SENATE COMMITTEE ON PUBLIC SAFETY

Senator Jesse Arreguín, Chair
2025 - 2026 Regular

Bill No:	AB 2593	**Hearing Date:**	June 23, 2026
Author:	Elhawary		
Version:	February 20, 2026		
Urgency:	No	**Fiscal:**	Yes
Consultant:	ML		

Subject: ***Corrections: treatment of prisoners***

HISTORY

Source: Union of American Physicians and Dentists, AFSCME Local 206

Prior Legislation: AB 1424 (C. Rodriguez), held Assembly Appropriations, 2025
AB 701 (Ortega), held in suspense, 2025
AB 280 (Holden), died on Assembly Floor, 2023
AB 353 (Jones-Sawyer), Ch. 429, Stats. of 2023
AB 2321 (Jones-Sawyer), Ch. 781, Stats. of 2022
AB 2632 (Holden), vetoed, 2022

Support: ACLU California Action; American Federation of State, County and Municipal Employees, AFL-CIO; California Public Defenders Association; Ella Baker Center for Human Rights; GRIP Training Institute; San Quentin Skunkworks

Opposition: None known

Assembly Floor Vote: 78 - 0

PURPOSE

The purpose of this bill is to prohibit the California Department of Corrections and Rehabilitation (CDCR) from denying medically necessary health care prescribed by a licensed health care provider.

Existing law establishes the position of Secretary of CDCR and vests the Secretary with responsibility for the care, custody, treatment, training, discipline, and employment of persons confined in state prisons. (Pen. Code, § 5054.)

Existing law authorizes CDCR to provide medically and psychologically necessary services, including prescreening for mental disorders, competency evaluations related to classification hearings, and evaluations relating to parole determinations. (Pen. Code, § 5058.5.)

Existing law requires the Director of Corrections to maintain psychiatric and diagnostic clinics within state correctional institutions staffed by licensed mental health professionals. States that these clinics are responsible for conducting evaluations and studies of incarcerated individuals, including their life history, causes of criminal behavior, and recommendations for treatment, training, and rehabilitation, subject to approval by the director. (Pen. Code, § 5079.)

Existing law requires that patients be provided an opportunity to report an illness or any other health problem and receive an evaluation of the condition and medically necessary treatment and follow-up by health care staff. (Cal. Code Regs., tit. 15, § 3999.206.)

Existing law defines "medically necessary" as health care services that are determined by the attending or primary medical, mental health, or dental care provider to be needed to protect life, prevent significant illness or disability, or alleviate severe pain, and are supported by health outcome data or clinical evidence as being an effective health care service for the purpose intended—or in the absence of available health outcome data is judged to be necessary and is supported by diagnostic information or specialty consultation. (Cal. Code Regs., tit. 15, § 3999.98.)

Existing law defines "health care services" as medical, mental health, dental, pharmaceutical, diagnostic, and ancillary services to identify, diagnose, evaluate, and treat a medical, mental health, or dental condition. (Cal. Code Regs., tit. 15, § 3999.98.)

Existing law defines "health care provider" as a Medical Doctor, Doctor of Osteopathy, Doctor of Podiatric Medicine, Clinical Psychologist, Dentist, Clinical Social Worker, Nurse Practitioner (NP), or Physician Assistant (PA). (Cal. Code Regs., tit. 15, § 3999.98.)

Existing law defines "health care staff" as those persons licensed by the state to provide health care services, who are employed by CDCR or are working under direct or indirect contract with CDCR to provide health care services. (Cal. Code Regs., tit. 15, § 3999.98.)

Existing law defines "licensed medical provider" to mean Chief Medical Executive, Deputy Medical Executive, Chief Physician and Surgeon, Physician and Surgeon, NP, PA, Nurse Anesthetist, Podiatrist, and Specialty Consultant Practitioners. (Cal. Code Regs., tit. 15, § 3999.98.)

Existing law requires CDCR to provide patients with the health care services that are medically necessary. (Cal. Code Regs., tit. 15, § 3999.200(a).)

Existing law states that medically necessary health care services may be subject to approval or disapproval by the licensed medical, mental health, or dental care supervisors, or one or more of the following committees including subcommittees thereof:

- Institutional Utilization Management (UM) Committee.
- Headquarters UM Committee.
- Statewide Medical Authorization Review Team.
- Dental Authorization Review Committee.
- Dental Program Health Care Review Committee. (Cal. Code Regs., tit. 15, § 3999.200(a).)

