SENATE COMMITTEE ON APPROPRIATIONS
Senator Anna Caballero, Chair
2025 - 2026 Regular Session

AB 512 (Harabedian) - Health care coverage: prior authorization

Version: July 14, 2025
Urgency: No
Hearing Date: August 18, 2025
Policy Vote: HEALTH 9 - 0
Mandate: Yes
Consultant: Agnes Lee

Bill Summary: AB 512 would revise the timelines for health plans and insurers to make utilization review decisions.

Fiscal Impact:

- The Department of Managed Health Care (DMHC) estimates costs of approximately $314,000 in 2025-26, $689,000 in 2026-27, $671,000 in 2027-28, $951,000 in 2028-29, and $944,000 in 2029-30 and annually thereafter for state operations (Managed Care Fund).

- The California Department of Insurance (CDI) estimates costs of $9,000 in 2025-26 and $21,000 in 2026-27 for state operations (Insurance Fund).

- Unknown potential cost pressures to capitation payments for Medi-Cal managed care plans for administration (General Fund and federal funds).

Background: Current law authorizes health plans and insurers to use prior authorization, which is a form of utilization review or utilization management, to determine whether to authorize, modify, or deny health care services. Utilization review can occur prospectively, retrospectively, or concurrently, and a health plan or insurer can approve, modify, delay or deny in whole or in part a request based on its medical necessity. California law requires written policies and procedures that are consistent with criteria or guidelines and supported by clinical principles and processes. These policies and procedures must be filed with regulators, and disclosed, upon request, to providers, enrollees/insureds, and the public.

Current law requires health plans and insurers to make prior or concurrent authorization decisions, not to exceed 5 business days from the plan's/insurer's receipt of the information reasonably necessary and requested by the plan/insurer to make the determination. For urgent requests, such as when an enrollee/insured faces an imminent and serious threat to the enrollee's/insured's health, prior or concurrent authorization decisions must be made in a timely fashion, not to exceed 72 hours after the plan's/insurer's receipt of the information reasonably necessary and requested by the plan/insurer to make the determination.

Proposed Law: Specific provisions of the bill would:

- Revise the timeline for health plans and insurers to make prior or concurrent authorization decisions, to no more than 3 business days from the plan's/insurer's

receipt via electronic submission, or 5 business days from the plan's/insurer's receipt via submission that is not electronic, of the information reasonably necessary and requested by the plan/insurer to make the determination.

- Revise the timeline for health plans and insurers to make prior or concurrent authorization decisions for urgent requests, to no more than 24 hours from the plan's/insurer's receipt via electronic submission, or 48 hours from the plan's/insurer's receipt via submission that is not electronic, of the information reasonably necessary and requested by the plan/insurer to make the determination.

Related Legislation: SB 306 (Becker) would, among other provisions, require a health plan or insurer to cease requiring prior authorization for the most frequently approved covered health care services. The bill is currently in the Assembly Appropriations Committee.

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