CONCURRENCE IN SENATE AMENDMENTS
AB 539 (Schiavo)
As Amended August 21, 2026
Majority vote

SUMMARY

Requires a prior authorization for a health care service to remain valid for a period of at least one year from the date of approval or the period requested by the provider, if less than one year.

Senate Amendments

1) Make clarifying changes to the one-year authorization period.

2) State that this bill does not permit a period of validity for a prescription drug that is longer than the validity period for the prescription drug established pursuant to state or federal law or regulation.

3) Clarify that the one-year authorization period does not apply if the enrollee or insured's coverage is terminated for any reason.

COMMENTS

Utilization review (UR) and utilization management (UM) are processes used by health plans to evaluate and manage the use of health care services. UR can occur prospectively, retrospectively, or concurrently and a plan can approve, modify, delay, or deny in whole or in part a request based on its medical necessity. Prior authorization is a UR technique used by health plans that requires patients to obtain approval of a service or medication before care is provided. Prior authorization is intended to allow plans to evaluate whether care that has been prescribed is medically necessary for purposes of coverage. Prior authorization is one type of UM tool that's used by health plans, along with others such as concurrent review and step therapy, to control costs, limit unnecessary care, and evaluate safety and appropriateness of a service.

Overall impact of prior authorization. In 2023, the California Health Benefits Review Program (CHBRP) published a report to help the Legislature better understand the ways in which prior authorization is used in California. CHBRP noted that prior authorization is an imperfect instrument that's utilized in a myriad of ways. This poses a challenge for policymakers, payers, patients, and providers since prior authorization is generally intended to decrease costs and waste, but it may also contribute to delays in treatment and additional barriers to care. Currently, evidence is limited as to the extent to which health insurance uses prior authorization and its impact on the performance of the health care system, patient access to appropriate care, and the health and financial interests of the general public. Despite the limited evidence, there is clear frustration from both patients and providers regarding prior authorization practices. According to CHBRP, complaints range from the time required to complete the initial authorization request and pursue denials, to delays in care, to a general lack of transparency regarding the process and criteria used to evaluate prior authorization requests. CHBRP further notes that people with disabilities, younger patients, African Americans, and people with lower incomes are more likely to report administrative burdens, including delays in care, due to prior authorization.

Cost impacts. One common reason prior authorization is used is to reduce and control health care spending. Total national health expenditures as a share of the gross domestic product have

increased steadily over time. While the overall increase in health care spending can be largely attributed to increased cost of services and increased utilization, there is another important piece that drives both increased utilization and cost of services. Unnecessary medical care or wasteful health care spending, such as administrative complexities and fraud, are additional drivers. CHBRP cites recent study estimates that between 20% and 25% of all health care spending in the United States is a result of wasteful and unnecessary spending, as well as missed opportunities to provide appropriate care. Health plans and insurers operating in California responding to CHBRP's query on areas of highest fraud and abuse noted that waste and abuse may occur more frequently when low-value or medically unnecessary care is delivered. Behavioral health, particularly applied behavioral analysis, was identified by health plans/insurers as a leading fraud risk.

Access to and utilization of care. Across state-regulated commercial plans and policies, 100% of enrollees are subject to some sort of prior authorization in their benefits. Plans reported that between 5% to 15% of all covered medical services and 16% to 25% of pharmacy services were subject to prior authorization. Evidence regarding whether prior authorization improves patient safety and ensures medically appropriate care is provided is mixed. Across studies reviewed by CHBRP, a sizable share of prior authorization denials were overturned upon appeal, ranging from 40% to 82% of denials being overturned. In instances when prior authorization is initially denied, a patient may need to pay out of pocket for services or may delay treatment due to lack of coverage. Much of the published literature regarding the impact of prior authorization focuses on prescription medications, finding that prior authorization requirements result in lower utilization of medications and decreases medication adherence.

Administrative burden. According to the American Medical Association (AMA), prior authorization leads to substantial administrative burdens for physicians, taking time away from direct patient care while costing practices money. AMA's 2024 physician survey on prior authorization found that on average, physicians and their staff spend 13 hours each week completing prior authorizations and 40% of physicians have staff who work exclusively on prior authorization. One in three physicians reported that prior authorization requests are often or always denied and 93% reported that prior authorization leads to care delays for their patients. 89% of physicians reported that prior authorization somewhat or significantly increases physician burnout.

