SENATE COMMITTEE ON HEALTH
Senator Akilah Weber Pierson, Chair

BILL NO: AB 539
AUTHOR: Schiavo
VERSION: April 28, 2025
HEARING DATE: July 1, 2026
CONSULTANT: Teri Boughton

SUBJECT: Health care coverage: prior authorizations

SUMMARY: Requires a health plan's or insurer's prior authorization to remain valid for at least one year from the date of approval, or throughout the course of prescribed treatment, if less than one year.

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Services Plan Act of 1975; the California Department of Insurance (CDI) to regulate health and other insurers; and, the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [HSC §1340, et seq., INS §106, et seq., and WIC §14000, et seq.]

2) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services to:
   a) Be developed with involvement from actively practicing health care providers;
   b) Be consistent with sound clinical principles and processes;
   c) Be evaluated, and updated if necessary, at least annually;
   d) If used as the basis of a decision to modify, delay, or deny services in a specified case review, be disclosed to the provider and the enrollee or insured in that specified case; and,
   e) Be available to the public upon request. [HSC §1363.5 and INS §10123.135]

3) Requires health plans and insurers, and any contracted entity that performs utilization review or utilization management functions, prospectively, retrospectively, or concurrently, based on medical necessity requests to comply with specified requirements, including a decision within five business days of receiving reasonable information to make a decision, conducting retrospective review within 30 days and decisions associated with imminent and serious threat within 72 hours or sooner. [HSC §1367.01 and INS §10123.135]

4) Prohibits any individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, from denying or modifying requests for authorization of services for an enrollee or insured for reasons of medical necessity. Requires the decision to be communicated to the provider within 24 hours of the decision, and the enrollee or insured (in writing) within two business days of the decision. In the case of concurrent review, prohibits discontinuance of care until the treating provider has been notified and has agreed to a care plan that is appropriate for the medical needs of the patient. [HSC §1367.01 and INS §10123.135]

5) Establishes requirements for health plans and insurers that use an artificial intelligence (AI), algorithm, or other software tool for utilization review or utilization management functions, and prohibits the AI, algorithm, or other software tool from denying, delaying, or modifying health care services based in whole or in part on medical necessity. [HSC §1367.01 and INS §10123.135]

6) Prohibits a health plan that authorizes a specific type of treatment by a provider from rescinding or modifying this authorization after the provider renders the health care service in good faith and pursuant to the 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. [HSC §1371.8 and INS §796.04]

7) Excludes, from health plan or insurer prior authorization requirements, covered health care services that have been approved by the plan/insurer 90% or more times, as determined by DMHC or CDI after reporting and evaluation. Excludes outpatient drugs that are on tier three or tier four of a health plan or insurer's formulary, drugs or devices recommended for a use different from what the federal Food and Drug Administration has cleared or approved, experimental or investigational services, services prescribed for novel applications, or services provided through an out-of-network provider. Sunsets on January 1, 2034. [HSC §1367.025 and INS §10133.52]

This bill: Requires a prior authorization to remain valid for at least one year from the date of approval, or throughout the course of prescribed treatment if less than one year.

FISCAL EFFECT: According to the Assembly Appropriations Committee, minor and absorbable costs to DMHC and CDI.

PRIOR VOTES:

Assembly Floor:	64 - 2
Assembly Appropriations Committee:	11 - 0
Assembly Health Committee:	12 - 0

COMMENTS:

1) *Author's statement.* According to the author, while prior authorization delays and denials continue to climb, so too does the harm to patients. What's worse, insurance companies are looking to AI to speed up the denial process while suggesting it leads to positive patient outcomes, and increased safety and affordability. The data is clear, insurers are using prior authorization to deny care and boost profits. Instead, this bill reduces health care administrative costs and speeds up patient care by extending the duration of an approved prior authorization by a health plan to one year or the duration of a physician's prescribed treatment. This approach will remove unnecessary bureaucratic delays, reduce the burden on physicians and patients, and help prevent lapses in vital life-saving care, especially for those with chronic illnesses, due to having to seek frequent approval for their care. This is one step that California can take to re-center patients, as opposed to health insurance profits, and reduce the harm caused by prior authorization delays.

