THIRD READING

Bill No: AB 539
Author: Schiavo (D)
Amended: 7/2/26 in Senate
Vote: 21

SENATE HEALTH COMMITTEE: 8-0, 7/1/26
AYES: Weber Pierson, Caballero, Durazo, Gonzalez, Menjivar, Padilla, Pérez, Smallwood-Cuevas
NO VOTE RECORDED: Valladares, Grove, Rubio

SENATE APPROPRIATIONS COMMITTEE: 5-0, 8/13/26
AYES: Cervantes, Cabaldon, Grayson, Richardson, Wahab
NO VOTE RECORDED: Seyarto, Dahle

ASSEMBLY FLOOR: 64-2, 5/12/25 - See last page for vote

SUBJECT: Health care coverage: prior authorizations

SOURCE: California Chronic Care Coalition
California Medical Association

DIGEST: This bill requires a health plan's or insurer's approved prior authorization 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.

ANALYSIS:

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. [Health and Safety Code (HSC) §1340, et seq., and Insurance

Code (INS) §106, et seq., and Welfare and Institutions Code (WIC) §14000, et seq]

2) 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]

3) 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]

4) 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]

5) 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:

1) Requires an approved prior authorization 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.

2) Indicates that this does not permit a period of validity for a medication that is longer than a validity period established pursuant to state or federal law and regulation.

3) Excludes the applicability of the one-year validity period if the enrollee/insured changes plans or policies within the one-year period.

Comments

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.

Background

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.

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.

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.

Related/Prior Legislation

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.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee, 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 DHCS for state administration (General Fund and federal funds).

DMHC anticipates minor and absorbable costs for state administration.

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).

SUPPORT: (Verified 8/14/26)

California Medical Association (cosource)
California Chronic Care Coalition (cosource)
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 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
Oncology Nursing Society
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

OPPOSITION: (Verified 8/14/26)

AIDS Healthcare Foundation
America's Health Insurance Plans
America's Physician Groups
Association of California Life & Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce
Local Health Plans of California

ARGUMENTS IN 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."

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.

ARGUMENTS IN OPPOSITION: *Oppose unless amended.* The AIDS Healthcare Foundation indicates that a periodic review is helpful in assuring the overall maintenance and, when necessary, reassessment of the treatment plan, and the inconvenience and administrative burden of prior authorization is secondary to the quality of the patient's care. 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 several amendments (see policy committee analysis).

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.

ASSEMBLY FLOOR: 64-2, 5/12/25
AYES: Addis, Aguiar-Curry, Ahrens, Alanis, Alvarez, Arambula, Ávila Farías, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Chen, Connolly, Davies, Elhawary, Fong, Gabriel, Garcia, Gipson, Jeff Gonzalez, Mark González, Haney, Harabedian, Hart, 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, Schiavo, Schultz, Sharp-Collins, Solache, Soria, Valencia, Wallis, Ward, Wicks, Wilson, Zbur, Rivas
NOES: DeMaio, Tangipa
NO VOTE RECORDED: Castillo, Dixon, Ellis, Flora, Gallagher, Hadwick, Hoover, Lackey, Macedo, Patterson, Sanchez, Stefani, Ta

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
8/14/26 11:03:35

****** END ******