SB 306 (Becker) Proposed Amendments

Summary: The proposed amendments delete the current contents of this bill and instead insert the following: Requires the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), by July 1, 2026, to issue instructions to health plans and health insurers to report all covered health care services subject to prior authorization (PA). Requires health plans and health insurers, by December 31, 2026, to report to the DMHC and CDI respectively the covered health care services subject to PA, including the percentage rate at which they are approved or modified. Requires DMHC and CDI to evaluate the reports received and identify the health care services most frequently approved by health plans, health insurers, or their delegated entities. Permits DMHC and CDI to consider specified following factors (described in 11) below) when determining the appropriateness of removing PA for a specific covered health care service, regardless of its approval percentage rate. Prohibits a health plan or health insurer, as of January 1, 2028, from imposing PA on any covered health care service included on the list published by the DMHC or CDI. Requires the provisions of this bill to only apply to covered health care services ordered or prescribed by in-network providers. Continues to allow health plans and insurers to impose PA for certain covered health care services, such as outpatient prescription drugs in tier three and four of a plan or insurer's formulary, and a drug or medical device prescribed or recommended for a use that is different from the use for which the drug or medical device has been cleared or approved for marketing by the federal Food and Drug Administration (FDA). Requires DMHC and CDI to issue instructions on a process by which a health plan or health insurer may petition DMHC or CDI to reinstate the ability of health plan or health insurer to use PA for a particular covered health care service upon a showing of good cause, as specified. Permits a health plan or health insurer to reinstate PA for a specific health care provider only if the health plan or health insurer has determined, based on clear and convincing evidence, that the health care provider has engaged in either fraudulent activity or a pattern or practice of repeatedly providing care that is clinically inappropriate or inconsistent with generally accepted standards of care, and that results in either potential harm to patients or excessive utilization of health care resources inconsistent with generally accepted standards of care. Requires DMHC and CDI, no later than four years after the date determined by DMHC and CDI for cessation of PA requirements under this bill, to publish a report regarding the impacts of the cessation of PA requirements. Sunsets the provisions of this bill on January 1, 2034.
Specifically, this bill:

1) Requires DMHC and CDI, by July 1, 2026, to issue instructions to health plans and health insurers to report all covered health care services subject to prior authorization (PA), the percentage rate at which they are approved or modified by the health plan, health insurer, or its delegated entity, and other statistics regarding PA determinations as determined by DMHC or CDI.

2) Defines "PA" for purposes of this bill to mean:

   a) The process by which utilization review determines the medical necessity or medical appropriateness of otherwise covered health care services prior to or concurrent with the rendering of those health care services; and,

   b) A health plan, health insurer, or its delegated entity's requirement that an enrollee or health professional notify the health plan or insurer before providing a health care service, including preauthorization, precertification, and prior approval.

3) Defines "covered health care service" for purposes of this bill to mean any health care item, product, drug, supply, procedure, treatment, or service covered by a health plan contract or health insurance policy.

4) Requires the provisions of this bill to only apply to covered health care services ordered or prescribed by in-network providers.

5) Requires the instructions in 1) to include a standard reporting template.

6) Requires health plans and health insurers, by December 31, 2026, to report to the DMHC and CDI respectively, in accordance with the instructions issued above, the following:

   a) The covered health care services subject to PA;

   b) The percentage rate at which they are approved or modified by the health plan, health insurer, or its delegated entity; and,

   c) Data regarding requested or authorized duration, frequency, or level of care of the health care services, and other statistics regarding PA determinations.

7) Requires a health plan or health insurer, if the plan or insurer delegates responsibility for decisions regarding PA requests to another entity, the health plan or health insurer to obtain information required by this bill from each delegated entity, and to include that information in the health plan and health insurer report to DMHC and CDI respectively.

8) Requires health plans and health insurers to require delegated entities to comply with the above-described request.

9) Requires DMHC and CDI to evaluate the reports received and identify the health care services "most frequently approved" by health plans, health insurers, or their delegated entities.

10) Defines "most frequently approved" to mean approved or modified at a threshold rate determined by the DMHC or CDI, and prohibits a threshold rate from exceeding 90%.

11) Permits DMHC and CDI to consider the following factors when determining the appropriateness of removing PA for a specific covered health care service, regardless of its approval percentage rate:

   a) Utilization of a health care service in a manner inconsistent with current clinical practice guidelines published in peer-reviewed medical literature or federal FDA-approved

indications, as applicable;

b) The potential for fraud, waste, and abuse;

c) The potential for cost savings from eliminating prior authorization, including, but not limited to, out-of-pocket cost savings to the enrollee;

d) The potential for improvements in quality of care, health care outcomes, and timely access to care for enrollees from eliminating PA; and,

e) Other factors deemed appropriate by DMHC or CDI.

12) Requires DMHC and CDI, prior to finalizing the list of covered health care services under this bill, to consult with interested stakeholders.

13) Requires, by July 1, 2027, the DMHC and CDI to publish the list of covered health care services identified by health plans and insurers as the most frequently approved.

14) Prohibits a health plan or health insurer, as of January 1, 2028, from imposing PA on any covered health care service included on the list published by the DMHC or CDI.

