SENATE COMMITTEE ON HEALTH
Senator Akilah Weber Pierson, Chair

BILL NO: AB 1843
AUTHOR: Elhawary
VERSION: June 8, 2026
HEARING DATE: June 24, 2026
CONSULTANT: Melanie Moreno

SUBJECT: Communicable diseases: hepatitis C

SUMMARY: Prohibits health plans and insurers from subjecting direct-acting antiviral drugs that are medically necessary for the treatment of hepatitis C to prior authorization.

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 and the California Department of Insurance (CDI) to regulate health insurers under the Insurance Code. [HSC §1340, et seq. and INS §106, et seq.]

2) Prohibits health plans/insurers from subjecting antiretroviral drugs that are medically necessary for the prevention of AIDS/HIV, including preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP), to prior authorization or step therapy, except that if the U.S. Food and Drug Administration (FDA) approves one or more therapeutic equivalents of a drug, device, or product for the prevention of AIDS/HIV, in which case health plans/insurers are only required to cover at least one therapeutically equivalent version without prior authorization or step therapy. [HSC §1342.74(a) and INS §10123.1933(a)]

3) Excludes, from health plan/insurer prior authorization requirements, health care services that have been approved by the plan/insurer 90% or more times, as determined by DMHC/CDI after evaluation of health plan and insurer reporting. This law does not apply to drugs that are on tier three or tier four of a health plan/insurer's formulary, and sunsets on January 1, 2034. [HSC §1367.025(c)(4) and INS §10133.52(c)(4)]

This bill:
1) Prohibits health plans/insurers from subjecting direct-acting antiviral (DAA) drugs, that are medically necessary for the treatment of hepatitis C, to prior authorization. Specifies that if the FDA has approved one or more therapeutic equivalents of a pangenotypic drug, device, or product for the treatment of hepatitis C, this bill does not require a health plan/insurer to cover all of the therapeutically equivalent versions without prior authorization, if at least one pangenotypic and therapeutically equivalent version is covered without prior authorization.

2) Requires health plan/insurers' clinical criteria for hepatitis C treatment and prior authorization to align with the 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 (AASLD-IDSA), or generally accepted clinical practice guidelines of another nonprofit health care provider professional association, or specialty society pertaining to clinical hepatology or infectious disease.

3) Prohibits health plans/insurers, for the purpose of determining prior authorization for hepatitis C treatment, from requesting:

a) A liver biopsy;
b) Genotype testing;
c) Proof of sobriety;
d) Fibrosis staging thresholds;
e) Documentation of elastography or other measures of liver stiffness;
f) Ultrasound documentation; or,
g) A specialist referral or evaluation.

FISCAL EFFECT: According to the Assembly Committee on Appropriations:

Costs to CDI of $7,000 in fiscal year (FY) 2026-27 and $19,000 in FY 2027-28 to review forms for compliance (Insurance Fund). DMHC anticipates minor and absorbable costs. California Health Benefits Review Program (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. No costs to the Medi-Cal program.

PRIOR VOTES:

Assembly Floor:	57 - 13
Assembly Appropriations Committee:	10 - 2
Assembly Health Committee:	12 - 2

COMMENTS:

1) *Author's statement.* 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) *Hepatitis.* 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. According to the Centers for Disease Control and Prevention (CDC), acute hepatitis C occurs within the first six 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 six months. According to the CHBRP review of this bill, studies estimate that acute hepatitis C leads to chronic infection in most patients (80% to 85%). The majority of individuals with acute and chronic hepatitis C are asymptomatic, and evidence suggests that one-third of people with hepatitis C are unaware of their infection status and can unknowingly transmit the virus to others. Studies estimate that on average one person with HCV infection transmits the virus to one to four other people. 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 woman. 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. Approximately two to four million people in the U.S. had hepatitis C. In 2023, the CDC found that there were 4,966 new reported cases of acute hepatitis C nationwide, but estimates new acute HCV infections at 69,000 after adjusting for underreporting. Based on California 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. According to 2023 CDC data, there were 11,194 deaths with hepatitis C listed as a cause of death in the U.S. (2.52 deaths per 100,000 population).

