April 9, 2021

Honorable Senator Anthony Portantino
Chair, Senate Committee on Appropriations
California State Capitol
Sacramento, CA

RE: Senate Bill 250 – Support

Dear Chair Anthony Portantino,

The Arthritis Foundation encourages your support of Senate Bill 250. This bill would reform the prior authorization process by authorizing the Department of Managed Health Care and the Insurance Commissioner to review a plan's or insurer's clinical criteria, guidelines, and utilization management policies to ensure compliance with existing law. If the criteria and guidelines are not in compliance with existing law, the bill would require the Director of the Department of Managed Health Care or the commissioner to issue a corrective action and send the matter to enforcement. The bill would require each department, on or before July 1, 2022, to develop a methodology for a plan or insurer to report the number of prospective utilization review requests it denied in the preceding 12 months. In addition, SB 250 would require a health plan or insurer to reimburse a contracting individual health professional the in-network cost-sharing amount for services provided to an enrollee or insured at a contracting health facility. The bill would also require a plan or insurer and its delegated entities, on or before January 1, 2023, and annually thereafter, to report, among other things, its average number of denied prospective utilization review requests. The bill would require, on and after January 1, 2023, a plan or insurer to examine an individual health professional's record of prospective utilization review requests during the preceding 12 months and grant the individual health professional "deemed approved" status for 2 years, meaning an exemption from the prospective utilization review process, if specified criteria are met. Lastly, Senate Bill 250 would authorize a plan or insurer to request an audit of a physician's an individual health professional's records after the initial 2 years of an individual health professional's deemed approved status and every 2 years thereafter, and would specify the audit criteria by which an individual health professional would keep or lose that status.

In a December 2020 survey by the American Medical Association [1], almost 70% of 1,000 practicing physicians surveyed reported that health insurers had either reverted to past prior authorizations policies or never relaxed these policies in the first place. More than nine in 10 physicians (94%) reported care delays while waiting for health insurers to authorize necessary care, and nearly four in five physicians (79%) said patients abandon treatment due to authorization struggles with health insurers. Patients surveyed by the Arthritis Foundation in 2017, then again in following years, indicated that prior authorization was one of the top two most burdensome insurance issues.

Typically, physicians must fill out a prior authorization form whenever they prescribe a specialty medication or treatment that is restricted or not covered under an insurance carrier's formulary.

[1] https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf

Many patients seeking medication vital to their arthritis treatment are held up by prior authorization, a process in which a physician must submit tedious paper work before writing a prescription. As a result, prior authorization typically causes lengthy delays in treatment, thereby restricting a person's access to vital care.

The Arthritis Foundation was proud to be on the steering committee, alongside the American Medical Association, in establishing "Prior Authorization and Utilization Reform Principles."[2] Amongst these principles was that health plans should offer providers/practices at least one physician-driven, clinically based alternative to prior authorization, such as but not limited to "gold-card" or "preferred provider" programs or attestation of use of appropriate use criteria, clinical decision support systems or clinical pathways. Prior authorization requirements are a burdensome way of confirming clinically appropriate care and managing utilization, adding administrative costs for all stakeholders across the health care system. Health plans should offer alternative, less costly options to serve the same functions.

Senate Bill 250 is a piece of a larger examination of utilization management protocols this session by this legislature. The theme throughout each of these reforms is to strike a balance between ensuring that patients receive their care in a timely manner and health care professionals are not overly burdened with insurance protocols, while still ensuring that health plans have their ability to employ cost control measures.

On behalf of the more than 5.7 million people in California with arthritis, the Arthritis Foundation strongly urges the Senate Committee on Appropriations to support SB 250.

Sincerely,

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CC: Members, Senate Committee on Appropriations

[2] Association, A. M. (n.d.). *Prior Authorization and Utilization Management Reform Principles*. Retrieved from https://www.ama-assn.org/system/files/2019-06/principles-with-signatory-page-for-slsc.pdf