2) *Prior authorization.* Prior authorization is a form of utilization review or utilization management. 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. 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. While there were significant differences among plans, some of the most frequently requested services and treatments were not necessarily the most expensive categories of treatments. Many under the medical benefit were services or treatment for ongoing care, such as behavioral health services and physical, occupational, or speech therapies. Some were rare or more expensive, but with low utilization rates.

Most Frequently Requested Services as Reported by Plans/Insurers

Medical Benefit	**Pharmacy Benefit**
Durable Medical Equipment	Adrenergic Medications (nerve stimulants)
Imaging (i.e., magnetic resonance imaging, computed tomography)	Antimigraine Agents
Behavioral Health Services	Diabetic Supplies
Mental Health Services	Central Nervous System (CNS) Agents – Attention-deficit/hyperactivity disorder (ADHD)
Therapy (physician therapy/occupational therapy, speech therapy)	Amphetamines
Outpatient Surgical Procedures	Antiobesity Agents – Incretin mimetics (mimic natural hormones)
Genetic Testing	Dermatological Agents
Home Care Training, Family; per session	Lipid Agents
Sleep Studies	Blood Glucose Regulators – Incretin mimetics
Referral for Acupuncture	Anti-inflammatory Tumor Necrosis Factor Inhibitor
Referral for Pediatrics	Opioid Analgesics
Psychological Tests and Evaluation Services	Sleep Disorder Agents
Referral for Psychiatry	Immunological Agents (for rheumatoid arthritis, psoriasis, atopic dermatitis, inflammatory bowel disease, etc.)
Referral for Neurology	Hematopoietic (blood) Agents/modifiers
Referral Pain Management	Sexual disorder Agents
Referral Maxillofacial, Temporomandibular Joint Syndrome	Androgenic Agents
Referral Plastic Surgery	Anticonvulsants
Referral Cardiology	Antineoplastic (cancer drugs)
Referral General Surgery	Gastrointestinal Agents
Referral Radiation Therapy	Sodium-glucose Co-Transport 2

	Inhibitors
Evaluation and Management of Established Patient in an Office or Outpatient Location	Human Interleukin 12/23 Inhibitors, Monoclonal Antibody
Gastrointestinal Endoscopy	Ophthalmic Agents
Echocardiography Procedures	CNS Agents – Botulinum Toxin, Multiple Sclerosis Agents
Referral Ophthalmology External	Local Anesthetics - Topical
Referral Hematology Oncology External	Antivirals, HIV-Specific
Referral Rheumatology External	Treatment for ADHC/Narcolepsy
Non-compounded Foam Sclerotherapy	Respiratory Tract/pulmonary Agents
Referral Family Practice	Topical Immunosuppressive Agents
Referral Dermatology	Cardiovascular Agents
	Topical Antiandrogenic Agents (prostate cancer)

CHBRP, October 11, 2023

3) *Validity period of Authorization.* CHBRP found, based on its survey results, that most prior authorization approvals remain valid for approximately six months or more before requiring recertification/approval. Responses ranged from four to six months to 12 to 24 months. CHBRP requested information from plans/insurers on whether prior authorization approvals for chronic or long-term conditions remain valid for longer periods of time. Plans either did not provide responses to this question or did not specifically have a policy separated out for these conditions.

4) *SB 306 Process.* Concerns about prior authorization's effectiveness, administrative burden, and patient outcomes led the Legislature to pass SB 306 (Becker, Chapter 408, Statutes of 2025), which exempts health care services that have over 90% approval rates from prior authorization by health plans and insurers. In July 2026, plans and insurers will begin reporting information to their regulators about prior authorization approval rates. DMHC and CDI will publish a list of services that receive prior authorization approval at least 90% of the time, and beginning January 1, 2028, health plans and insurers will no longer require prior authorizations for those services. Regulators are also required to publish a report on the impact of the elimination of prior authorization, including data on prior authorization requests and determinations, the volume of covered health care services subjected to prior authorization, administrative costs, timely access to care, enrollee/insured health outcomes, and data on reinstatements of prior authorization.

