

ASSEMBLY THIRD READING

AB 1843 (Elhawary)

As Amended March 2, 2026

Majority vote

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.

COMMENTS

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.

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 essential health benefits (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:

- 1) *Premium increases & enrollee out-of-pocket decreases*. Premiums paid by employers and enrollees would increase upon enactment 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.
- 2) *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.

- 3) *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 prior authorization 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.
- 4) *Public health impacts.* CHBRP 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.

Utilization Management (UM) and Utilization Review (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.

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.

Office of Health Care Affordability (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.

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.

Arguments in 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 SB 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.

Arguments in 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.

FISCAL COMMENTS

According to the Assembly Committee on Appropriations:

- 1) Costs to the Department Insurance (CDI) of \$7,000 in fiscal year (FY) 2026-27 and \$19,000 in FY 2027-28 to review forms for compliance (Insurance Fund).
- 2) The Department of Managed Health Care (DMHC) anticipates minor and absorbable costs.
- 3) CHBRP estimates this bill would increase premiums for DMHC-regulated plans in the California Public Employees Retirement System (CalPERS) by \$38,000, of which about \$18,000 would be state General Fund costs. There would be additional General Fund costs for the CDI-regulated CalPERS insurance policies, possibly around \$10,000.
- 4) No costs to the Medi-Cal program.

VOTES

ASM HEALTH: 12-2-2

YES: Bonta, Addis, Aguiar-Curry, Ahrens, Caloza, Carrillo, Mark González, Patel, Rogers, Schiavo, Sharp-Collins, Stefani

NO: Johnson, Sanchez

ABS, ABST OR NV: Chen, Patterson

ASM APPROPRIATIONS: 10-2-3

YES: Wicks, Aguiar-Curry, Caloza, Fong, Mark González, Krell, Pacheco, Pellerin, Sharp-Collins, Solache

NO: Hoover, Tangipa

ABS, ABST OR NV: Arambula, Dixon, Ta

UPDATED

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CONSULTANT: Riana King / HEALTH / (916) 319-2097

FN: 0002482