GOVERNOR'S VETO
AB 574 (Mark González)
As Enrolled September 5, 2025
2/3 vote

SUMMARY

Prohibits a health care service plan (health plan) or health insurer that provides coverage for physical therapy (PT) from requiring prior authorization (PA) for the initial 12 treatment visits for a new condition PT. Permits a health plan and health insurer, for a recurring condition, to impose PA if the individual seeks care within 180 days of their last PT intervention for that condition. Exempts Medi-Cal managed care plans from the requirements of this bill.

Senate Amendments
Change the requirement in the Assembly-approved version prohibiting PA for a "new episode of care" to a "new condition" and add the above described language permitting PA for a recurring condition if the individual seeks care within 180 days of their last PT intervention for that condition.

Governor's Veto Message
This bill would prohibit health plans or insurers from requiring prior authorization (PA) for the initial 12 physical therapy visits for a new condition.

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.

COMMENTS

Utilization management (UM) and utilization review (UR) 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. PA is a UR technique used by health plans that requires patients to obtain approval of a service or medication before care is provided. PA is intended to allow plans to evaluate whether care that has been prescribed is medically necessary for purposes of coverage. PA 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.

In 2023, the California Health Benefits Review Program (CHBRP) published a report to help the Legislature better understand the ways in which PA is used in California. CHBRP noted that PA is an imperfect instrument that is utilized in a myriad of ways. This poses a challenge for policymakers, payers, patients, and providers since PA 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 PA 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 PA 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 PA 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 PA.

One common reason PA 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.

Across state-regulated commercial health plans and policies, 100% of enrollees are subject to some sort of PA 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 PA. Evidence regarding whether PA improves patient safety and ensures medically appropriate care is provided is mixed. Across studies reviewed by CHBRP, a sizable share of PA denials were overturned upon appeal, ranging from 40% to 82% of denials being overturned. In instances when PA 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 PA focuses on prescription medications, finding that PA requirements result in lower utilization of medications and decreases medication adherence.

According to CHBRP, many aspects of PA 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 such as PA.

According to the Author
Barriers to medically necessary PT present significant challenges for patients seeking to recover. The author states that such barriers can negatively impact patient outcomes and hinder the effective delivery of health care. The author shares an example that patients in chronic pain may be forced to rely on painkillers while waiting for authorization to proceed with prescribed PT. The author continues that some insurers base prior authorization and UR decisions on provider profiles or computer algorithms rather than the patient's specific medical needs. The author argues that currently there is no practical accountability for insurers or third-party UM companies when a denied or delayed PT treatment results in negative patient outcomes. The author continues that these delays and denials frequently lead to reductions in the frequency and duration of prescribed treatments. The author concludes that the appeals process is often lengthy, making it untimely for patients in need of care.

Arguments in Support
The California Physical Therapy Association (CPTA), sponsor of this bill, states that an increasing number of health plans, insurers and third-party administrators are using computer algorithms and automated systems for decision-making over the care their beneficiaries may receive. CPTA continues that such practices often have no basis in research and are inconsistent with community standards of care for the symptoms and diagnoses presented by patients and seem more directed toward limiting the number of visits patients may obtain. CPTA states that these practices create barriers and challenges for patients by delaying access to medically necessary care and increasing the administrative burden required to navigate prior authorization, unnecessary reviews, and manage appeals. CPTA notes that research studies indicate that delays in treatment can result in poorer outcomes for patients. CPTA cites a recent study of patients with neck pain which showed that delays in access to PT increased overall health care costs, as well as reliance upon opioids as a treatment alternative. CPTA shared another study of patients with low back pain which showed that early referral to PT resulted in lower utilization and overall costs. CPTA continues that the 12 PT visits defined in this bill are consistent with research and studies indicating that most conditions resolve within this treatment range. CPTA states that more serious conditions necessitate further treatment, and it is logical for a plan or insurer in those instances to monitor the development of such conditions more closely in determining medical necessity for ongoing care. Doing so at earlier intervals, according to CPTA, only results in unnecessary administrative burdens on providers and delays in patient treatment intervals.