5) *Related legislation.* AB 1843 (Elhawary) would prohibit health plans and insurers from subjecting direct-acting antiviral drugs that are medically necessary for the treatment of hepatitis C to prior authorization. *AB 1843 is set for hearing on August 3, 2026 in the Senate Appropriations Committee.*

   AB 1887 (Zbur) would require prior authorization or utilization review for prescription drugs prescribed for the treatment of a rare disease to be complete within 30 days of the initial request by a provider. Requires approval of the prescription if the 30-day timeline is not met due to an unresolved decision or dispute. Prohibits step therapy for prescription drugs for the treatment of a rare disease if the drug is prescribed by a specialist with expertise in the

condition or disease being treated and the specialist has determined the drug is medically necessary, unless a biosimilar, interchangeable biologic or generic is available. *AB 1887 is set for hearing on July 1, 2026 in this Committee..*

6) *Prior legislation.* SB 306 (Becker, Chapter 408, Statutes of 2025) excludes covered health care services that have been approved by the plan/insurer 90% or more times from health plan or insurer prior authorization requirements, as determined by DMHC or CDI after reporting and evaluation.

AB 512 (Harabedian of 2025) would have shortened the decision timeline for prior or concurrent authorization requests for health plans and health insurers to be no longer than three business days for standard requests, or 24 hours for urgent requests, if the request is made by electronic submission. *AB 512 was vetoed by Governor Newsom, who stated, in part: "I strongly support the goal of improving the PA process. Accordingly, I recently signed SB 306 (Becker), which seeks to ensure that enrollees receive timely responses to requests for care by taking a holistic approach to improve the PA process… I am concerned that this bill's significantly shortened deadlines may inadvertently increase the number of denials and force health care plans to make critical decisions with incomplete or inaccurate information. I believe SB 306 is a more balanced approach to improve the PA system as a whole, alleviate burdens for providers, and improve patient outcomes in the long term.".*

AB 574 (Mark González) would have prohibited a health plan or insurer that provides coverage for physical therapy from requiring prior authorization for the initial 12 physical therapy treatments for a new episode of care. *AB 574 was vetoed by Governor Newsom, who stated, in part: "Prior authorization, when applied appropriately, is a crucial tool for containing healthcare costs, protecting patients from unanticipated billing, and ensuring patients receive medically necessary care. Further, existing law requires health plans to provide appointments within a timely access minimum standard, even when prior authorization is required. I support the author's goals of improving the PA process and ensuring that enrollees receive timely responses to requests for physical therapy. To this end, I recently signed SB 306 (Becker), which provides a more comprehensive solution to improve the PA process. This new law will require health plans and health insurers to submit data to the California Department of Managed Health Care and the California Department of Insurance, respectively, regarding the types of health care services subject to PA requirements, and require the departments to analyze the data and then issue a list of services that should not be subject to a PA requirement. This approach strikes a reasonable balance that will lead to improved transparency in the PA system as a whole, alleviate burdens for providers, and ultimately enhance patient outcomes. It would be premature to establish limitations on the use of PA, as proposed by this bill, until SB 306 is fully implemented."*

SB 516 (Skinner of 2024) would have: required DMHC and CDI to issue instructions, including a standard reporting template, to health plans and insurers to report specified information, including all covered health care services, items, and supplies subject to prior authorization; required health plans and insurers to report that information to DMHC or CDI, and would have required DMHC and CDI to evaluate the reports received; required DMHC and CDI, after evaluating the reports, to identify and to publish a list of the most frequently approved or modified services, items, and supplies no longer subject to prior authorization, and how a health plan and insurers could reinstate prior authorization upon a showing of good cause; required DMHC and CDI, within four years of the end date of the prior

authorization requirements, to publish a report of those requirements; and, exempted specialized health plans and insurers, except to the extent the plans provide or administer essential health benefits, health plans contracting with DHCS, or a nonprofit health plan with at least 3.5 million enrollees. *SB 516 was not heard in the Assembly Health Committee.*

