SENATE COMMITTEE ON APPROPRIATIONS
Senator Sabrina Cervantes, Chair
2025 - 2026 Regular Session

AB 539 (Schiavo) - Health care coverage: prior authorizations

Version: July 2, 2026
Urgency: No
Hearing Date: August 3, 2026

Policy Vote: HEALTH 8 - 0
Mandate: Yes
Consultant: Agnes Lee

Bill Summary: AB 539 would require an approved prior authorization for a health care service requested by an in-network provider to remain valid for the period required by the treating provider for the course of the prescribed treatment, as specified.

Fiscal Impact:

- Unknown ongoing costs in the Medi-Cal managed care program due to potential increases in the utilization of health care services; and unknown ongoing costs, potentially hundreds of thousands, for the Department of Health Care Services (DHCS) for state administration (General Fund and federal funds).

- The Department of Managed Health Care (DMHC) anticipates minor and absorbable costs for state administration.

- The California Department of Insurance (CDI) estimates costs of $92,000 in 2026-27, $180,000 in 2027-28, and $146,000 in 2028-29 and ongoing thereafter for state administration (Insurance Fund).

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, plans, and enrollees or insureds. There are required timelines for health plans and insurers to respond to requests once medical information that is reasonably necessary to make the determination is provided. A health plan or insurer that authorizes a specific type of treatment by a provider cannot rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to the authorization.

Current law requires the DMHC and CDI to publish a list of services that have a prior authorization approval rate of at least 90 percent by the health plan/insurer. By January 1, 2028, health plans and insurers must cease requiring prior authorizations for those services, with exceptions. These provisions sunset on January 1, 2034.

Proposed Law: AB 539 would require an approved prior authorization for a health care service requested by an in-network provider to 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, if less than one year.

-- END --