3) *Hepatitis C screening and treatment*. AASLD-IDSA, the CDC, and the U.S. Preventive Services Task Force recommend universal one-time HCV screening for adults aged 18 years and older. The purpose of antiviral treatment regimens for HCV infection is to prevent long-term health complications of chronic HCV infection. According to CHBRP, despite recommendations for universal HCV screening, studies have found delays in diagnosis and linkage to treatment for patients with HCV. A large national study published in the journal *Digestive Diseases* in September 2025 identified delayed diagnosis in 90% of patients with chronic hepatitis C, and 75% of patients experienced liver complications, despite availability of DAA treatment. This study also found that the majority of hepatitis C patients started DAA treatment after a liver complication had occurred, and only 6% of nondelayed diagnosis patients started DAA treatment more than two years before liver complications occurred. For individuals with HCV infection, the AASLD/IDSA guidelines include simplified HCV treatment algorithms for adults who have never been treated without cirrhosis. These simplified algorithms decrease requirements for pretreatment assessments for uncomplicated patients and are intended to be used by any health care provider knowledgeable about HCV treatment as long as they can consult a specialist if needed. The AASLD-IDSA guidelines recommend DAA treatment for all adults with acute or chronic HCV infection (except for individuals with short life expectancy). There are currently five DAA treatments available. Typical treatment duration is 8 to 12 weeks; some patients with decompensated cirrhosis receive treatment for 24 weeks. Three DAAs are pangenotypic (the treatments specified in this bill, applicable to any HCV genotype) and considered first-line treatment.

   Although the guidelines continue to recommend interventions and lifestyle changes to prevent further liver damage, they no longer condition initiation of antiviral therapy on abstinence from alcohol or sobriety testing, genotype testing, or other tests for cirrhosis. According to CHBRP, as guidelines have continued to evolve, prior authorization requirements have not kept pace with updated guidelines by continuing to require pretreatment assessments. Pretreatment assessments commonly required as part of prior authorization requirements include those prohibited under this bill.

4) *Prior authorization.* Prior authorization is a form of utilization review or utilization management. California 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. In 2023, at the request of the Legislature, CHBRP conducted a survey of California-regulated plans and insurers and found that overall, between 5% and 15% of all covered medical services, and between 16% and 25% of pharmacy benefits, were subject to prior authorization requirements. While there were significant differences among plans, some of the most frequently requested services and treatments were not necessarily the most expensive categories of treatments. Many under the

medical benefit were services or treatment for ongoing care, such as behavioral health services and physical, occupational, or speech therapies. Some were rare or more expensive, but with low utilization rates.

5) *SB 306 process.* A growing number of bills have been introduced over the past ten years to remove health plan and insurer prior authorization requirements for a variety of health care services and treatments. Last year the Legislature passed, and the Governor signed, SB 306 (Becker, Chapter 408, Statutes of 2025), which will exempt health care services that have high approval rates (90% or higher) from prior authorization by health plans and insurers. During the debate over SB 306, supporters stated that insurance companies frequently use prior authorization as a cost-control tool, but that it often results in delays or denials of essential treatments for patients. SB 306 set up a process by which high-approval services do not require prior authorization. In July 2026, plans and insurers began reporting information to their regulators about prior authorization approval rates, and regulators are required to publish a list of services that receive prior authorization at least 90% of the time. Beginning January 1, 2028, health plans and insurers will cease requiring prior authorizations for services with high approval rates as identified by the regulators. DMHC/CDI are also required to publish a report regarding the impact of the cessation of prior authorization requirements and include data on the volume of covered health care services subjected to prior authorization, statistics on prior authorization requests and determinations, administrative costs, timely access to care, enrollee health outcomes, and data on reinstatements of prior authorization.

   SB 306 allows health plans and insurers to continue prior authorizations on a variety of services, such as a novel application of existing therapy, services by an out-of-network or noncontracting provider, clear and convincing concerns about fraud or clinically inappropriate care, and services that are used differently from the use approved or cleared by the FDA. Additionally, outpatient drugs in Tier 3 or Tier 4 of a drug formulary are excluded from the SB 306 process. Tier 3 and Tier 4 drugs are defined in existing law as brand name drugs that generally have a preferred and less costly therapeutic alternative at a lower tier and specialty drugs. The drugs specified under this bill are Tier 3 and 4 drugs.

