bartz-Altadonna Community Health Center

Beyond Aids Foundation
California Academy of Preventive Medicine
California Life Sciences Association
California STD/HIV Controller's Association - Executive Committee
Community Health Project LA
County Health Executives Association of California
End Hep C SF
Glide
Health Officers Association of California
Healthright 360
Insurance Commissioner Ricardo Lara / California Department of Insurance
Kedren Health
National Health Law Program
San Francisco Aids Foundation
Sunburst Projects
One individual

Opposition

Association of California Life & Health Insurance Companies
California Association of Health Plans
California Small Business Association

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