CONCURRENCE IN SENATE AMENDMENTS
AB 512 (Harabedian)
As Amended September 5, 2025
Majority vote

SUMMARY

Shortens the decision timeline for prior or concurrent authorization requests for health plans and health insurers to be no longer than three business day for standard requests (instead of five days in existing law) if the request is made by electronic submission, and 24 hours for urgent requests involving an imminent and serious threat to the enrollee's health if the request if made by electronic submission or 48 hours (instead of 72 hours in existing law). Requires Medi-Cal managed care plan (MCMC) plan contracts with the Department of Health Care Services (DHCS) to meet the prior and concurrent authorization timeframes, rather than the faster turnaround timeframes required by this bill.

Senate Amendments

1) Apply the shortened timeframe of three business days for standard requests and 24 hours for urgent requests to authorization requests submitted electronically.

2) Define "electronic submission" to mean submission through an electronic portal designated by the health plan or health insurer, or an electronic submission in accordance with the California Health and Human Services Data Exchange Framework and applicable federal interoperability rules.

3) Require MCMC plan contracts with DHCS to meet the existing law prior and concurrent authorization timeframes.

COMMENTS

Prior authorization is a form of utilization review or utilization management. Utilization review can occur prospectively, retrospectively, or concurrently, and a 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, plans, and enrollees or insureds. There are timelines in the law for plans and insurers to respond to requests once any medical information that is reasonably necessary to make the determination is provided (as described in the summary above). Under this bill, the current law requirements would still apply to MCMC and Program of All-Inclusive Care for the Elderly (PACE) plans, and this bill does affect the existing prescription drug prior authorization requirements.

In 2023, at the request of the Legislature, the California Health Benefits Review Program (CHBRP) conducted a survey of California-regulated plans and insurers and found overall, between 5% and 15% of all covered medical services, and between 16% and 25% of pharmacy benefits, were subject to prior authorization requirements. CHBRP's survey of state regulated health plans and insurers shows the average time for a manual prior authorization by phone, mail, or fax in 2022 was 100-120 hours (medical benefit) and 30.5-55 hours for pharmacy benefit. For electronic prior authorizations in 2022 the average response time was 12-46 hours (medical benefit) and 31-69 hours for pharmacy benefit.

According to the Author
Delays in prior authorization create unnecessary barriers to timely medical care, leading to worsened patient outcomes, increased healthcare costs, and provider burnout. The author continues that this bill ensures that health insurers make prior authorization decisions within three business days instead of five days for standard requests submitted electronically, and 24 hours (if submitted electronically) instead of 48 hours for urgent cases, reducing delays that prevent patients from receiving necessary treatment. The author concludes that by streamlining the process, the bill improves access to care, lowers avoidable health care expenses, and allows providers to focus on patient needs.

Arguments in Support
The California Medical Association (CMA), sponsor of this bill, states that burdensome PA processes contribute to more adverse effects on patient care outcomes, especially when they result in delays in treatment. CMA continues that adding to these delays are the sluggish response times by health plans to prior authorization requests. CMA states that California currently has some of the slowest response timelines in the nation – 5 business days for non-urgent requests and 72 for urgent requests. CMA argues that these slow-moving response times lead to delays that negatively impact patient health. CMA continues that current prior authorization timelines are inadequate for many patients, and delays can cause unnecessary suffering, increased healthcare costs due to complications from postponed treatment, and administrative burdens on physicians. CMA concludes that by shortening response timelines, this bill ensures that health plans respond to a prior authorization request in a timelier manner, avoiding unnecessary delays to crucial medical care that have resulted in unnecessary pain, the worsening of patients' illnesses and in some cases even death.

Arguments in Opposition
America's Health Insurance Plans (AHIP) believes shortened PA timeframes are not the right approach. AHIP says almost half of PA requests are submitted manually. AHIP launched an initiative to understand the impact of electronic prior authorization that demonstrated faster time to patient care, faster time to decision, and improved information for providers. AHIP says insurance plans have recently announced a series of commitments to streamline and simplify prior authorization, including standardizing electronic prior authorization with a new framework operational and available to plans and providers by January 1, 2027. By 2027 for all coverage types of signatory plans at least 80% of prior authorizations will be answered in real-time. The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Physician Groups propose an alternative to this bill that would mandate all request be submitted electronically, require all necessary information to make an appropriate determination which means plans and insurers can answer at least 80% in real time, and the effective date should be delayed to allow providers sufficient time to comply with electronic submission requirements.

FISCAL COMMENTS

According to the Senate Appropriations Committee:

1) The Department of Managed Health Care 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).

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

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

VOTES:

ASM HEALTH: 13-0-3
YES: Bonta, Addis, Aguiar-Curry, Rogers, Carrillo, Mark González, Krell, Patel, Celeste Rodriguez, Sanchez, Schiavo, Sharp-Collins, Stefani
ABS, ABST OR NV: Chen, Flora, Patterson

ASM APPROPRIATIONS: 12-0-3
YES: Wicks, Arambula, Calderon, Caloza, Dixon, Elhawary, Fong, Mark González, Hart, Pacheco, Pellerin, Solache
ABS, ABST OR NV: Sanchez, Ta, Tangipa

ASSEMBLY FLOOR: 68-1-10
YES: Addis, Aguiar-Curry, Ahrens, Alanis, Alvarez, Arambula, Ávila Farías, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Connolly, Davies, Dixon, Elhawary, Fong, Gabriel, Gallagher, Garcia, Gipson, Jeff Gonzalez, Mark González, Haney, Harabedian, Hart, Hoover, Irwin, Jackson, Kalra, Krell, Lee, Lowenthal, McKinnor, Muratsuchi, Nguyen, Ortega, Pacheco, Papan, Patel, Pellerin, Petrie-Norris, Quirk-Silva, Ramos, Ransom, Celeste Rodriguez, Michelle Rodriguez, Rogers, Blanca Rubio, Sanchez, Schiavo, Schultz, Sharp-Collins, Solache, Soria, Stefani, Valencia, Wallis, Ward, Wicks, Wilson, Zbur, Rivas
NO: DeMaio
ABS, ABST OR NV: Castillo, Chen, Ellis, Flora, Hadwick, Lackey, Macedo, Patterson, Ta, Tangipa

UPDATED

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