15) Requires DMHC and CDI to issue instructions to health plans and health insurers regarding all of the following:

a) The date, no later than January 1, 2028, by which the health plan, health insurer, and its delegated entities are required to cease requiring PA for the covered health care services identified by DMHC and CDI;

b) Requires DMHC and CDI, when issuing the date by which a health plan, health insurer, and its delegated entities are required to cease requiring PA pursuant to this bill, to take into consideration the time necessary for plans and insurers to update their policies;

c) Requirements for notifying to providers of the change in PA; and,

d) The process by which a health plan or health insurer may petition DMHC or CDI to reinstate the ability of health plans or health insurer to use PA for a particular covered health care service upon a showing of good cause that a lack of PA for the covered health care service has resulted in a demonstrable increase in the cost of care or decrease in the quality of care for the health plan or health insurer's enrollees and subscribers, including, but not limited to, fraud, waste, or abuse.

16) Requires DMHC and CDI's determination on a petition to be made within 60 days of receipt of all information necessary for DMHC and CDI to issue a decision on the petition.

17) Prohibits a health plan or health insurer from reinstating PA for a covered health care service under this bill until authorized by the DMHC or CDI and in accordance with any other law,

as applicable.

18) Permits the Director of DMHC and the Commissioner of CDI to issue other instructions deemed necessary and appropriate, to implement this bill.

19) Continues to allow a health plan and health insurer to impose PA on any of the following:

    a) Outpatient prescription drugs in tier three and four of a health plan or health insurer's formulary, as those tiers are defined in existing law;

    b) A drug or medical device prescribed or recommended for a use that is different from the use for which the drug or medical device has been cleared or approved for marketing by the federal FDA;

    c) A health care service that is experimental or investigational, excluding services for which there is medical or scientific evidence, as that phrase is defined in existing law for purposes of the independent medical review process for experimental or investigational therapies for individual enrollees who have a life-threatening or seriously debilitating condition; and,

    d) A health care service that is prescribed or recommended for a use that is a novel application of an existing therapy or technology, excluding uses for which there is medical or scientific evidence, as that phrase is defined in existing law for purposes of the IMR process for experimental or investigational therapies for individual enrollees who have a life-threatening or seriously debilitating condition; and,

    e) A covered health care service delivered, furnished or dispensed by a non-contracted provider.

20) Requires a covered health care service that is exempted from PA pursuant to this bill to constitute a service authorized by the health plan or health insurer for purposes of a specified provision of existing law that prohibits plans and insurers from rescinding or modifying after the provider renders the health care service in good faith and pursuant to an authorization for any reason, including, but not limited to, the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility.

21) Prohibits a health plan, health insurer, or its delegated entity from denying or reducing the contracted or agreed upon payment, or the applicable rate or reimbursement methodology specified in a plan or insurer contract, for a covered health care service exempted from PA under this bill unless the provider failed to substantially perform or supply the covered health care service.

22) Permits a health plan or health insurer, in accordance with any other applicable law, to reinstate PA for a specific health care provider only if the health plan or health insurer has determined, based on clear and convincing evidence, that the health care provider has

engaged in either of the following:

a) Fraudulent activity related to the provision or billing of health care services; or,

b) A pattern or practice of repeatedly providing care that is clinically inappropriate or inconsistent with generally accepted standards of care, and that results in either potential harm to patients or excessive utilization of health care resources inconsistent with generally accepted standards of care.

23) Exempts from the requirements of this bill:

a) A specialized health plan or health insurance policy, except to the extent the plan or insurer provides or administers essential health benefits pursuant to health plan contracts or health insurance policies; and,

b) A Medi-Cal managed care contract with the Department of Health Care Services under the Medi-Cal program.

24) Permits DMHC and CDI to contract with a consultant or consultants with expertise in this subject area to assist DMHC or CDI in implementing this bill, including but not limited to developing instructions, evaluating the reports received by DMHC or CDI, developing and publishing a list of exemptions from PA, developing other implementation instructions, and drafting the report required pursuant to this bill.

25) Requires DMHC and CDI's contract with a consultant to include conflict-of-interest provisions to prohibit a person from participating in any report in which the person knows or has reason to know they have a material financial interest, including, but not limited to, a person who has a consulting or other agreement with a person or organization that would be affected by the results of the report.

26) Requires contracts entered into pursuant to the authority in this bill to be exempt from specified provisions of the Government Code and Public Contract Code, and exempt from the review or approval of the Department of General Services.

27) Requires DMHC and CDI, no later than four years after the date determined by DMHC and CDI for cessation of PA requirements under this bill, to publish a report regarding the impacts of the cessation of PA requirements.

28) Requires health plans and health insurers to report information and data regarding the impact of implementing this bill for inclusion in the report, including:

a) Effects on the volume of covered health care services subjected to PA;

b) Statistics on PA requests and determinations;

c) Administrative costs;

d) Timely access to care;

e) Enrollee health outcomes;

f) Data on reinstatement of PA on individual health care providers to be included in this report.

29) Permits DMHC and CDI to implement, interpret, or make specific this bill by means of all-plan letters, methodologies, rules, definitions, policies, forms, information or data requests, or similar instructions, without taking regulatory action pursuant to the Administrative Procedure Act.

30) Requires DMHC and CDI to consult with each other before issuing instructions under this bill.

31) Prohibits a health care service plan from delegating the requirements of this bill to a delegated provider, pharmacy benefit manager, or other entity, unless the parties have negotiated and agreed upon a new provision to the parties' contract, as provided in a specified section of existing law. Requires a change to the parties' contract under this provision to be considered a material change. Requires a health plan to comply with this bill, notwithstanding any delegation authorized.

32) Sunsets the provisions of this bill on January 1, 2034.