6) *CHBRP report.* AB 1996 (Thomson, Chapter 795, Statutes of 2002) 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. CHBRP was created in response to AB 1996 and reviewed this bill. Key findings include:
   a) Benefit Coverage. Among the 13.2 million enrollees with a state-regulated pharmacy benefit, CHBRP estimates 5.7 million enrollees (43%) are in plans or policies out of compliance with this bill due to prior authorization requirements, and 7.5 million enrollees (57%) are in plans or policies that are compliant. This bill would not exceed essential health benefits.
   b) Medical Effectiveness. There is very strong evidence that DAAs 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 DAAs. There is some evidence that removing prior authorization requirements leads to increased utilization of DAAs and not enough research to determine whether removing prior authorization for DAAs improves health outcomes.
   c) Cost Impacts. Among the 3,423 enrollees with a state-regulated pharmacy benefit that included prior authorization requirements at baseline who are diagnosed with hepatitis C

within the first year, approximately 10% (or 342 enrollees) would receive DAAs. Postmandate, these enrollees would avoid an estimated 924 pretreatment tests and services per year from the removal of prior authorization requirements, resulting in an annual estimated decrease of $346 in costs per enrollee. Furthermore, postmandate, CHBRP estimates the treatment rate for enrollees diagnosed with hepatitis C would increase to 11%, leading to 34 additional enrollees receiving DAAs to treat hepatitis C at a cost of $33,000 per course of treatment. 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, resulting in the change in their expenses to range from a decrease of $895 to an increase of $644 depending on the market segment and plan design. Total annual premiums would increase by $708,000, paid by employers and enrollees ($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 DAAs would decrease by $40,000.

d) Public Health Impacts. CHBRP projects no measurable 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 DAAs and the 342 enrollees avoiding pretreatment assessments no longer required under prior authorization. Barriers related to cost sharing and access to screening and treatment may remain.

e) Long-Term Impacts. Recent updates to HCV treatment guidelines have expanded eligibility, decreased requirements for testing and monitoring, and emphasized that HCV treatment can often be managed by nonspecialist providers. Increased uptake of the recently updated guidelines in conjunction with the removal of prior authorization is likely to increase the number of nonspecialists prescribing DAA therapy for patients with HCV infection, thereby increasing access to treatment and cure.

7) *Related legislation.* AB 1887 (Zbur) would prohibit prior authorization, step therapy, or any other utilization management for a drug approved for the treatment of a rare disease, as specified. *AB 1887 is set for hearing on July 1, 2026 in this Committee.*

8) *Prior legislation.* SB 306 (Becker, Chapter 408, Statutes of 2025) excludes, from health plan and insurer prior authorization requirements, health care services that have been approved by the plan or insurer 90% or more of the time, as determined by DMHC/CDI after evaluation of health plan and insurer reporting. SB 306 sunsets on January 1, 2034.

AB 554 (Gonzalez and Haney of 2025) would have prohibited nongrandfathered health plans (established by the federal Affordable Care Act) and insurance policies from imposing any cost-sharing for antiretroviral drugs, devices, or drug products that are approved by the FDA for PreP. AB 554 would have applied its provisions and the law it amends to an antiretroviral drug, drug device, or drug product regardless of whether or not it is self-administered. *AB 554 was vetoed by Governor Newsom, who stated, in part: "…certain components of this measure raise concerns about affordability. By exceeding the cost-sharing provisions under the ACA, this bill would result in increased costs to health plans, which would then be passed on to consumers. At a time when individuals are facing double-digit rate increases in their health care premiums across the nation, the state must weigh the potential benefits of all new mandates against the comprehensive costs to the entire health care delivery system."*

SB 339 (Weiner, Chapter 1, Statutes of 2024) permits a pharmacist to furnish up to a 90-day course of PrEP, or beyond 90-days if specified conditions are met. Requires a health

plan/insurer to cover PrEP and PEP furnished by a pharmacist, including costs for the pharmacist's services and related testing ordered by the pharmacist.

SB 159 (Weiner, Chapter 532, Statutes of 2019) prohibits health plans/insurers from requiring prior authorization or step therapy for PrEP or PEP, and requires coverage of pharmacist-prescribed PrEP and PEP. Prohibits health plans/insurers from covering PrEP furnished by a pharmacist in excess of a 60-day supply to a single patient once every two years, unless the pharmacist has been directed otherwise by a prescriber. Allows Medi-Cal reimbursement for pharmacists prescribing PrEP and PEP.