SB 598 (Skinner of 2023) would have prohibited a health plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered services if the plan or insurer approved or would have approved at least 90% of the requests the health professional submitted in the most recent one-year contracted period. *SB 598 was held on the Assembly Appropriations Committee suspense file.*

SB 250 (Pan of 2022) would have prohibited a health plan or insurer from requiring, for a period of two years, a contracted health care provider to obtain prior authorization for any health care services if the health plan or insurer approved, or would have approved, at least 90% of the prior authorization requests that a provider submitted in the most recent one-year contracted period. SB 250 would have required a health plan or insurer to include physician representation in developing prior authorization criteria, provided that a physician has the right to have an appeal of a prior authorization decision conducted by a physician of the same or similar specialty, and prohibited a health plan or insurer from requiring a physician to file an appeal challenging an adverse result of a prior authorization request before filing an independent medical review. *SB 250 was held on the Assembly Appropriations Committee suspense file.*

7) *Support.* According to this bill's sponsor, the California Medical Association (CMA), this bill ensures that physicians do not have to resubmit the same claim for services, especially surgeries. CMA writes, "Many conditions require ongoing treatment plans that benefit from strict adherence. Recurring prior authorization requirements can lead to disruptions in care delivery and threaten a patient's health. According to the American Medical Association survey, 88% of physicians said that prior authorizations interfere with continuity of care for patients. Even more troubling is that 78% of physicians reported that prior authorization can lead to treatment abandonment altogether, inevitably leading patients to seek more expensive forms of care, including emergency room visits and even unexpected hospitalization. The current standard for an approved prior authorization request is about 60 to 90 days. This standard leads to physicians having to submit multiple requests for the same services, even when the treatment plan has not changed since the initial claim. Adding to the frustration of physicians and patients is that identical claims submitted weeks apart will have different outcomes – one that is approved while the other is denied. These arbitrary delays disrupt a patient's treatment plan and interfere with continuity of care." The ALS Association writes "For individuals living with ALS, timely and consistent medical care is critical. ALS is a progressive neurodegenerative disease that leads to significant loss of mobility and independence. Patients require ongoing access to treatments, medications, and medical equipment to maintain their quality of life. However, the current prior authorization system forces patients and providers to repeatedly seek approval for the same necessary care, creating unnecessary delays and barriers that disrupt continuity of treatment." The California Academy of Child and Adolescent Psychiatry writes, "Currently, providers, families, and patients can face disruptions in essential care when prior authorizations expire prematurely or are otherwise rescinded. This is especially concerning in the context of mental health treatment, where continuity of care is paramount for children and adolescents. For many patients, a break in coverage for medications, therapy sessions, or other crucial interventions can result in a relapse or a deterioration of mental health. By guaranteeing year-long validity,

this bill helps eliminate repeated paperwork, administrative confusion, and needless gaps in treatment so that health care providers can focus on what matters most—caring for their patients." The California Association of Medical Product Suppliers (CAMPS) provides a hypothetical example where a patient with chronic obstructive pulmonary disease is stabilized on home oxygen therapy but delays in prior authorization renewal cause the patient's condition to deteriorate and lead to an emergency department visit. Another example from CAMPS is a patient with type one diabetes who is stable on a continuous glucose monitoring system but a required renewal of prior authorization causes a delay that causes the patient to experience multiple hypoglycemic episodes, including one that results in an emergency room visit. CAMPS writes reducing administrative hurdles associated with prior authorization allows providers to deliver timely, appropriate care, improving outcomes for patients and reducing costs associated with preventable emergencies.

8) *Support if amended.* The California Optometric Association (COA) would like this bill to apply to specialized health plans and insurance policies because patients with chronic eye diseases such as glaucoma, diabetic retinopathy, and macular degeneration currently face interruptions that can lead to permanent vision loss. COA writes this would prevent patients with long-term eye conditions from having to repeatedly reapply for treatment approval, preventing dangerous treatment lapses. The California Chiropractic Association also requests this amendment.