Existing law states that treatment refers to attempted curative health care services and does not preclude palliative therapies to alleviate serious debilitating conditions such as pain management and nutritional support. (Cal. Code Regs., tit. 15, § 3999.200(b).)

Existing law prohibits CDCR from providing the following:

- Treatment for conditions that improve on their own without treatment.
- Treatment for conditions that are judged to inadequately respond to treatment including, but not limited to, the following: temporomandibular joint dysfunction; shrinkage and atrophy of the bony ridges of the jaws; benign root fragments whose removal would cause greater damage or trauma than if retained for observation; benign oral lesions; traumatic oral ulcers; or recurrent aphthous ulcers.
- Treatment for conditions that are cosmetic.
- Surgery that is not medically necessary including, but not limited to, the following: vasectomy; tubal ligation; extractions of asymptomatic teeth or root fragments unless required for a dental prosthesis or for the general health of the patient's mouth; removal of a benign bony enlargement (torus) unless required for a dental prosthesis; or surgical extraction of asymptomatic un-erupted teeth.
- Treatment that has no established outcome on morbidity or improved mortality for acute health care conditions including, but not limited to, the following: root canals on posterior teeth (bicuspids and molars); dental implants; fixed prosthodontics (dental bridges); laboratory processed crowns; or orthodontics. (Cal. Code Regs., tit. 15, § 3999.200(b)(1)-(5).)

Existing law authorizes that excluded treatment may be provided in cases where the following criteria are met:

- The patient's attending or primary medical, mental health, or dental care provider(s) prescribes the treatment as medically necessary; and
- The treatment is approved by the Dental Authorization Review Committee and the Dental Program Health Care Review Committee for dental treatment, or the institutional UM Committee and the headquarters UM Committee for medical or mental health treatment. The decision to approve an otherwise excluded treatment shall be based on available health care outcome data or clinical evidence supporting the effectiveness of the treatment. (Cal. Code Regs., tit. 15, § 3999.200(c)(1)-(2).)

Existing law requires that all terminally ill patients remaining in CDCR custody receive health care appropriate and necessary to their situation, including counseling, hospice and palliative care. (Cal. Code Regs., tit. 15, § 3999.200(d).)

Existing law prohibits patients in the custody of CDCR from being provided aid-in-dying drugs, as specified. (Cal. Code Regs., tit. 15, § 3999.200(d).)

Existing law prohibits CDCR employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under the End of Life Option Act on CDCR premises managed by or under the direct control or management of CDCR or while acting within the course and scope of any employment by, or contract with, CDCR. (Cal. Code Regs., tit. 15, § 3999.200(d).)

Existing law requires that each CDCR facility maintain contractual arrangements with local off-site agencies for those health services deemed to be medically necessary, as defined, and that are not provided within the facility. States that such services may include medical, surgical, laboratory, radiological, dental, and other specialized services likely to be required for a patient's health care. (Cal. Code Regs., tit. 15, § 3999.200(e).)

Existing law authorizes, when medically necessary services are not available for a patient within a facility, the facility's Chief Medical Executive or Supervising Dentist to request the institution head's approval to temporarily place that patient in a community medical facility for such services. (Cal. Code Regs., tit. 15, § 3999.200(f).)

Existing law authorizes that, in an extreme emergency when a physician is not on duty or immediately available, the senior custodial officer on duty may, with assistance of on-duty health care staff, place a patient in a community medical facility. Requires that such emergency action be reported to the facility's administrative and medical officers-of-the-day as soon as possible. (Cal. Code Regs., tit. 15, § 3999.200(g).)

This bill prohibits a supervisor, administrator, or employee of CDCR from knowingly interfering with or refusing to implement health care prescribed or determined to be medically necessary by a licensed health care provider acting within the scope of their licensure that results in substantial emotional distress or serious bodily injury.

This bill defines "serious bodily injury" as a serious impairment of physical condition, including, but not limited to, the following: loss of consciousness; concussion; bone fracture; protracted loss or impairment of function of any bodily member or organ; a wound requiring extensive suturing; and serious disfigurement.