Arguments in Opposition
The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) oppose this bill, stating that PA protocols promote safe, effective, and affordable care for plan enrollees while ensuring that patients receive the right care, at the right time, from the right provider. CAHP and ACLHIC continue that this bill would undermine this process by allowing PT providers to provide their patients with up to 12 visits without any oversight or review by the patient's health plan or primary care physician. CAHP and ACLHIC argue that in essence, this policy change would grant unfettered access to this particular service, restricting the health plan or insurer's ability to determine if the treatments and visits are medically necessary or follow the standard clinical guidelines. CAHP and ACLHIC continue that without this assessment, they are concerned that patients may receive unnecessary

and/or inappropriate treatments or therapies that are not tailored to their specific needs. CAHP and ACLHIC conclude that they believe this bill will unnecessarily increase administrative costs, decrease affordability, and potentially lead to unneeded and unnecessary care delivery for their members.

FISCAL COMMENTS

According to the Senate Appropriations Committee, pursuant to Senate Rule 28.8, negligible state costs.

VOTES

ASM HEALTH: 16-0-0
YES: Bonta, Chen, Addis, Aguiar-Curry, Rogers, Carrillo, Flora, Mark González, Krell, Patel, Patterson, Celeste Rodriguez, Sanchez, Schiavo, Sharp-Collins, Stefani

ASM APPROPRIATIONS: 14-0-1
YES: Wicks, Sanchez, Arambula, Calderon, Caloza, Dixon, Elhawary, Fong, Mark González, Hart, Pacheco, Solache, Ta, Alanis
ABS, ABST OR NV: Pellerin

ASSEMBLY FLOOR: 73-1-5
YES: Addis, Aguiar-Curry, Ahrens, Alanis, Alvarez, Arambula, Ávila Farías, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Castillo, Chen, Connolly, Davies, Dixon, Elhawary, Ellis, Flora, Fong, Gallagher, Garcia, Gipson, Jeff Gonzalez, Mark González, Hadwick, Haney, Harabedian, Hart, Hoover, Irwin, Jackson, Kalra, Krell, Lackey, Lee, Lowenthal, Macedo, McKinnor, Muratsuchi, Nguyen, Ortega, Pacheco, Papan, Patel, Pellerin, Quirk-Silva, Ramos, Ransom, Celeste Rodriguez, Michelle Rodriguez, Rogers, Blanca Rubio, Sanchez, Schiavo, Schultz, Sharp-Collins, Solache, Soria, Ta, Valencia, Wallis, Ward, Wicks, Wilson, Zbur, Rivas
NO: DeMaio
ABS, ABST OR NV: Gabriel, Patterson, Petrie-Norris, Stefani, Tangipa

SENATE FLOOR: 39-0-1
YES: Allen, Alvarado-Gil, Archuleta, Arreguín, Ashby, Becker, Blakespear, Cabaldon, Caballero, Cervantes, Choi, Cortese, Dahle, Durazo, Gonzalez, Grayson, Grove, Hurtado, Jones, Laird, Limón, McGuire, McNerney, Menjivar, Niello, Ochoa Bogh, Padilla, Pérez, Reyes, Richardson, Rubio, Seyarto, Smallwood-Cuevas, Stern, Strickland, Umberg, Valladares, Wahab, Wiener
ABS, ABST OR NV: Weber Pierson

ASSEMBLY FLOOR: 76-1-2
YES: Addis, Aguiar-Curry, Ahrens, Alanis, Alvarez, Arambula, Ávila Farías, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Castillo, Chen, Connolly, Davies, Dixon, Elhawary, Ellis, Flora, Fong, Gallagher, Garcia, Gipson, Jeff Gonzalez, Mark González, Hadwick, Haney, Harabedian, Hart, Hoover, Irwin, Jackson, Kalra, Krell, Lackey, Lee, Lowenthal, Macedo, McKinnor, Muratsuchi, Nguyen, Ortega, Pacheco, Papan, Patel, Patterson, Pellerin, Petrie-Norris, Quirk-Silva, Ramos, Ransom, Celeste Rodriguez, Michelle Rodriguez, Rogers, Blanca Rubio, Sanchez, Schiavo, Schultz, Sharp-Collins, Solache, Soria, Stefani, Ta, Valencia, Wallis, Ward, Wicks, Wilson, Zbur, Rivas
NO: DeMaio
ABS, ABST OR NV: Gabriel, Tangipa

UPDATED

VERSION: September 5, 2025

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