9) *Oppose unless amended.* America's Physician Groups (APG) writes that this bill "expands all authorizations for one year, regardless of type, patient safety implications, or impact on affordability in the health care system. Sound medical practice indicates that care authorizations should be tied to/limited to the patient's eligibility, not a statutory timeline unaligned with the care needs of the patient. A reauthorization process allows for the re-evaluation of the necessity and value in continued authorization. Authorizations that are not "unit specific", creating a year-long authorization term would allow patients to render most services multiple times a year, even if the intent of the authorization was a single use. For example: if an MRI is approved, it is approved for one MRI, not 38 MRIs in the same year. In the opinion of our chief medical officers within APG member groups, this proposed expanded authorization is even more concerning and expensive when applied to medications, home health, and rehab/therapy, for which re-evaluation and reauthorization ensures the provider can monitor and re-evaluate the necessity, success and value of the continued authorization." The Association of California Health and Life Insurance Companies (ACLHIC) and the California Association of Health Plans (CAHP) raise concerns that this bill will prolong the timeline for completing services, which could have significant negative impacts on the patient and their health. Additionally, ACLHIC and CAHP believe this bill will invite potential fraud, waste, and abuse and increase health care costs because of duplicative and low-value care. ACLHIC and CAHP have requested the following amendments:
   a) Electronic submissions: Mandate that all authorization requests be submitted electronically by providers. It is essential for providers to embrace electronic authorization for care technology to ensure a more efficient and transparent system for the patients we serve. This will also expedite the turnaround time for approvals.
   b) Clinically complete requests: Require authorizations subject to the proposed timelines to include all necessary information to make an appropriate determination.
   c) Limit the validity period to a maximum of six months. This would strike a better balance between administrative burdens and the need for timely clinical review.

d) Limit the validity period to specific treatments/drugs for certain chronic conditions. If a longer validity period is deemed necessary, it should be narrowly tailored to specific long-term or chronic conditions where a stable treatment plan is anticipated.
e) Exempt certain treatments and drugs. Services and medications with a high risk of inappropriate use, safety concerns (e.g., opioids, benzodiazepines), or those intended for single or limited use should be exempt from a mandated validity period.
f) Expiration and timeline: Specify that the validity timeline is based on the expected course of treatment, or the clinically appropriate timeline associated with the service, and include a provision stating that once the authorized service is utilized, the authorization period ends. These changes to the bill would allow flexibility based on the specific medical needs of the patient and prevent misuse.
g) Clarify the impact of eligibility termination. The bill must explicitly state that if a patient changes coverage, any existing prior authorization expires on the date of the change.
h) Delayed implementation date: A later effective date will allow providers sufficient time to comply with electronic submission requirements.

The California Chamber of Commerce (Chamber) requests to add specificity that all prior authorization requests be submitted electronically to expedite and streamline all prior authorizations and provide clarity as to why the bill is necessary as this policy leads to safety concerns. The Chamber believes there should be no reason it takes a year for a patient to get in for an approved service or access to a prescription. The Local Health Plans of California (LHPC) believe this bill does not account for the many nuances that would necessitate shorter prior authorization durations, in particular as it relates to Medi-Cal where eligibility can change month to month. LHPC writes, "There may be a clinical indication to get treatment within a specified timeframe; for example, an IV antibiotic treatment after discharge from an acute care facility. Placement in a skilled nursing facility is another example of care authorized for a specific duration based on clinical indications. This bill would not allow for plans to place controls in those instances. Additionally, providers would not be prompted to perform necessary reassessments or re-evaluations of treatment plans. For example, a member may only need six weeks of home health services. If a home health authorization was valid for a full year, there would be nothing prompting the provider to reassess the need for continued use of home health at the six-week mark. This could potentially lead to waste and unnecessary or inappropriate utilization."

10) *DMHC Technical Assistance.* DMHC has raised safety and fiscal concerns and suggests the following to alleviate those concerns:

1371.8 (b) A prior authorization for a health care service shall remain valid for a period of at least one year from the date of approval or through the course of prescribed treatment, if less than one year, *and if the following conditions are established in the request for authorization:*

(1) The requested heath care service is not a prescription drug; and,
(2) The requested health care service is for treatment of enrollee's serious chronic condition, as defined by Section 1373.96.

(c) Nothing in this section shall prohibit a plan from conducting utilization management, including but not limited to recission or modification of a prior authorization, in accordance with this chapter.