COMMENTS

1. Need for This Bill

The author writes:

> For far too long, the voices of our incarcerated patients and the medical professionals who care for them have been pushed aside. Doctors and providers inside our prisons are often prevented from exercising their professional judgment[.] We have seen where that leads. It's one of the reasons California's prison health care system ended up in federal receivership in the first place—because medical decisions were being ignored and providers were forced to practice in ways that didn't serve their patients.
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> AB 2593 is about fixing that. It's about making sure the people trained to provide care can actually do their jobs and make decisions based on current medical standards. When we incarcerate someone, we take the responsibility of their care. The least we can do is make sure the professionals responsible for that care are able to practice medicine the way it's meant to be practiced.

2. Health Care at CDCR Facilities

In 2001, a class-action lawsuit, later renamed *Plata v. Newsom*, was filed in federal court contending the state violated the Eighth Amendment of the U.S. Constitution prohibiting cruel and unusual punishment by providing inadequate medical care in the state's prisons. The court found, among other problems, that the CDCR prison medical system was poorly managed; provided inadequate access to medical care; had deteriorating facilities and disorganized medical record systems; and lacked sufficient qualified physicians, nurses, and administrators to deliver

medical services.[1] The court concluded that, on average, one person died every week in state prisons and that many more had been injured by the lack of reliable access to quality medical care.[2] In addition, a federal three-judge panel in 2009 ruled that the state must reduce prison overcrowding as it was the primary reason that CDCR was unable to provide adequate health care, which was upheld by the U.S. Supreme Court.

Today, after a number of reforms, about 90,000 people are incarcerated in California prisons, down from a peak of about 170,000.[3] The state spent about $1.3 billion from the General Fund—about $7,400 per person in prison—on medical care in 2005-06, adjusted for inflation. In contrast, the state spent about $3.3 billion (more than double) and $32,700 per person (four times more) in 2021-22.[4] Additionally, the number of prison health care positions (including medical staff such as doctors and nurses) per person in prison has dramatically increased. Specifically, CDCR staffing of health care positions has increased from about 3 positions for every 100 people in prison in 2005-06 to about 15 positions for every 100 people in 2021-22.[5]

Despite these improvements, CDCR still faces significant challenges related to its mental health care services.[6] As a result, a series of federal court orders—in the case now known as *Coleman v. Newsom*—have directed the state to make various changes, including reducing vacancy rates below 10 percent in certain key mental health classifications. However, CDCR has struggled to meet this standard for various reasons, including the challenging working conditions at prisons and the limited pool of providers where prisons are located. In September 2025, the court—citing, in part, the ongoing failures to reduce vacancies—established a mental health Receivership "to take control of the delivery of mental health services."[7]

The Legislative Analyst's Office has recommended, despite the appointment of the Receiver, the Legislature continue to exercise oversight over the delivery of prison mental health, track progress towards exiting the mental health Receivership, direct CDCR to take additional steps to address mental health vacancies (such as increasing the use of tele-mental health), and monitor the impact of the recent salary increases for CDCR mental health staff implemented by the Receiver.[8]

3. Public Employment Relations Board Decision Regarding CDCR Substance Use Treatment

In September of 2018, the Receiver directed the California Correctional Health Care Services (CCHCS) to implement a Medication-Assisted Treatment (MAT) program for inmates with substance-use disorders (SUD). CCHCS developed a plan to do so as part of an overall Integrated Substance Use Disorder Treatment program (ISUDT). The 2019-2020 state budget

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[1] Legislative Analyst's Office, *Overview and Update on the Prison Receivership* (Nov. 8, 2023) <https://lao.ca.gov/Publications/Report/4813> [as of June 13, 2026]
[2] *Ibid.*
[3] Cayla Mihalovich, *California shrank prisons with resentencing changes. A new study shows how that's working*, CalMatters (Sept. [Day], 2025) <https://calmatters.org/justice/2025/09/california-prisons-recidivism-study/> [as of June 13, 2026].
[4] *Overview and Update on the Prison Receivership, supra,* at note 1.
[5] *Ibid.*
[6] Legislative Analyst's Office, *Addressing Chronic Vacancies in Prison Mental Health Care* (Feb. 23, 2026) <https://lao.ca.gov/Publications/Report/5134> [as of June 13, 2026]
[7] *Ibid.*
[8] *Addressing Chronic Vacancies in Prison Mental Health Care*, *supra*, at note 5.