Antiquated systems. According to CHBRP, many aspects of prior authorization workflow still rely on the resource-intense use of paper forms, telephone calls, facsimile communications, and portal access. Contributing to the resource intense process is the type of technology (or lack of) used by providers and plans. Although many providers have transitioned to electronic health records (EHRs), for some providers, the cost to do so is prohibitive. Additionally, not all EHRs easily communicate with other EHRs, thereby still requiring a person to manually transfer information from one system to another. In light of these challenges, there are ongoing state and federal efforts to improve data sharing across health care entities to improve processes like prior authorization.

In January of 2024, the federal Centers for Medicare & Medicaid Services (CMS) released the CMS Interoperability and Prior Authorization Final Rule. This rule emphasizes the need to improve health information exchange to achieve appropriate and necessary access to health records for patients, healthcare providers, and payers. The rule also focuses on efforts to improve prior authorization processes through policies and technology, to help ensure that patients remain

at the center of their own care. Impacted payers are required to implement certain provisions by January 1, 2026 and meet remaining requirements by January 1, 2027.

AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, establishes the California Health and Human Services (CalHHS) Data Exchange Framework (DxF) and required CalHHS to finalize a data sharing agreement by July 1, 2022. The DxF defines the entities that will be subject to these new data exchange rules and sets forth a common set of terms, conditions, and obligations to support secure, real-time access to and exchange of health and social services information, in compliance with applicable federal, state, and local laws, regulations, and policies. DxF is not a new technology or centralized data repository, it is an agreement across health and human services systems and providers to share information safely. Many health care entities were required to participate beginning January 2024. Remaining entities are required to participate by January 2026.

According to the Author
While prior authorization delays and denials continue to climb, so too do the harms to patients. What's worse is insurance companies are looking to artificial intelligence to speed up the denial process while suggesting it leads to positive patient experiences, and increased safety and affordability. The data is clear, insurers are using prior authorization to deny care and boost profits. This bill reduces health care administrative costs and speeds up patient access to care by extending the duration of an approved prior authorization by a health plan to one year. 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.

Arguments in Support
The California Medical Association (CMA), sponsor of this bill, states that many conditions require ongoing treatment plans that benefit from strict adherence and recurring prior authorization requirements can lead to disruptions in care delivery and threaten a patient's health. CMA shares that according to an AMA survey, 88% of physicians reported that prior authorizations interfere with continuity of care for patients and 78% of physicians reported that prior authorization can lead to treatment abandonment, inevitably leading patients to seek more expensive forms of care, including emergency room visits and even unexpected hospitalization. CMA continues that the current standard for an approved prior authorization request is about 60 to 90 days, which 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. CMA argues that these arbitrary delays disrupt a patient's treatment plan and interfere with continuity of care. CMA concludes that by extending the duration of approved prior authorizations to one year, this bill reduces inefficient administrative burdens on providers, addresses redundancies in the current approval process, and ensures that patients have access to the care they need without delays or interference from health plans.

Arguments in Opposition
The Association of California Health and Life Insurance Companies (ACLHIC) and the California Association of Health Plans (CAHP) are opposed to this bill, stating that a blanket

one-year authorization period would undermine important safeguards that help ensure patient safety, care quality, and responsible use of health care resources. Additionally, ACLHIC and CAHP believe this bill will lead to higher costs from duplicative or low-value care, reduce follow-up and reassessment, and increase the risk of unnecessary or inappropriate services being delivered.

Various groups are opposed to this bill unless it is 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. APG argues that 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. APG continues that authorizations that are not "unit specific," and 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. APG believes 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 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 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.

FISCAL COMMENTS

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 the Department of Health Care Services for state administration (General Fund and federal funds). The Department of Managed Health Care anticipates minor and absorbable costs for state administration. The California Department of Insurance 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).

VOTES:

ASM HEALTH: 12-0-4
YES: Bonta, Addis, Aguiar-Curry, Rogers, Carrillo, Mark González, Krell, Patel, Celeste Rodriguez, Schiavo, Sharp-Collins, Stefani
ABS, ABST OR NV: Chen, Flora, Patterson, Sanchez

ASM APPROPRIATIONS: 11-0-4
YES: Wicks, Arambula, Calderon, Caloza, Elhawary, Fong, Mark González, Hart, Pacheco, Pellerin, Solache
ABS, ABST OR NV: Sanchez, Dixon, Ta, Tangipa

ASSEMBLY FLOOR: 64-2-13
YES: 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
NO: DeMaio, Tangipa
ABS, ABST OR NV: Castillo, Dixon, Ellis, Flora, Gallagher, Hadwick, Hoover, Lackey, Macedo, Patterson, Sanchez, Stefani, Ta

UPDATED

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