11) *CDI concerns.* CDI indicates it would be more appropriate to add this bill language into the more updated and comprehensive utilization management statute found at 10123.135. This

section includes the requirement for an insurer to develop policies and procedures for utilization management and submit these to the commissioner [10123.135(b)]. CDI suggests the following:

10123.135 *In conducting utilization management for covered health care services and benefits for diagnosis, prevention, and treatment, a health insurer shall apply the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. If no criteria exists a health insurer must use generally accepted standards of care.* A prior authorization for a health care service shall remain valid for a period of at least one year from the date of approval, *so long as consistent with the applicable criteria and guidelines, or generally accepted standards of care*.

In addition, CDI indicates it would be helpful to clarify whether the responsibility for fulfilling the service authorization remains with the original health insurer if the insured changes insurers during that timeframe or if a new authorization would be required if a change occurs prior to the end of the year. (The latter would be more consistent with the contract between insurer and insured, unless initiation of services has already occurred under the original insurer. In that case, continuity of care provisions may apply). CDI also raises a concern that such a long period of validity may be problematic if health status changes or the time frame allows for undue delay for fulfillment by a health care provider.

12) *Policy comment.* The CHBRP prior authorization survey of plans indicates that there is range of validity periods from four, six, 12, and 24 months but most plans have a validity period of six or more months. As CDI and others mention, for some requests a long validity period may be inappropriate especially if health status changes, or a person delays treatment that would result in a better outcome if received earlier. As written, this bill applies broadly and may need to be narrowed for the best interest of the patient and to ensure valuable health care resources are not authorized when no longer needed.

13) *Amendments.* The Chair requests the following amendments:
(b) A**n approved** prior authorization for a health care service **requested by an in-network provider** shall remain valid for **the period required by the treating provider for the course of the prescribed treatment not to exceed** a period of at least one year from the date of approval, ~~or throughout the course of prescribed treatment~~, if less than one year.

(c) Nothing in this section shall be interpreted to permit a period of validity for a medication that is longer than a validity period established pursuant to state or federal law and regulations.

(d) The one-year validity period established in subdivision (b) would not apply if the enrollee changes plans within the one year period.

SUPPORT AND OPPOSITION:

Support: California Medical Association (sponsor)
ALS Association
American Academy of Pediatrics, California
American Diabetes Association

Association for Clinical Oncology
Association for Creatine Deficiencies
Association of Northern California Oncologists
California Academy of Child and Adolescent Psychiatry
California Academy of Family Physicians
California Academy of Preventive Medicine
California Association of Medical Product Suppliers
California Association of Public Hospitals and Health Systems
California Chapter American College of Cardiology
California Chronic Care Coalition
California Hospital Association
California Kidney Care Alliance
California Orthopedic Association
California Podiatric Medical Association
California Radiological Society
California Retired Teachers Association
California Rheumatology Alliance
California Society of Dermatology & Dermatologic Surgery
California Society of Plastic Surgeons
California State Association of Psychiatrists
Children's Specialty Care Coalition
Coalition of State Rheumatology Organizations
County of Santa Clara
Crohn's and Colitis Foundation
CSN2A1 Foundation
Cure CMD
Fresenius Medical Care North America
Health Access California
Hemophilia Council of California
Medical Oncology Association of Southern California
Mental Health America of California
National Adrenal Disease Foundation
National Infusion Center Association
National PKU Alliance
National Tay-Sachs & Allied Diseases Association
Patients Rising
Physician Association of California
Planned Parenthood Affiliates of California
Providence St. Joseph Health
Rare & Ready Coalition
Rasopathies Network
San Francisco Marin Medical Society
The Akari Foundation
U.S. Pain Foundation
Western Center on Law & Poverty, Inc.
One individual

Oppose: AIDS Healthcare Foundation (unless amended)
America's Health Insurance Plans (unless amended)

America's Physician Groups (unless amended)
Association of California Life & Health Insurance Companies (unless amended)
California Association of Health Plans (unless amended)
California Chamber of Commerce (unless amended)
Local Health Plans of California (unless amended)

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