allocated $71.3 million to the ISUDT program, and the 2020-2021 budget allocated $161.9 million to the program.[9]

The primary SUD medication for inmates in the ISUDT and MAT programs is Suboxone, often prescribed for inmates with opioid use disorder. At this time, providers lacking waivers from the federal Drug Enforcement Agency could not prescribe Suboxone beyond three-day "bridge" orders. CDCR required all primary care providers to participate in implementation of the program. Physicians expressed that they did not have the necessary education and training at the time to be able to prescribe medications like Suboxone across the board, yet were required to by CDCR policy. They argued that in the past, mental health professionals had primarily overseen treatment for SUD and patients' other mental health needs; CCHCS significantly changed duties and increased workload by requiring primary care providers to take on primary responsibility for SUD, a complex, immediately life-threatening mental health condition.[10]

In 2022, the California Public Employment Relations Board (PERB) ruled that CDCR and CCHCS violated labor laws when implementing statewide substance use treatment initiatives.[11] Specifically, the Board ruled that CDCR made unilateral changes by forcing unionized providers—represented by the Union of American Physicians and Dentists, AFSCME Local 206, also the sponsors of this bill—to implement the ISUDT program and MAT program at CDCR facilities, without bargaining with the union as legally required, thereby increasing workloads without implementing pay increases.

4. Effect of This Bill

This bill prohibits a supervisor, administrator, or employee of CDCR from knowingly interfering with or refusing to implement health care prescribed or determined to be medically necessary by a licensed health care provider acting within the scope of their licensure that results in substantial emotional distress or serious bodily injury.

This bill defines "serious bodily injury" as a serious impairment of physical condition, including, but not limited to, the following: loss of consciousness; concussion; bone fracture; protracted loss or impairment of function of any bodily member or organ; a wound requiring extensive suturing; and serious disfigurement. Notably, this bill does not define "substantial emotional distress." If someone has a panic attack in CDCR custody because they have an SUD and do not have access to Suboxone, is that "substantial emotional distress"? The author and Committee may consider defining this term to avoid unconstitutional vagueness and lack of clarity when implementing the law.

Existing CDCR regulations require that patients be provided an opportunity to report an illness or any other health problem and receive an evaluation of the condition and medically necessary treatment and follow-up by health care staff. (Cal. Code Regs., tit. 15, § 3999.206.) "Medically necessary" means health care services that are determined by the attending or primary medical, mental health, or dental care provider to be needed to protect life, prevent significant illness or disability, or alleviate severe pain, and are supported by health outcome data or clinical evidence as being an effective health care service for the purpose intended—or in the absence of available health outcome data is judged to be necessary and is supported by diagnostic information or

[9] PERB Decision No. 2823-S.
[10] PERB Decision No. 2823-S.
[11] PERB Decision No. 2823-S.

specialty consultation. (Cal. Code Regs., tit. 15, § 3999.98.) Medically necessary health care services may be subject to approval or disapproval by CDCR's licensed medical, mental health or dental care supervisors, as specified. (Cal. Code Regs., tit. 15, § 3999.200(a).)

5. Argument in Support

The American Federation of State, County and Municipal Employees, AFL-CIO writes:

> AB 2593 establishes an important safeguard by making clear that supervisors, administrators, or employees of CDCR may not knowingly interfere with or refuse to implement treatment that has been prescribed or determined to be medically necessary by a licensed health care provider acting within the scope of their licensure when doing so results in serious harm. This protection reinforces a fundamental principle of health care: medical decisions should be made by qualified medical professionals based on clinical judgment and patient needs.
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> In correctional settings, physicians and psychiatrists must often navigate institutional pressures, operational constraints, and administrative oversight while still upholding their professional and ethical obligations to provide appropriate care. When non-medical personnel interfere with treatment decisions, it can jeopardize patient safety, undermine the professional integrity of medical providers, and expose the state to significant legal and financial risk.
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> By ensuring that licensed medical professionals retain authority over medically necessary care, AB 2593 helps strengthen the integrity of the correctional health care system and supports providers in fulfilling their duty to deliver appropriate treatment. This clarity in law will help protect both patients and physicians and psychiatrists who care for them.

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