9) *Support.* San Francisco AIDS Foundation and End Hep C SF write that the definitive medical guidelines for hepatitis C treatment in the U.S., published by AASLD-IDSA, recommend timely treatment for almost all people living with HCV. The guidelines also note that treating hepatitis C is highly cost-effective. Treating hepatitis C saves the health care system money. This stands to reason: the cost of a single course of medication is much lower than the cost of treating a lifetime of complications like cirrhosis and liver failure (and the cost of treating one person with HCV is clearly lower than the cost of treating multiple people to whom the first person may otherwise transmit the virus). Supporters state that based on the AASLD-IDSA guidelines 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 prior-authorization requirements. In contrast, many commercial health insurers selling policies in California do impose prior authorization requirements on treatment. In addition, as part of their processes, many of these insurers request information or procedures that are no longer required for treatment. For example, some insurers ask for the "genotype" (i.e., distinct genetic strain) of the patient's HCV, but current medications treat all genotypes (i.e., are "pangenotypic"). Others request liver biopsies, which are not recommended before HCV treatment–but are costly and dangerous. Requiring prior authorization for HCV medications and requesting unnecessary information or procedures as part of their processes, often results in people with HCV not getting the treatment they need. Both surveys of providers and analyses of patient data indicate that prior authorization causes delays in care, treatment abandonment, and ultimately worse health. Many people with HCV have a history of injection drug use and/or incarceration, so may face a high level of instability in their lives. This puts them at elevated risk of falling out of care due to barriers such as prior authorization. About two thirds of people who have private insurance and are diagnosed with HCV do not successfully initiate treatment within 360 days; prior authorization is one reason why.

10) *Opposition.* The Association of California Life & Health Insurance Companies and California Association of Health Plans (ACLHIC/CAHP) writes that while they appreciate the intent of this bill, they oppose the provisions of the bill that would limit a health plan's/insurer's ability to conduct prior authorization. Just last year, the Legislature enacted SB 306, establishing a comprehensive regulatory process to evaluate the use of prior authorization and determine which services and medications should be exempt from those requirements. As part of that process, the Legislature specifically considered whether specialty drugs, particularly higher-cost Tier 3 and Tier 4 medications, should be exempt. Ultimately, they determined these medications should remain subject to prior authorization requirements. That decision reflected the significant costs associated with many of these medications and the important role prior authorization can play in helping ensure enrollees receive clinically appropriate treatment at the lowest available cost. By removing prior authorization requirements for certain drugs used to treat hepatitis C, this bill would deviate

from the Legislature's recent and deliberate policy decision to maintain utilization management safeguards for higher-cost specialty medications. Additionally, ACLHIC/CAHP remain concerned with the provision of the bill that would codify specific clinical criteria and treatment guidelines into statute. While clinical guidelines can help inform evidence-based care and establish the efficacy and safety of diagnostic tests or therapeutic interventions, codifying them into law is problematic because medical evidence and standards of care evolve over time. Guidelines are intended to support, not replace, individualized clinical decision-making, and patient needs may vary significantly from the populations on which the guidelines are based. As a result, statutory clinical requirements risk becoming outdated and may reduce the flexibility needed to incorporate new evidence and advances in care.

SUPPORT AND OPPOSITION:

Support: End Hep C San Francisco (co-sponsor)
San Francisco AIDS Foundation (co-sponsor)
Access Support Network
AIDS Healthcare Foundation
APLA Health
Beyond AIDS Foundation
Bienestar Human Services
California Academy of Preventive Medicine
California & Hawai'i Chapter of the American Academy of HIV Medicine
California LGBTQ Health and Human Services Network
California Life Sciences Association
California Medical Association
Community Health Project Los Angeles
County Health Executives Association of California
DAP Health
Drug Policy Alliance
GLIDE
Health Access California
Health Officers Association of California
HealthRIGHT 360
Insurance Commissioner Ricardo Lara / California Department of Insurance
Kedren Community Health Center
Liver Coalition of San Diego
National Health Law Program
Sunburst Projects

Oppose: Association of California Life & Health Insurance Companies
California Association of Health Plans

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